period 2, respectively. Surgery was the mainstay of treatment in both periods (p=0.356). The adoption of minimally invasive surgery was consistent in the two study periods (p=0.976). Before COVID-19 pandemic, 1,848 (72.8%), 666 (26.3%), and 25 (0.9%) patients had minimally invasive, open and vaginal surgery, respectively. During the COVID-19 pandemic, 1,663 (72.8%), 582 (25.5%), and 41 (1.7%) patients had minimally invasive, open, and vaginal surgery, respectively. Nodal assessment was omitted in 689 (27.3%) and 484 (21.2%) patients treated in period 1 and 2, respectively (p<0.001). While, the prevalence of patients undergoing sentinel node mapping (with or without backup lymphadenectomy) has increased during the COVID-19 pandemic (46.7% in period 1 vs. 52.8% in period 2; p<0.001). Overall, 1,280 (50.4%) and 1,021 (44.7%) patients had no adjuvant therapy in period 1 and 2, respectively (p<0.001). Adjuvant therapy (in particular chemotherapy) use has increased during COVID-19 pandemic (p<0.001).

Conclusion Our data suggest that the COVID-19 pandemic had a significant impact on the characteristics and patterns of care of EC patients. These findings highlight the need to implement healthcare services during the pandemic.

### Abstracts

**Characterization of Adverse Reactions in Patients with Advanced Endometrial Cancer (aEC) Receiving Lenvatinib + Pembrolizumab (Study 309/KEYNOTE-775)**

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**Methodology** In Study 309/KEYNOTE-775, patients were randomized to lenvatinib 20 mg QD PO + pembrolizumab 200 mg IV Q3W (n=411) or TPC (n=416; doxorubicin 60 mg/m2 IV Q3W or paclitaxel 80 mg/m2 IV QW, 3 weeks on/1 week off). Herein, characterization of key ARs is based on incidence and known association with lenvatinib+pembrolizumab, and interventions for ARs in aEC patients. Key ARs are grouped by preferred terms per FDA definitions for ARs in patients with endometrial carcinoma from the US prescribing information; ARs include hypertension, musculoskeletal pain, fatigue, nausea, diarrhea, decreased appetite, stomatitis, vomiting, hypothyroidism, palmar-plantar erythrodysesthesia (PPES), and decreased weight.

**Result(s)** Median times (weeks) to first onset of key ARs [any grade] were: hypertension (2.1), fatigue (2.3), musculoskeletal pain (3.2), nausea (4.7), decreased appetite (4.9), stomatitis (4.9), vomiting (7.6), diarrhea (7.9), hypothyroidism (8.9), PPES (9.6), and decreased weight (10.7). Among ARs described, those that led to withdrawal of lenvatinib included decreased appetite (2%), fatigue (2%), hypertension (2%), diarrhea (1%), musculoskeletal pain (1%), vomiting (1%), and decreased weight (1%); only decreased appetite (1%) and diarrhea (1%) led to withdrawal of pembrolizumab. Hypertension most frequently led to lenvatinib dose reduction (18%); diarrhea and hypertension most frequently led to dose interruption of lenvatinib (11%) as last action taken with lenvatinib. Diarrhea most frequently led to pembrolizumab interruption (8%). Change in sum of target lesion diameters over time, exposure-adjusted ARs, and AR management strategies will be reported.

**Conclusion** In general, ARs due to lenvatinib+pembrolizumab were as expected and often occurred within 3 months of treatment initiation. As will be presented, clinicians play a critical role in prompt identification and AR-directed management of patients with aEC; such management may potentially reduce treatment interruption(s) and/or lenvatinib dose reduction.

**Increased Survival in Non-Endometrioid Endometrial Cancer after Introduction of Swedish National Guidelines**

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**Introduction/Background** The first Swedish national guidelines for endometrial cancer (NGEC) recommended adequate staging with pelvic and paraaortic lymphadenectomy for patients with high-risk disease, including non-endometrioid endometrial cancer (EC). The recommended adjuvant oncological treatment protocol was chemotherapy to all non-endometriod EC and radiotherapy only for those with stage IIIIC. Before the NGEC, the stipulated surgery was solely hysterectomy and bilateral salpingectomy followed by adjuvant chemo-and radiotherapy to all non-endometrioid ECs. The aim of this study was to investigate the outcome in survival and recurrence of this shift in treatment strategy.
Methodology All women with non-endometrioid EC, defined as serous, clearcell, carcinosarcoma and undifferentiated, were identified through the Swedish Quality Registry for Gynecological Cancer in the western Sweden health care region (1.9 million inhabitants) between 2010-2017 where the NGEC were implemented in 2013. Recurrences were identified including location and relative survival (RS), overall survival (OS) and disease-free survival (DFS) were analysed. The cohort was divided according to treatment protocol before and after NGEC implementation and compared.

Results In total 401 patients were identified and after exclusion for neoadjuvant chemotherapy, palliative treatment and preoperative stage IV, the final study cohort consisted of 261 patients who underwent primary surgical treatment with no evidence of disease at start of follow-up. The cohort before NGEC implementation was 103 patients and 158 patients after. The total recurrence rate was 26% and 6% were local only to vagina. The RS rate for all patients diagnosed with a recurrence was 14.1% (95%CI 7.7-26.0) compared to 92.8% (95%CI 85.7-100.5) with no recurrence. Both the RS and OS rates were significantly improved after implementation of the NGEC. The 5-year RS was 58.8% (95%CI 48.6-71.0) for treatment in the first period and 79.8% (95%CI 71.0-89.8) for the second period (p=0.005). The 5-year OS was 54.3% (95%CI 43.5-64.9) and 68.7% (95%CI 61.3-77.0) respectively (p=0.011).

Conclusion In this population-based study of a complete cohort of non-endometrioid ECs we conclude that adequate lymphnode staging followed by adjuvant chemotherapy to all patients and radiotherapy only to those with positive nodes is associated with superior survival compared to chemo- and radiotherapy to all regardless of lymphnode status.

185 ENGOT-en11/GOG-3053/KEYNOTE-B21: PHASE 3 STUDY OF PEMBROLIZUMAB OR PLACEBO + ADJUVANT CHEMOTHERAPY ± RADIOTHERAPY FOR HIGH-RISK ENDOMETRIAL CANCER

Introduction/Background Pembrolizumab, an anti-PD-1 antibody, has demonstrated activity in patients with previously treated mismatch repair (MMR) deficient (dMMR; 57.1% objective response rate [ORR] as monotherapy and 63.6% ORR as combination therapy with lenvatinib) and MMR proficient (pMMR; 36.2% ORR as combination therapy with lenvatinib) endometrial cancer. ENGOT-en11/GOG-3053/KEYNOTE-B21 (NCT04634877) is a phase 3, randomized, double-blind study of pembrolizumab or placebo in combination with adjuvant chemotherapy with/without radiotherapy in patients with endometrial cancer.

Methodology Eligible patients are ≥18 years old with newly diagnosed, high-risk (stage I/II non-endometrioid or with p53 abnormality and any histology, stage III/IVA), previously untreated endometrial cancer following surgery with curative intent with no evidence of disease post-operatively. Approximately 990 patients are randomized to receive pembrolizumab 200 mg or placebo every 3 weeks (Q3W) for 6 cycles plus chemotherapy (carboplatin area under the curve [AUC] 5/6 plus paclitaxel 175 mg/m² Q3W or carboplatin AUC 2/2.7 plus paclitaxel 60 mg/m² QW) in stage I. Patients receive pembrolizumab 400 mg or placebo Q6W for 6 cycles in stage 2. Radiotherapy (external beam radiotherapy [EBRT] and/or brachytherapy) ± radiosensitizing cisplatin 50 mg/m² (days 1 and 29) may be administered after completion of chemotherapy. Randomization is stratified by MMR status (pMMR vs dMMR) and, within pMMR, by planned radiation therapy (cisplatin-EBRT vs EBRT vs no EBRT), histology (endometrioid vs non-endometrioid), and International Federation of Gynecology and Obstetrics surgical stage (I/II vs III/IVA). Dual primary endpoints are disease-free survival (DFS; per investigator assessment) and overall survival (OS). Secondary endpoints include DFS (per blinded independent central review), DFS (per investigator assessment) and OS by biomarker status (PD-L1 and tumor mutational burden), safety (per National Cancer Institute Common Terminology Criteria for Adverse Events version 5.0), and quality of life (per European Organization for Research and Treatment of