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 not 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.

145

CHARACTERIZATION OF ADVERSE REACTIONS IN PATIENTS WITH ADVANCED ENDOMETRIAL CANCER (AEC) RECEIVING LENVATINIB + PEMBROLIZUMAB (STUDY 309/KEYNOTE-775)

N Colombo, ^{3D} Lorusso, ^{4AD} Santin, ^{5YM} Kim, ^{6AC} Herráez, ^{7K} Yonemori, ^{8K} Fujiwara, ^{9E} Colomba, ^{10DS} Miller, ^{11S} Pignata, ^{12BJ} Monk, ^{13EM} Guerra, ^{14R} Kristeleit, ^{15M} Orlando, ^{16UA} Sanli, ^{17L} Dutta, ^{18R} Orlowski, ^{17M} Ren, ^{19V} Makker. ¹Gynecologic Oncology Program, University of Milan-Bicocca, European Institute of Oncology IRCCS, Milan, Italy; ²Gynecologic Oncology Program, University of Milan-Bicocca, European Institute of Oncology IRCCS, Milan, Italy; ³Division of Gynecologic Oncology, Fondazione Policlinico Universitario Agostino Gemelli IRCCS and Catholic University of Sacred Heart, Rome, Italy; ⁴Department of Obstetrics, Gynecology and Reproductive Sciences, Yale University School of Medicine, New Haven, USA; ⁵Department of Obstetrics and Gynecology, Asan Medical Center, University of Ulsan, Seoul, Korea, Rep. of South; ⁶Department of Medical Oncology, San Carlos University Teaching Hospital, Madrid, Spain; ⁷Department of Breast and Medical Oncology, National Cancer Center Hospital: Kokuritsu Gan Kenkyu Center Chuo Byoin, Tokyo, Japan; ⁸Department of Gynecologic Oncology, Saitama Medical University International Medical Center, Hidaka, Japan; ⁹Department of Cancer Medicine, Gustave Roussy Cancerology Institute, Villejuif, GINECO group, France; ¹⁰Division of Gynecologic Oncology, University of Texas Southwestern Medical Center, Dallas, USA; ¹¹Department of Urology and Gynecology, Istituto Nazionale Tumori IRCCS-Fondazione G. Pascale, Naples, Italy; ¹²Arizona Oncology (US Oncology Network), University of Arizona, Creighton University, Phoenix, USA; ¹³Servicio de Oncología Médica, Hospital Universitario Ramón y Cajal, Madrid, Spain; ¹⁴Department of Oncology, Guy's and St Thomas' NHS Foundation Trust, London, UK; ¹⁵Oncología Clínica, Instituto Alexander Fleming, Buenos Aires, Argentina; ¹⁶Department of Medical Oncology, Ege University, Izmir, Turkey; ¹⁷Clinical Research, Eisai Inc., Woodcliff Lake, USA; ¹⁸Late Stage Clinical Development, Merck and Co., Inc., Kenilworth, USA; ¹⁹Department of Medicine, Memorial Sloan Kettering Cancer Center; Weill Cornell Medical Center, New York, USA

10.1136/ijgc-2021-ESGO.120

Introduction/Background* In Study 309/KEYNOTE-775, lenvatinib+pembrolizumab showed significant and clinically meaningful improvements in OS, PFS, and ORR versus treatment of physician's choice (TPC) in aEC patients following prior platinum-based therapy. Safety considerations are also important in EC. Herein, we characterize common adverse reactions (ARs) in patients with aEC in Study 309/KEYNOTE-775 and their respective management strategies. Additionally, the clinician's role in proactively managing ARs will be highlighted.

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% each) 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.

176

INCREASED SURVIVAL IN NON-ENDOMETRIOID ENDOMETRIAL CANCER AFTER INTRODUCTION OF SWEDISH NATIONAL GUIDELINES

^{1,2A} Åkesson*, ^{3C} Adok, ^{1,2P} Dahm-Kähler. ¹Inst of Clinical Sciences, Sahlgrenska Academy at the University of Gothenburg, Obstetrics and gynecology, Göteborg, Sweden; ²Sahlgrenska University Hospital, Gynecology, Göteborg, Sweden; ³Regionalt cancercentrum väst, Göteborg, Sweden

10.1136/ijgc-2021-ESGO.121

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-endometrioid EC and radiotherapy only for those with stage IIIC. 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.

Result(s)* 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 localized 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 45.5-64.9) and 68.7% (95%CI 61.3-77.0) respectively ($p=0.011$).

Conclusion* In this populationbased 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.

183 SENTINEL NODE, IN ENDOMETRIAL CANCER. OUR RESULTS

F Fargas Fabregas*, R Fàbregas. Barcelona, Barcelona, Spain

10.1136/ijgc-2021-ESGO.122

Introduction/Background* the goal is the detection of the sentinel node in initial endometrial cancer, in our center; and compare the different techniques (blue, technetium and indocyanine green)

Methodology All patients diagnosed with an early stage of endometrial cancer, who are performed sentinel node technique

The objective is to assess the detection capability of the sentinel node based on the tracer used, and the validity of this technique in low-risk tumors, in our center

Result(s)* we have recruited a total of 119 patients. Sentinel node detection results vary depending on the plotter used. the best results were those of the combination of blue with indocyanine green (91%), as already described in the literature.

The number of positive nodes in this subgroup of patients (low risk) was very low.

Conclusion* Indocyanine green is the best tracer, for sentinel node detection.

Although the number of positive nodes, in these patients, is very low, the low morbidity that presents the technique, we would not recommend the NO relaxation of this technique, because we can perform a more specific analysis of these nodes.

185

ENGOT-EN11/GOG-3053/KEYNOTE-B21: PHASE 3 STUDY OF PEMBROLIZUMAB OR PLACEBO + ADJUVANT CHEMOTHERAPY ± RADIOTHERAPY FOR HIGH-RISK ENDOMETRIAL CANCER

¹T Van Gorp*, ²MR Mirza, ³A Lortholary, ⁴IB Vergote, ⁵D Cibula, ⁶A Walther, ⁷A Savarese, ⁸MP Barretina-Ginesta, ⁹FU Ortac, ¹⁰C Papadimitriou, ¹¹L Bodnar, ¹²CH Lai, ¹³K Hasegawa, ¹⁴X Xie, ¹⁵EL Barber, ¹⁶R Coleman, ¹⁷J Lichfield, ¹⁸A Grandhi, ¹⁹B Slomovitz. ¹UZ Leuven, Leuven, Belgium; ²NSGO-CTU and Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; ³Centre Catherine de Sienne, Hôpital Privé du Confluent, Nantes, France; ⁴BGOG and University Hospitals Leuven, Leuven Cancer Institute, Leuven, Belgium; ⁵Department of Obstetrics and Gynecology, General Faculty Hospital in Prague, First Faculty of Medicine, Charles University, Prague, Czech Republic; ⁶Bristol Cancer Institute, University Hospitals Bristol, Bristol, UK; ⁷Istituto Nazionale Tumori Regina Elena, Rome, Italy; ⁸Catalan Institute of Oncology and Girona Biomedical Research Institute, Medical School University of Girona, Girona, Spain; ⁹Ankara University School of Medicine, Ankara, Turkey; ¹⁰Aretaio University Hospital, National and Kapodistrian University of Athens, Athens, Greece; ¹¹Department of Oncology and Immunooncology, Warmian-Masurian Cancer Center of the Ministry of the Interior and Administration's Hospital, Olsztyn, Poland; ¹²TGOG and Department of Gynecology and Obstetrics, Chang Gung Memorial Hospital, Linkou Branch, Taoyuan, Taiwan; ¹³Department of Gynecologic Oncology, Saitama Medical University, Hidaka, Saitama Prefecture, Japan; ¹⁴Women's Hospital, School of Medicine, Zhejiang University, Hangzhou, China; ¹⁵Northwestern University Feinberg School of Medicine, Chicago, IL, USA; ¹⁶US Oncology Research, The Woodlands, TX, USA; ¹⁷MSD, UK; ¹⁸Merck and Co., Inc., Kenilworth, NJ, USA; ¹⁹Broward Health, Fort Lauderdale, FL, USA

10.1136/ijgc-2021-ESGO.123

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 1. 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