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 postive 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 Fábregas. *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 indocianin 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 indocian green (91%), as already described in the literature.

The number of positive nodes in this subgroup of patients (low risk) was very low.
Conclusion* Indocianin 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 tecnique, we would not recommend the NO relaization 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

[1]T Van Gorp*, [2]MR Mirza, [3]A Lortholary, [4]IB Vergote, [5]D Cibula, [6]A Walther, [7]A Savarese, [8]MP Barretina-Ginesta, [9]FU Ortac, [10]C Papadimitriou, [11]L Bodnar, [12]CH Lai, [13]K Hasegawa, [14]X Xie, [15]EL Barber, [16]R Coleman, [17]J Lichfield, [18]A Grandhi, [19]B Slomovitz. *[1]UZ Leuven, Leuven, Belgium; [2]NSGO-CTU and Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; [3]Centre Catherine de Sienne, Hôpital Privé du Confluent, Nantes, France; [4]BGOG and University Hospitals Leuven, Leuven Cancer Institute, Leuven, Belgium; [5]Department of Obstetrics and Gynecology, General Faculty Hospital in Prague, First Faculty of Medicine, Charles University, Prague, Czech Republic; [6]Bristol Cancer Institute, University Hospitals Bristol, Bristol, UK; [7]Istituto Nazionale Tumori Regina Elena, Rome, Italy; [8]Catalan Institute of Oncology and Girona Biomedical Research Institute, Medical School University of Girona, Girona, Spain; [9]Ankara University School of Medicine, Ankara, Turkey; [10]Aretaieio University Hospital, National and Kapodistrian University of Athens, Athens, Greece; [11]Department of Oncology and Immunooncology, Warmian-Masurian Cancer Center of the Ministry of the Interior and Administration's Hospital, Olsztyn, Poland; [12]TGOG and Department of Gynecology and Obstetrics, Chang Gung Memorial Hospital, Linkou Branch, Taoyuan, Taiwan; [13]Department of Gynecologic Oncology, Saitama Medical University, Hidaka, Saitama Prefecture, Japan; [14]Women's Hospital, School of Medicine, Zhejiang University, Hangzhou, China; [15]Northwestern University Feinberg School of Medicine, Chicago, IL, USA; [16]US Oncology Research, The Woodlands, TX, USA; [17]MSD, UK; [18]Merck and Co., Inc., Kenilworth, NJ, USA; [19]Broward 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/m^2 Q3W or carboplatin AUC 2/2.7 plus paclitaxel 60 mg/m^2 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/m^2 (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