Methodology GARNET is a multicentre, open-label, single-arm study. Here we report on 2 independent expansion cohorts of patients with recurrent or advanced EC that progressed on or after a platinum-based chemotherapy regimen. Patients were assigned to cohort A1 (dMMR/MSI-H EC) or cohort A2 (mismatch repair-deficient/microsatellite-stable [MMRp/MSS] EC) based on immunohistochemistry testing. Patients received 500 mg of dostarlimab intravenously once every 3 weeks for 4 cycles, then 1000 mg once every 6 weeks until disease progression, discontinuation or withdrawal. The primary endpoints are objective response rate (ORR) and duration of response by blinded independent central review using RECIST version 1.1. 

Result(s)* In total, 129 dMMR/MSI-H and 161 MMRp/MSS patients were enrolled and dosed. Of these, 108 dMMR/MSI-H and 156 MMRp/MSS patients who had measurable disease at baseline and ≥6 months of follow-up were included for efficacy analyses. ORR and disease control rate (DCR) for dMMR/MSI-H EC was 43.5% and 55.6%, respectively; ORR and DCR for MMRp/MSS EC was 14.1% and 34.6%, respectively (table 1). Overall, 16 patients (5.5%) discontinued treatment due to a treatment-related adverse event (5 dMMR/MSI-H, 11 MMRp/MSS). Table 2 shows safety by cohort and overall. No deaths were attributed to dostarlimab. 

Conclusion* Dostarlimab demonstrated durable antitumour activity in both dMMR/MSI-H and MMRp/MSS advanced/recurrent EC. dMMR/MSI-H status was associated with a higher response rate. DCR achieved in MMRp/MSS EC was noteworthy, considering MMRp/MSS tumours are historically associated with a poor prognosis. The dostarlimab safety profile was manageable. 

Clinical trial registration NCT02715284
of post-operative adjuvant therapy. Benefits of a laparoscopic approach are shorter hospitalisations, lower blood loss, faster postoperative recovery.

**Methodology** Safe, step by step method of total hysterectomy and bilateral salpingo-oophorectomy with pelvic and para-aortic lymph node dissection. Dissection and visualisation of anatomical landmarks as safest, most reliable method of performing laparoscopic surgery.

**Result(s)** 54 year old woman with endometrial cancer G2 FIGO IB was qualified for laparoscopic surgery. Total hysterectomy and bilateral salpingo-oophorectomy with pelvic and para-aortic lymph node was performed. Patient was discharged from hospital after 3 days in good condition, with no significant blood loss or other complications. Final histopathology result: TIBN0M0, 68 lymph nodes from paraaortic and pelvic lymphadenectomy. LVI negative

**Conclusion** We are convinced that our approach to laparoscopic total hysterectomy with lymphadenectomy is safe and repetitive. By dissection and visualisation key anatomical landmarks we can avoid complications such as bleeding, damage to the ureters, nerves and vessels.

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**MINI-INVASIVE (MIS) VS. OPEN SURGERY (OSU): PROGNOSTIC IMPACT OF THE SURGICAL APPROACH FOR ENDOMETRIAL CANCER. A FRANCOGYN COLLABORATIVE GROUP SURVEY**


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**Introduction/Background** Thanks to technical improvements, total non-conservative hysterectomy evolved towards MIS as the standard approach for early-stage endometrial cancer (EC). MIS has recently been called into question for cervical cancer treatment due to its negative prognosis impact. In this context, we carry out a study comparing OSu vs. MIS with Disease Free Survival (DFS) as primary endpoint.

**Methodology** Retrospective study, within the French collaborative group FRANCOGYN from 1999 to 2020. All patients aged over 18 who achieved hysterectomy for endometrial cancer were included whatever the pathological subtype. Secondary endpoints were: Overall Survival (OS) and subgroup analysis according to FIGO stage, ESMO-ESGO-ESTRO Consensus Conference risk-group 2015 (E3CC), pathological subtypes, lymph node metastasis and lympho-vascular space invasion (LVS1). To assess primary endpoint, we use inverse probability of treatment weighting (IPTW) based on propensity score to construct two weighted cohort.

A Cox proportional-hazard model standard multivariate analysis was used for subgroup analysis.

**Result(s)** Nine hundred and forty-five (945) patients were included, 380 (40.2%) received OS and 565 (59.8%) received MIS. The median follow-up was 34.2 months (29.1 SD). The study other measured characteristics were strongly unbalanced in disfavor of the OSu group for pathological subtype (p<0.001), FIGO stage (p<0.001) and ESMO-ESGO-ESTRO risk group (p<0.001). Hence, after propensity score matching, Cox proportional-hazards model displays a trend of worse DFS in the OSu vs. MIS group (HR = 0.72, 95% CI 0.52-1.00 p = 0.054) and significantly altered OS in the OSu vs. MIS group (HR = 0.52, 95% CI 0.35-0.78 p = 0.0018).

DFS was significantly impaired by the following characteristics: Age, BMI, histological grade 3 (HR=2.04, 95% CI [1.15-2.04] p = 0.015), E3CC High Risk Group (HR = 2.62, 95% CI [1.03-6.67] p = 0.43) and FIGO Stage 3 (HR = 2.21, 95% CI [1.07-4.56] p = 0.031).

**Conclusion** This study cover 20 years of clinical practice and consolidate MIS place for EC surgical treatment with an increasing use of MIS over years whatever the FIGO staging and clinical characteristics.

Every effort should be made to improve a standardized MIS approach the more that patient is frail or at high risk of relapse.

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**MOLECULAR CLASSIFICATION OF ENDOMETRIAL CARCINOMA SUBSTANTIALLY CHANGING RISK-ASSESSMENT: RESULTS FROM A EUROPEAN MULTICENTRE INITIATIVE**


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**Introduction/Background** Endometrial carcinoma patient care was based on histopathologic examination for many years. However, conventional pathologic features are known to suffer from high inter-observer variability and may be irreproducible in many cases. TCGA-derived molecular classification was shown to provide clinically meaningful data and was recently introduced to ESGO/ESTRO/ESP endometrial carcinoma consensus guidelines. It was the aim of this study to quantify