Abstract 272 Table 1 Antitumour activity

Variable	dMMR/MSI-H EC, n=108	MMRp/MSS EC, n=156
Median follow-up time, mo	16.3	11.5
Objective response rate,[a] n (%, 95% CI)	47 (43.5%, 34.0–53.4)	22 (14.1%, 9.1–20.6)
Complete response, n (%)	11 (10.2)	3 (1.9)
Partial response, n (%)	36 (33.3)	19 (12.2)
Stable disease, n (%)	13 (12.0)	32 (20.5)
Progressive disease, n (%)	39 (36.1)	85 (54.5)
Not evaluable, n (%)	9 (8.3)	17 (10.9)
Disease control rate,[b] n (%)	60 (55.6%)	54 (34.6%)
Response ongoing, n (%)	42 of 47 (89.4)	14 of 22 (63.6)
Median duration of response (range), mo	Not reached (2.63 to 28.09+)	Not reached (1.54+ to 30.36+)
Kaplan–Meier estimated probability of remaining in response, %		
at 6 mo	97.9	80.7
at 12 mo	90.9	62.1
at 18 mo	80.1	62.1

[a]Responses required confirmation at a subsequent scan; SD had to be observed at ≥12 weeks on study to qualify as SD; [b]Includes confirmed CR, PR or SD at ≥12 weeks.
CR, complete response; dMMR, mismatch mutation repair deficient; EC, endometrial cancer; MMRp, mismatch mutation repair proficient; PR, partial response; SD, stable disease.

Abstract 272 Table 2 Most common adverse events

MedDRA preferred term, n (%)	dMMR/MSI-H EC N=129	MMRp/MSS EC N=161	Overall N=290
Any-grade TRAEs			
Fatigue	17 (13.2)	34 (21.1)	51 (17.6)
Diarrhoea	21 (16.3)	19 (11.8)	40 (13.8)
Nausea	16 (12.4)	24 (14.9)	40 (13.8)
Grade ≥3 TRAEs			
Anaemia	6 (4.7)	4 (2.5)	8 (2.8)
Alanine aminotransferase increased	2 (1.6)	2 (1.2)	4 (1.4)
Diarrhoea	2 (1.6)	2 (1.2)	4 (1.4)
Fatigue	0	4 (2.5)	4 (1.4)
Lipase increased	3 (2.3)	1 (0.6)	4 (1.4)
TRAEs leading to discontinuation			
Alanine aminotransferase increased	1 (0.8)	2 (1.2)	3 (1.0)
Aspartate aminotransferase increased	1 (0.8)	1 (0.6)	2 (0.7)
Transaminases increased	2 (1.6)	0	2 (0.7)

dMMR, mismatch mutation repair deficient; EC, endometrial cancer; MMRp, mismatch mutation repair proficient; TRAE, treatment-related adverse event.

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 mutation repair-proficient/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

340 UNIVERSAL SCREENING FOR MISMATCH REPAIR DEFICIENCY IN ENDOMETRIAL CANCER PATIENTS: IMPLICATIONS FOR CLINICAL PRACTICE

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Introduction/Background* Universal screening for mismatch repair deficiency (MMRd) in endometrial cancer has been included as a component of the integrated molecular risk assessment and can be used for screening patients with a genetic predisposition for cancer (eg. Lynch syndrome). MMR status is also emerging as an important marker for choosing candidate patients for immunotherapy. We designed a study to evaluate the characteristics of patients with MMR deficient tumours and the impact screening had on their management.

Methodology We included a cohort of consecutively treated women with endometrial cancer in a prospective study between January 2020 to March 2021 at the University Medical Centre Maribor, Slovenia. Cancerous tissue of patients with endometrial cancer was stained using immunohistochemistry (IHC) for the proteins of MMR genes MLH1, PMS2, MSH2 and MSH6. Descriptive statistics are reported in median values (range), categorical variables were evaluated using χ^2 and continuous variables were evaluated using the Mann-Whitney U test. Statistical analysis was performed using SPSS version 23.

Result(s)* Fourty-five women with EC were identified. Fifteen women (33.3%) had IHC MMRd tumours and 30 women (66.7%) had MMR proficient (MMRp) tumours. Women with MMRd tumours were older ($p<.015$) with a median age of 72.0 years (49-87) vs. 62.5 years (32-82) and had significantly more frequent deep myometrial invasion ($p<.027$) as well as lymphovascular space invasion ($p<.028$) of tumours. There was no significant difference between tumour grade ($p>.069$). Three women (6.7%) fulfilled traditional criteria for genetic counselling referral. Based on the implementation of universal MMR testing, 15 (33.3%) women with MMRd tumours were additionally identified as candidates for genetic counselling.

Conclusion* Universal MMR testing enables a more personalised risk score and the identification of women with a genetic predisposition for cancer in which EC might present as the »sentinel cancer«. Cost effective screening could improve personalised care and future cancer prevention.

357 STEP BY STEP LAPAROSCOPIC HYSTERECTOMY WITH PELVIC AND PARAAORTIC LYMPHADENECTOMY. ANATOMICAL LANDMARKS

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Introduction/Background* Surgical management of endometrial cancer is initial treatment for most patients and in early stages of disease is usually curative.The first laparoscopic treatment for endometrial cancer was described by Childers in 1993. Since then, indications for laparoscopic surgery are rising. Comprehensive staging of endometrial cancer guides the use

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 lyphadectomy.LVSI 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.

377 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 sub-group analysis according to FIGO stage, ESMO-ESGO-ESTRO Consensus Conference risk-group 2015 (E3CC), pathological subtypes, lymph node metastasis and lympho-vascular space invasion (LVSI). To assess primary endpoint, we use inverse probability of treatment weighting (IPW) 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 group (HR = 0.72, 95% CI O.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.

382 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