Methodology A retrospective cohort study including 119 patients recruited from the University Hospitals of Leicester from 01/01/2015 to 01/01/2020 with a diagnosis of AEH by pipelle or endometrial biopsy. Patients were divided into two groups according to the management modality: primary surgery (n=99) and conservative treatment (n=20).

Results EC was diagnosed in 34.4% of patients with AEH managed by primary surgery. Moreover, the incidence of EC in patients with AEH managed conservatively is 25%. The main reason for opting for conservative management was that patients were unfit for surgery when assessed in the high-risk Anaesthetic Clinic (35%).

Conclusion Total hysterectomy is the safest first line of treatment in AEH due to the high risk of concurrent EC and progression to EC. Currently, there is no reliable follow up intervention to distinguish between concurrent EC and progression of AEH. Adequate discussion and counselling are essential when discussing conservative management for women with atypical complex endometrial hyperplasia. Moreover, counselling patients regarding high risk of developing concurrent endometrial cancer and/or progression to endometrial cancer should be done.

2022-RA-825-ESGO THE IMPACT OF AGE ON PROGNOSIS IN WOMEN WITH ENDOMETRIAL CANCER: A POOLED ANALYSIS OF THE PORTEC-1, -2 AND -3 RANDOMISED TRIALS

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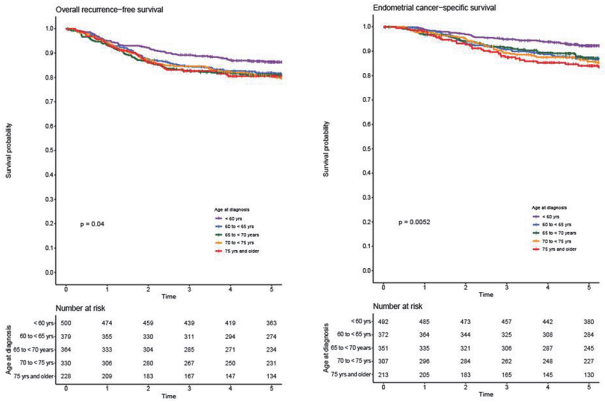
Introduction/Background Numerous studies showed that elderly women with endometrial cancer (EC) have a higher risk of recurrence and cancer-related death. It is unclear whether ageing is a risk factor by itself, or whether other risk factors become increasingly common at older age. We addressed to this using the large PORTEC collection of molecularly classified EC with long-term follow-up data.

Methodology Data of 1801 women participating in the randomised PORTEC trials were pooled and analysed. PORTEC-1 included 714 women with intermediate-risk EC, PORTEC-2 427 with high-intermediate risk EC, and PORTEC-3 660 with high-risk EC. Overall recurrence-free and EC-specific survival were estimated using Kaplan-Meier's method. Prognostic value of age (continuous) was determined by multivariable Cox regression analyses with correction for all significant risk factors identified by univariable analyses.



Abstract 2022-RA-825-ESGO Figure 1 Clinical outcomes by age of women with endimetrial cancer participanting in the PORTEC-1, -2 and -3 trial

Abstract 2022-RA-825-ESGO Table 1 The relation of age with clinicopathological and molecular variable of EC

Age groups	<60	60-<65	65-<70	70-<75	≥75	All	p-value
	n = 500 (%)	n = 379 (%)	n = 364 (%)	n = 330 (%)	n = 228 (%)	n = 1801 (%)	
Received adjuvant therapy							**< 0.0001[b]**
None	107 (21.4)	71 (18.7)	69 (19.0)	81 (24.5)	44 (19.3)	372 (20.7)	
External beam RT	250 (50.0)	173 (45.6)	194 (53.3)	158 (47.9)	112 (49.1)	887 (49.3)	
Chemoradiation	127 (25.4)	87 (23.0)	55 (15.1)	42 (12.7)	16 (7.0)	327 (18.2)	
Brachytherapy	16 (3.2)	48 (12.7)	46 (12.6)	49 (14.8)	56 (24.6)	215 (11.9)	
Stage							**< 0.0001[b]**
I	303 (60.6)	266 (70.2)	286 (78.6)	274 (83.0)	202 (88.6)	1331 (73.9)	
II	70 (14.0)	40 (10.6)	34 (9.3)	21 (6.4)	7 (3.1)	172 (9.6)	
III	127 (25.4)	73 (19.3)	44 (12.1)	35 (10.6)	19 (8.3)	298 (16.5)	
Histograde							**< 0.0001[b]**
Endometrioid gr 1-2	318 (63.6)	265 (69.9)	237 (65.1)	237 (71.8)	175 (76.8)	1232 (68.4)	
Endometrioid gr 3	113 (22.6)	62 (16.4)	72 (19.8)	45 (13.6)	29 (12.7)	321 (17.8)	
Serous	30 (6.0)	27 (7.1)	25 (6.9)	30 (9.1)	13 (5.7)	125 (6.9)	
Clear cell	24 (4.8)	15 (4.0)	12 (3.3)	10 (3.0)	5 (2.2)	66 (3.7)	
Other	15 (3.0)	10 (2.6)	18 (4.9)	8 (4.9)	6 (2.6)	57 (3.2)	
Myometrial invasion[1]							**< 0.0001[a]**
< 50%	231 (46.4)	127 (33.6)	106 (29.1)	90 (27.3)	50 (21.9)	604 (33.6)	
≥ 50%	267 (53.6)	251 (66.4)	258 (70.9)	240 (72.7)	178 (78.1)	1194 (66.4)	
Lymphovascular space invasion[2]							**< 0.0001[a]**
Absent	288 (64.6)	243 (70.6)	239 (73.3)	242 (80.7)	169 (84.5)	1181 (73.1)	
Present	158 (35.4)	101 (29.4)	87 (26.7)	58 (19.3)	31 (15.5)	435 (26.9)	
Molecular class[3]							**< 0.0001[b]**
POLE mut	62 (18.2)	21 (7.8)	11 (4.1)	17 (7.2)	5 (2.7)	116 (9.0)	
MMRd	108 (31.8)	82 (30.6)	75 (28.1)	59 (25.1)	61 (33.5)	385 (29.8)	
p53abn	26 (7.6)	43 (16.0)	41 (15.4)	39 (16.6)	30 (16.5)	179 (13.9)	
NSMP	144 (42.4)	122 (45.5)	140 (52.4)	120 (51.1)	86 (47.3)	612 (47.7)	
5-year RFS (SE)	86.5 (1.5)	81.8 (2.0)	81.0 (2.1)	80.6 (2.2)	80.5 (2.7)	82.6 (0.9)	**0.040[c]**
Mean RFS (95%CI)	15.0 (14.5-15.5)	13.8 (13.2-14.5)	13.9 (13.2-14.5)	13.6 (12.9-14.4)	12.5 (11.2-13.7)	14.2 (13.9-14.5)	
5-year CCS	92.3 (1.2)	87.3 (1.7)	87.1 (1.8)	85.7 (2.0)	84.1 (2.6)	88.0 (0.8)	**0.005[c]**
Mean CCS (95%CI)	15.8 (15.4-16.2)	14.8 (14.3-15.3)	15.1 (14.5-15.6)	15.7 (15.0-16.4)	13.1 (12.0-14.3)	16.2 (15.9-16.5)	

Definition of abbreviations: RT = radiotherapy, *POLE* mut = DNA polymerase-episilon mutated, MMRd = mismatch-repair deficient, p53abn = p53 abnormal, NSMP = no-specific molecular profile, RFS = overall recurrence-free survival. CSS = endometrial cancer specific survival.
Significance of the relation of age as a contious variable across groups was tested using the a) Mann-Whitney U test, b) Kruskal-Wallis test
Survival across 5 age categories was estimated accoding to Kaplan-Meier's method and tested using the c) log-rank test
1) 3 missing, 2) 185 missing, 3) 509 missing.

Results Median follow-up was 12.3 years for PORTEC-1, 10.5 years for PORTEC-2 and 6.1 years for PORTEC-3. Overall recurrence-free and EC-specific survival significantly decreased with age (figure 1). The relation of age with clinicopathological and molecular variables of EC is shown in table 1. Women ≥60 years had significantly less often *POLE*mut (5.7% vs. 18.2%) and more often p53abn EC (16.1% vs. 7.6%, p<0.0001). In multivariable analysis, age was an independent risk factor for overall recurrence with a hazard ratio (HR) of 1.03 per year (95%CI 1.02–1.05; p<0.0001), corrected for stage, histotype and grade, myometrial invasion, lymphovascular space invasion (LVSI), molecular class and received adjuvant treatment. Likewise, age had independent prognostic value for EC-specific survival with an HR of 1.05 per year (95%CI 1.02–1.07; p<0.0001), corrected for stage, histotype and grade, LVSI and molecular class.

Conclusion The molecular profile of elderly women was less favourable. The risk of recurrence and EC-related death continuously increases with age, especially from 60 years onwards. Our study showed that age is a significant and independent prognostic risk factor.