Conclusion Ngs can help classify rare diseases if the classical pathological diagnostics do not give a satisfying diagnosis. There are currently no clear treatment recommendations for STK11 adnexal tumors yet. International registries and solid clinical follow-up data are urgently needed to enhance our knowledge on these potentially aggressive tumors.

**Abstract 2022-RA-945-ESGO**

**ANTITUMOUR ACTIVITY OF DOSTARLIMAB BY PD-L1 AND TUMOUR MUTATION BURDEN IN PATIENTS WITH MISMATCH REPAIR DEFICIENT AND PROFICIENT TUMORS IN THE GARNET TRIAL**

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Methodology GARNET (NCT02715284) is a phase 1, multi-centre, open-label, single-arm study of dostarlimab in patients with mismatch repair deficient (dMMR) recurrent/advanced endometrial cancer (EC) that has progressed on or after platinum-based chemotherapy or solid tumours that have progressed on or after prior treatment, with no satisfactory alternative treatment options. We report a post hoc analysis of antitumour activity by PD-L1 expression and tumour mutational burden (TMB) in patients with dMMR and MMR proficient (MMRp) solid tumours in the GARNET trial.

<table>
<thead>
<tr>
<th>Biometric Distribution (n (%)</th>
<th>A1 (MMR EC) (n=18)</th>
<th>F (MMR-AX) (n=10)</th>
<th>A1 Fitzgerald (AA) (n=18)</th>
<th>A2 (MMR EC) (n=22)</th>
<th>A2 Fitzgerald (AA) (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>12 (66.7)</td>
<td>8 (80.0)</td>
<td>11 (61.1)</td>
<td>17 (77.3)</td>
<td>17 (77.3)</td>
</tr>
<tr>
<td>Low</td>
<td>6 (33.3)</td>
<td>2 (20.0)</td>
<td>5 (28.6)</td>
<td>5 (22.7)</td>
<td>5 (22.7)</td>
</tr>
</tbody>
</table>

**Conclusion**

1Conclusion PD-L1-H and TMB-H were frequently observed in the dMMR EC and non-EC cohorts, regardless of tumour type; PD-L1-H was also prevalent in MMRp EC tumours. Although not a powered analysis, ORR by BICR per RECIST v1.1 was higher in patients with TMB-H and PD-L1-H solid tumours. Across cohorts, dMMR status was predictive of response.

**REFERENCE**

predicted PD prior to imaging by an average of ~2.5 months (lead-time) and was significantly associated with worse progression-free survival (PFS) compared to patients with decreased ctDNA (HR=0.14, 95% CI: 0.03–0.60; p<0.01). TMB and MSI status (binary) were not predictive of response in univariate (p=0.4, p=0.4) analyses.

Conclusion ctDNA dynamics can accurately predict clinical benefit and allow for early prediction of PD in patients with advanced ovarian cancer receiving immunotherapy. Further study is warranted to evaluate the clinical utility of a personalized, tumor-informed ctDNA assay in patients with gynecologic malignancies undergoing systemic therapies.

### 2022-RA-1093-ESGO
**VALIDATION OF SELF-SAMPLING USE FOR A MULTIPLEXED BIOMARKER ASSAY FOR HPV AND DYSPLASIA DETECTION**
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### Introduction/Background
The use of self-sampling in cervical cancer (CxCa) screening increases the number of participants and enables the inclusion of prior underscreened women in rural areas. For PCR and DNA-based testing self-sampling is as sensitive as physician-sampling. We compared self- and physician-sampling for analysis by QuantiGene-Molecular-Profiling-Histology assay (QG-MPH) to detect and grade cervical dysplasia in a triage setting.

### Methodology
Women with an equivocal screening result were recruited and a cervical sample (Cervex broom) was taken into ThinPrep/PreservCyt. Participants were asked to take a self-sample (Evelyn-Brush) and fill a questionnaire. Crude lysates were used for the QG-MPH assay. This multiplexed Luminex bead-based technology platform (QuantiGene 2.0) detects and quantifies the mRNA abundance of 18 Human Papillomavirus (HPV) genotype-specific oncogenes, reference genes and cellular biomarkers characterizing dysplasia stages, simultaneously. Formerly developed biomarker-based risk scores predict CIN2+, CIN3+, or CxCa.

### Results
Of 699 study participants, 601 performed self-sampling (85.9%). Invalid samples in QG-MPH was comparable between self- and physician-sampling with 16.1% and 14.9%, respectively. Of 132 histologically confirmed CIN3 lesions QG-MPH determined in the physician-taken sample 61.4% (n=81) as CIN3 or higher, 25.8% (n=34) as low-grade lesions, and 12.9% (n=17) were not evaluable. Of 109 self-samplers from CIN3 positive women QG-MPH determined 17.4% (n=19) as CIN3 or higher, 59.6% (n=65) as low-grade and 22.9% (n=25) were not evaluable. PCR-based HPV testing detected 78.2% of physician- and 74.9% of self-samples positive while QG-MPH 52.5% (n=315) and 32.3% (n=194), respectively. Concordance was 82.0% by PCR and 63.8% by QG-MPH.

### Conclusion
While cellularity of self-taken samples is sufficient for valid measurement by QG-MPH, less high-grade lesions and HPV-infections are detected. Optimization of cutoffs for the self-taken sample may improve the sensitivity. We hypothesize that ‘missed’ CIN3 by QG-MPH biomarker profiling may be non-progressor lesions. This will be investigated further.