tumor stage, therapy), monitoring of lifestyle before and after diagnosis and adherence to treatment modalities were recorded.

**Results** Between 12/2021 and 04/2023, 656 patients with EC (median age: 65.0[20.0; 92.0] years) completed the survey. Major recruitment took place in Germany (56%) and Switzerland (41%). The most common comorbidities were hypertension (42%), diabetes (13%) and hypothyroidism (20%). 46% of patients reported not exercising before diagnosis of EC. Only 14% increased their activity after diagnosis, 39% did even less (49% of those due to weakness). The need for medical exercise programs was low – only 30% were interested - although 55% felt that more activity would benefit their disease. 62% reported that they had not changed their diet after diagnosis. 31% would be interested in a professional nutrition counseling program, 81% did not receive one during treatment. Regarding screening programs, 52% participated in the colonoscopy program, 61% in the cervical cancer program, 34% in the skin cancer program and 71% in mammography screening.

**Conclusion** A majority of patients believe in a potential positive impact of lifestyle changes, such as exercising and diets. Nevertheless, physical activity appeared to be relatively low and most patients did not change their diet after diagnosis. There is a need for better support of patients in these aspects, to achieve the known benefits of holistic treatment.

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**Abstract**

**#446** **INFLUENCE OF COMORBIDITY ON THE RISK OF DEATH: A SINGLE INSTITUTION STUDY OF 1915 WOMEN WITH EARLY-STAGE UTERINE CANCER**

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**Introduction/Background** The study goal is to utilize a validated comorbidity scoring to determine its impact on recurrence-free (RFS), disease-specific (DSS) and overall survival (OS) in women with early-stage endometrioid carcinoma (EC).

**Methodology** We identified 1915 patients with EC stages I-II who underwent hysterectomy. Charlson Comorbidity Index (CCI) at time of hysterectomy was calculated by trained physician. Survival endpoints was correlated with CCI. Univariate and multivariate modeling with Cox regression analysis was used to determine significant predictors of OS, DSS, and RFS.

**Results** After a median follow-up of 104 months, 529 deaths were recorded, only 87 patients died from EC [16%], and 442 [84%] from other causes). Median CCI score for the study cohort was 0 (range, 0 to 12). On the basis of CCI, patients were grouped as follows: 0 score (group 1, n=1083), score 1-2 (group 2, n = 690), and score of 3 or more (group 3, n = 142). By CCI grouping, the 5-year RFS, DSS, and OS were 94%, 96%, and 97% for group 1, 92%, 94%, and 78% for group 2, and 86%, 95% and 60% for group 3 (P < 0.0001). The cause of death in the first 10 years after hysterectomy in our study was mainly non-uterine cancer-related (80% vs. 20% for uterine cancer-related) causes. On multivariate analyses, higher CCI, lymphovascular space invasion (LVSI), higher tumor grade, and older age were significant predictors of shorter OS. On multivariate analysis for DSS and RFS, only high tumor grade and LVSI were significant predictors.

**Conclusion** The cause of death for women with early-stage EC is mainly nonuterine cancer-related. Comorbidity score is a significant predictor of OS in our study cohort. Comorbidity scores may be useful as a stratification factor in any prospective clinical trial for women with early-stage EC.

**Disclosures** No disclosure.

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**Abstract #447** **COMPARISON BETWEEN IMMUNOHISTOCHEMICAL-BASED MODEL AND GENOMIC PROFILING IN ENDOMETRIAL CANCER MOLECULAR STRATIFICATION: A PROPENSITY-MATCHED SURVIVAL ANALYSIS**

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**Introduction/Background** Nowadays, immunohistochemistry analysis together with POLE sequencing (genomic profiling-based model, GP-M) is the gold-standard for endometrial cancer (EC) classification into molecular classes: POLE-mutated, no specific molecular profile, mismatch repair deficient (MMRd), and p53-abnormal (p53abn). This study aims to investigate the non-inferiority of immunohistochemistry model (IHC-M) in classifying ECs compared to the standard (GP-M) in terms of oncologic outcomes.

**Methodology** All presumed uterine-confined ECs undergoing surgical staging at Fondazione Policlinico Universitario Agostino A. Gemelli and University Hospitals of Leuven were retrospectively included. Patients classified by IHC-M were stratified into: MMR-proficient (MMRp) and estrogen receptor (ER) positive, MMRp and ER-negative, MMRd, and p53abn. First, a case-control comparison was performed with a control cohort of ECs classified by GP-M. Second, a propensity match analysis was performed: ECs classified by IHC-M were matched in a 3:1 ratio with patients classified by GP-M.

**Results** 1592 ECs were included (1321 classified by IHC-M, and 271 classified by GP-M). Age, BMI, histology, and adjuvant treatment differed between the two cohorts (p < 0.05). The Kaplan-Meier survival curves for disease-free survival demonstrated similar validity of the two models in stratifying the two cohorts (p < 0.0001). Applying the propensity score adjustment (PSA), the outcome of both models was similar (p > 0.05).

**Abstract #447 Figure 1** The Kaplan-Meier survival curves for disease-free survival of the two cohorts stratified according to the two models.