

EP156/#642

SURVIVAL OUTCOMES IN ADVANCED STAGE OPERABLE CARCINOMA ENDOMETRIUM: EXPERIENCE OF SURGICAL TREATMENT AT A TERTIARY CARE CANCER CENTRE

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Introduction There is a lack of consensus regarding the surgical management of advanced-stage endometrial cancer. We aim to look at survival outcomes of advanced-stage carcinoma endometrium, managed through surgery and adjuvant treatment.

Methods This was a retrospective study from a tertiary care cancer centre in India that included all women registered between 1st August 2011 and 31st January 2021 with operable advanced-stage carcinoma endometrium (stages 3 and 4). Their relevant data were collected from electronic medical records.

Results Out of 1760 endometrial cancer cases screened 102 women with stage 3 and 4 disease were operable. The mean age was 59 years. Most women were parous (85%) with an ECOG status of 0 or 1 (90%). Histopathology was high grade in 73 women (71.6%). Surgeries performed were: Staging surgery 50(49%), debulking surgery 38(37.2%), surgery after chemotherapy 6(5.8%). Eight women (7.8%) were operable but given only chemotherapy for various reasons. 72 (76.6%) patients received planned adjuvant treatment. Overall, 50 patients (56.8%) were upstaged after surgery. At the time of analysis, 32 (31.4%) women were alive without disease. Median disease-free survival of stage 3, stage 4 and both combined were 32.8 months (95%CI: 0–87), 19 months (7.6–30.3), and 23.5 months (95% CI: 13.7–33.2) respectively. Median overall survival was not reached for stage 3. For stage 4 and both combined, it was 41 months (95% CI: 18.8–63.1) and 50.1 months (95% CI: 31.2–69.1) respectively.

Conclusion/Implications Upfront surgery in advanced-stage endometrial carcinoma gives a respectable survival outcome after maximal surgical attempt.

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THE DIFFERENCE BETWEEN ESTROGEN RECEPTOR AND PROGESTERONE RECEPTOR POSITIVITY IN TYPE I AND TYPE II ENDOMETRIAL CANCER

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Introduction Endometrial cancer is a major gynecological cancer in women and can be classified into two types: type I and type II. Type I endometrial cancer is often estrogen-dependent and typically express estrogen receptors (ER) and progesterone receptors (PR), while Type II endometrial cancer is known to do not typically express these receptors and has a poor prognosis. This study aims to investigate the differences in ER and PR positivity between Type I and Type II endometrial cancer.

Methods A retrospective analysis was performed on medical records of 170 endometrial cancer patients who underwent molecular analysis between 2010 and 2022 at a single-center. Immunohistochemistry was used to assess ER and PR expression in tumor samples, and the results were compared between the two groups.

Results Of 161 patients, 80(49.69%) were diagnosed with Type I endometrial cancer, and 81(50.31%) were diagnosed with Type II endometrial cancer. The study found that ER or PR positivity was significantly higher in Type I endometrial cancer compared to Type II endometrial cancer (Type I – 84.21% vs. Type II – 65.45%). Specifically, ER positivity was observed in 78.79% of Type I compared to 55.93% of Type II. And PR positivity was 80.36% of Type I compared to 50.91% of Type II endometrial cancer.

Conclusion/Implications In conclusion, the results of this study highlight the importance of distinguishing between Type I and Type II endometrial cancer and tailoring treatment strategies accordingly based on the expression of ER and PR.

EP158/#445

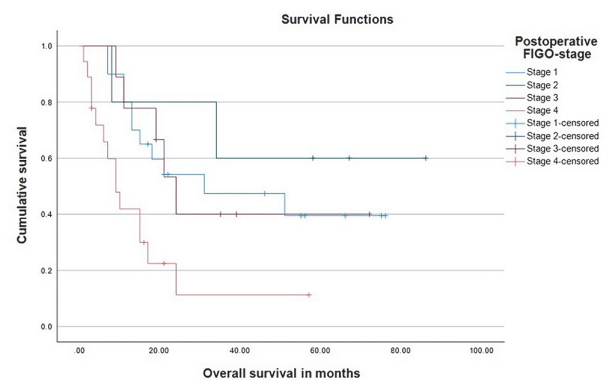
SURVIVAL AND QUALITY OF LIFE IN PATIENTS WITH UTERINE CARCINOSARCOMA: A TERTIARY CENTER OBSERVATIONAL STUDY

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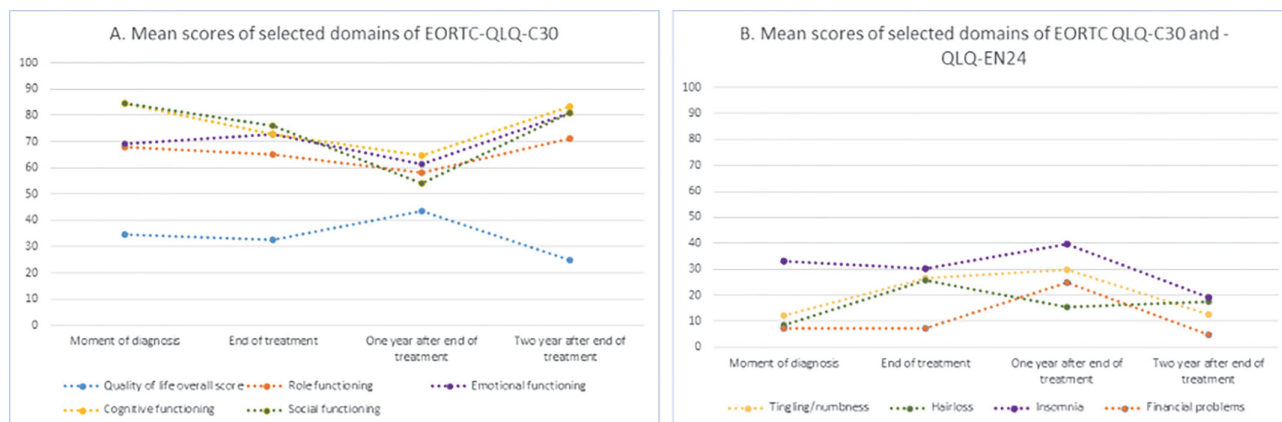
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Introduction Patients with uterine carcinosarcoma (UCS) have a dismal prognosis despite receiving extensive treatment which also may abate the quality of life (QoL). Our aim is to determine the survival in patients with UCS and to assess the QoL during and after treatment.

Methods An observational study was performed in the Erasmus Medical center between 2016 – 2021, including all patients with UCS. Clinical data was collected from diagnosis until 5 years after treatment or death. EORTC QLQ-C30 and -EN24 were obtained at four time points: pre-operative, end



Abstract EP158/#445 Figure 1 Kaplan-Meier curve for overall survival (OS) among patients with FIGO stage I, II, III and IV UCS. Patients who were lost to follow up or alive at end of follow up are censored



Abstract EP158/#445 Figure 2 A) Mean scores of total study population at four time points of selected domains of EORTC-QLQ-C30: quality of life overall score and role, emotional, cognitive, and social functioning. These domains were statistically different compared to normative data of a matched reference group (women from 60–69 years) which was respectively 76.5, 83.8, 85.9, 91.3 and 91.3 (not depicted). For these domains, a higher score equals a higher quality of life. B) Mean scores of total study population at four time points of selected domains of EORTC-QLQ-C30 and QLQ-EN-24: Tingling/numbness, hairloss, insomnia and financial problems. These domains were statistically more affected at advanced stage disease (not separately depicted). For these domains, a lower score equals a higher quality of life. Data of patients who were deceased at later timepoints were not included in the analysis

of treatment (ET), one year, and two year after treatment. QLQ-C30 outcomes were also compared with normative data of a matching reference group.

Results 52 patients were included in the study, with a mean age of 69 years (range 50–86 years) at the time of diagnosis. The majority of patients were diagnosed with early-stage disease (N=20, N=5, N=9, N=18 patients respectively with FIGO stage I-IV). Median overall survival (OS) was 18 months, with the poorest survival seen in patients with stage IV disease (median OS=9 months) (figure 1). QoL assessment indicated that patients with advanced stage disease reported significantly more deterioration on insomnia, financial problems, tingling/numbness and hair loss. Furthermore, comparing QLQ-C30 outcomes at ET showed a significant difference compared to normative data in overall quality of life, role, emotional, cognitive and social functioning (figure 2).

Conclusion/Implications Patients with UCS face a poor prognosis, and the effect of treatment on QoL be considered in clinical decision-making, particularly in patients with advanced stage disease.

EP159/#1534

LEVERAGING PERSONALIZED CIRCULATING TUMOR DNA MONITORING TO PREDICT TREATMENT RESPONSE AND RECURRENCE IN HIGH-RISK ENDOMETRIAL CANCER

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Introduction Adjuvant therapy is often used in high risk endometrial cancer (HREC) due to increased risk of recurrence. Histology alone does not accurately predict recurrence. Circulating tumor DNA (ctDNA) is a validated prognostic biomarker for many solid tumors, yet its utility in HREC is unclear.

Methods In an ongoing, prospective registry, serial plasma samples were collected pre- and post-hysterectomy, and post-adjuvant treatment (AT) from 25 patients with newly diagnosed HREC treated with primary surgery. CtDNA was detected using a tumor-informed assay (Signatera™ Natera, Inc.) and correlated with recurrence-free survival (RFS).

Results Personalized ctDNA assays were successfully designed for 24/25 patients. Median age was 63 years (range: 30–74). Pre-operatively, ctDNA was detectable in 60.87% patients (median 1.3 mean tumor molecules/mL), with 55% and 80% in stage I and II-IV, respectively. ctDNA cleared with surgery in 83% (10/12) patients; only one (10%) of these patients recurred. Three patients were ctDNA-positive post-operatively; 2/3 remained ctDNA-positive post-AT and recurred; 1/3 cleared ctDNA post-AT and remained disease-free. Seven patients recurred; ctDNA-positivity was observed in 43% (3/7) pre-operatively, 33% (2/6) post-operatively, and 29% (2/7) post-AT. There was no association between pre-operative ctDNA and recurrence ($p=0.27$). Post-AT, ctDNA-positivity was significantly associated with shorter RFS compared to ctDNA-negativity ($p=0.02$; HR=7.92; 95%CI: 1.43–43.73).

Conclusion/Implications Post-AT ctDNA negativity and/or clearance were associated with better response and RFS in HREC patients. ctDNA detection was feasible across multiple time-points in early-stage HREC patients. Future studies will determine whether the addition of ctDNA to other molecular/histologic characteristics can identify patients who may benefit from escalation/de-escalation of AT.