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2026.10. 23. (금) - 24. (토)
정부세종컨벤션센터
세종 코트야드 바이 메리어트

최신 부인암 병기설정시스템 확인 및 진료 최신 업데이트 - 자궁내막암

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DECLARATION OF INTERESTS

Nothing to declare

FIGO 2023 staging overview

TABLE 1 2023 FIGO staging of cancer of the endometrium.[a,b]

Stage	Description
Stage I	Confined to the uterine corpus and ovary[c]
IA	Disease limited to the endometrium OR non-aggressive histological type, i.e. low-grade endometroid, with invasion of less than half of myometrium with no or focal lymphovascular space involvement (LVSI) OR good prognosis disease
	IA1 Non-aggressive histological type limited to an endometrial polyp OR confined to the endometrium
	IA2 Non-aggressive histological types involving less than half of the myometrium with no or focal LVSI
	IA3 Low-grade endometrioid carcinomas limited to the uterus and ovary[c]
IB	Non-aggressive histological types with invasion of half or more of the myometrium, and with no or focal LVSI[d]
IC	Aggressive histological types[e] limited to a polyp or confined to the endometrium
Stage II	Invasion of cervical stroma with extrauterine extension OR with substantial LVSI OR aggressive histological types with myometrial invasion
IIA	Invasion of the cervical stroma of non-aggressive histological types
IIB	Substantial LVSI[d] of non-aggressive histological types
IIC	Aggressive histological types[e] with any myometrial involvement
Stage III	Local and/or regional spread of the tumor of any histological subtype
IIIA	Invasion of uterine serosa, adnexa, or both by direct extension or metastasis
	IIIA1 Spread to ovary or fallopian tube (except when meeting stage IA3 criteria)[c] IIIA2 Involvement of uterine subserosa or spread through the uterine serosa
IIIB	Metastasis or direct spread to the vagina and/or to the parametria or pelvic peritoneum
	IIIB1 Metastasis or direct spread to the vagina and/or the parametria IIIB2 Metastasis to the pelvic peritoneum
IIIC	Metastasis to the pelvic or para-aortic lymph nodes or both[f]
	IIIC1 Metastasis to the pelvic lymph nodes IIIC1i Micrometastasis IIICii Macrometastasis IIIC2 Metastasis to para-aortic lymph nodes up to the renal vessels, with or without metastasis to the pelvic lymph nodes IIIC2i Micrometastasis IIIC2ii Macrometastasis
Stage IV	Spread to the bladder mucosa and/or intestinal mucosa and/or distance metastasis
IVA	Invasion of the bladder mucosa and/or the intestinal/bowel mucosa
IVB	Abdominal peritoneal metastasis beyond the pelvis
IVC	Distant metastasis, including metastasis to any extra- or intra-abdominal lymph nodes above the renal vessels, lungs, liver, brain, or bone

FIGO 2009 vs 2023 : what changed?

Table 2: Differences between the 2009 and 2023 FIGO Staging Systems for Endometrial Cancer

2009 FIGO Staging System	2023 FIGO Staging System
Stage I	
Definition: tumor confined to the uterine body	Definition: depends on a combination of histologic findings and presence and depth of myometrial invasion
Subdivision: 2009 FIGO IA and IB stages are subdivided according to the depth of myometrial invasion, with IA tumors confined to the uterine corpus with <50% myometrial invasion and stage IB tumors confined to the uterine corpus with >50% invasion	Subdivision: 2023 FIGO IA and IB stages are revised to include only nonaggressive tumor histologic findings with no LVSI; IA tumors are subdivided according to the depth of myometrial invasion, with IA tumors involving <50% myometrial invasion and IB tumors involving >50% myometrial invasion
No differences between myometrial invasion <50% and no myometrial invasion at all (all stage IA)	In nonaggressive types of tumors without LVSI, the 2023 FIGO system subdivides stage based on the following: no myometrial invasion (IA1), myometrial invasion <0% (IA2 and IA3), and myometrial invasion >50% (IB)
	In aggressive types of tumors, the 2023 FIGO system subdivides stages based on no myometrial invasion (IC) and any myometrial invasion (IIC)
	Ovarian involvement in low-grade endometrioid lesions without LVSI and myometrial invasion <50% is included in stage I (IA3)
Stage II	
Definition: tumor confined to the uterus with cervical stroma invasion	Definition: depends on a combination of histologic findings, the presence of myometrial invasion, and the presence of cervical stromal invasion
	Includes nonaggressive types with cervical stromal invasion (IIA) but also any nonaggressive type with LVSI (IIB) and aggressive types with any myometrial invasion (IIC)
Stage III	
Definition: local tumor spread outside of the uterus	Definition: local and/or regional spread
Ovarian and serosal involvement grouped together (IIIA)	Introduces the concept of uterine subserosa; differentiates between adnexal (IIIA1) versus uterine serosal infiltration (IIIA2)
...	Pelvic peritoneal involvement is considered locoregional to better reflect clinical treatment decisions and classified as IIIB2 according to the 2023 FIGO scoring system (previously stage IV in the 2009 FIGO system)
No differences between micro- and macroscopic nodal metastases to the pelvic (IIIC1) or para-aortic (IIIC2) lymph nodes	Microscopic pelvic (IIIC1i) and para-aortic nodal metastases (IIIC2i) are differentiated from macroscopic pelvic (IIIC1ii) and para-aortic nodal metastases (IIIC2ii)
Stage IV	
Distant metastases, including intra-abdominal metastases and inguinal lymph nodes grouped under the same stage (IVB)	Abdominal peritoneal spread (IVB) is distinguished from distant metastases in any extra- or intra-abdominal lymph nodes above the renal vessels, lungs, liver, brain, or bone (IVC)

Molecularly defined FIGO stages

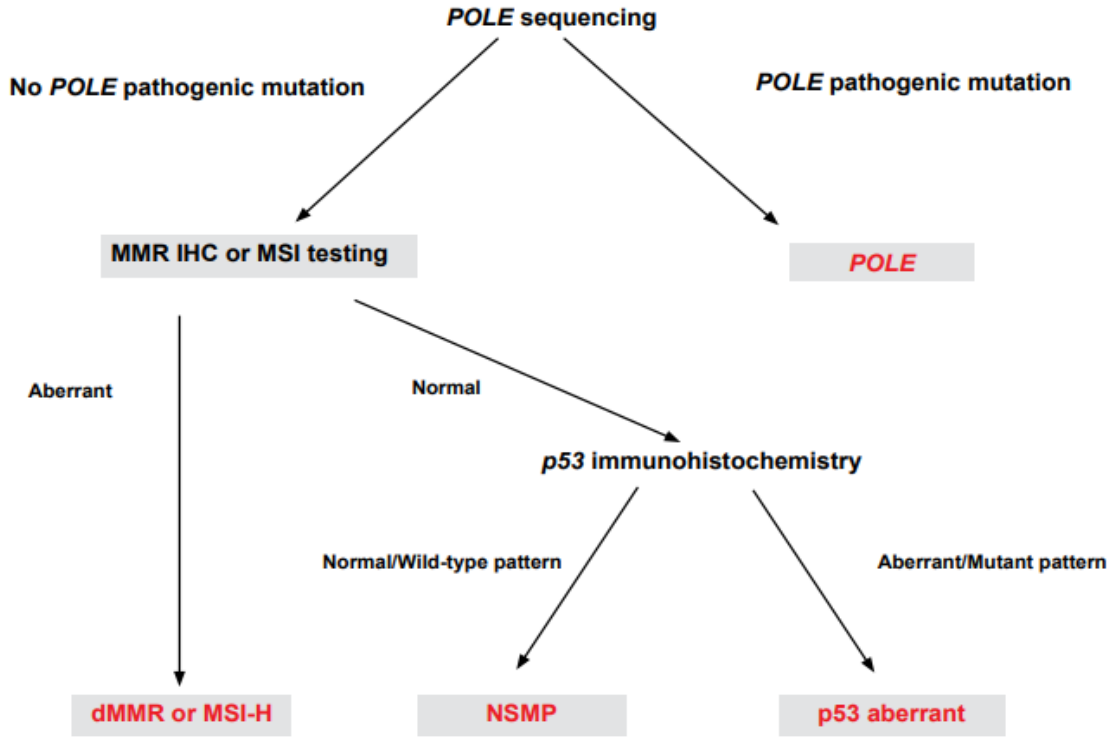
2023 Figo Stage	*Defining Criteria*
IA1	non-aggressive histological type limited to the endometrium or an endometrial polyp
IA2	non-aggressive histological type involving <50% myometrium, with no/focal LVSI
IA3	low-grade EEC limited to the uterus and ovary
$IAm_{POLEmut}$	*POLEmut EC, confined to the uterine corpus or with cervical extension, regardless of LVSI or histological type*
IB	non-aggressive histological type involving ≥50% myometrium, and with no/focal LVSI
IC	aggressive histological type limited to the endometrium or an endometrial polyp
IIA	non-aggressive histological type with invasion of the cervical stroma
IIB	non-aggressive histological type with substantial LVSI
IIC	aggressive histological type with any myometrial infiltration
$IICm_{p53abn}$	*p53abn EC, confined to the uterine corpus with any myometrial infiltration, with or without cervical invasion, and regardless of LVSI or histological type*
IIIA1	spread to ovary or fallopian tube (except if it meets the Stage IA3 criteria)
IIIA2	involvement of uterine subserosa/serosa
IIIB1	metastasis or direct spread to the vagina and/or the parametria
IIIB2	metastasis to the pelvic peritoneum

2023 FIGO Staging System of endometrial carcinoma, including molecularly defined stages (in blue italic).

Molecular classification algorithm

PRINCIPLES OF MOLECULAR ANALYSIS

FIGURE 1: PATHOLOGY AND GENOMICS IN ENDOMETRIAL CARCINOMA
(The decision to use molecular testing/classification depends on the availability of resources and the multidisciplinary team of each center.)[f,g]



[f] Adapted with permission from Murali R, Delair DF, Bean SM, et al. Evolving roles of histologic evaluation and molecular/genomic profiling in the management of endometrial cancer. J Nat Compr Canc Netw 2018;16:201-209.
[g] Diagnostic algorithm for integrated genomic-pathologic classification of endometrial carcinomas.

2025 ESGO–ESTRO–ESP: Molecular-integrated risk stratification

FIGO 2023 stage + molecular class should be interpreted together

POLEmut
Excellent prognosis
IAm_POLEmut: adjuvant th erapy generally not indicat ed

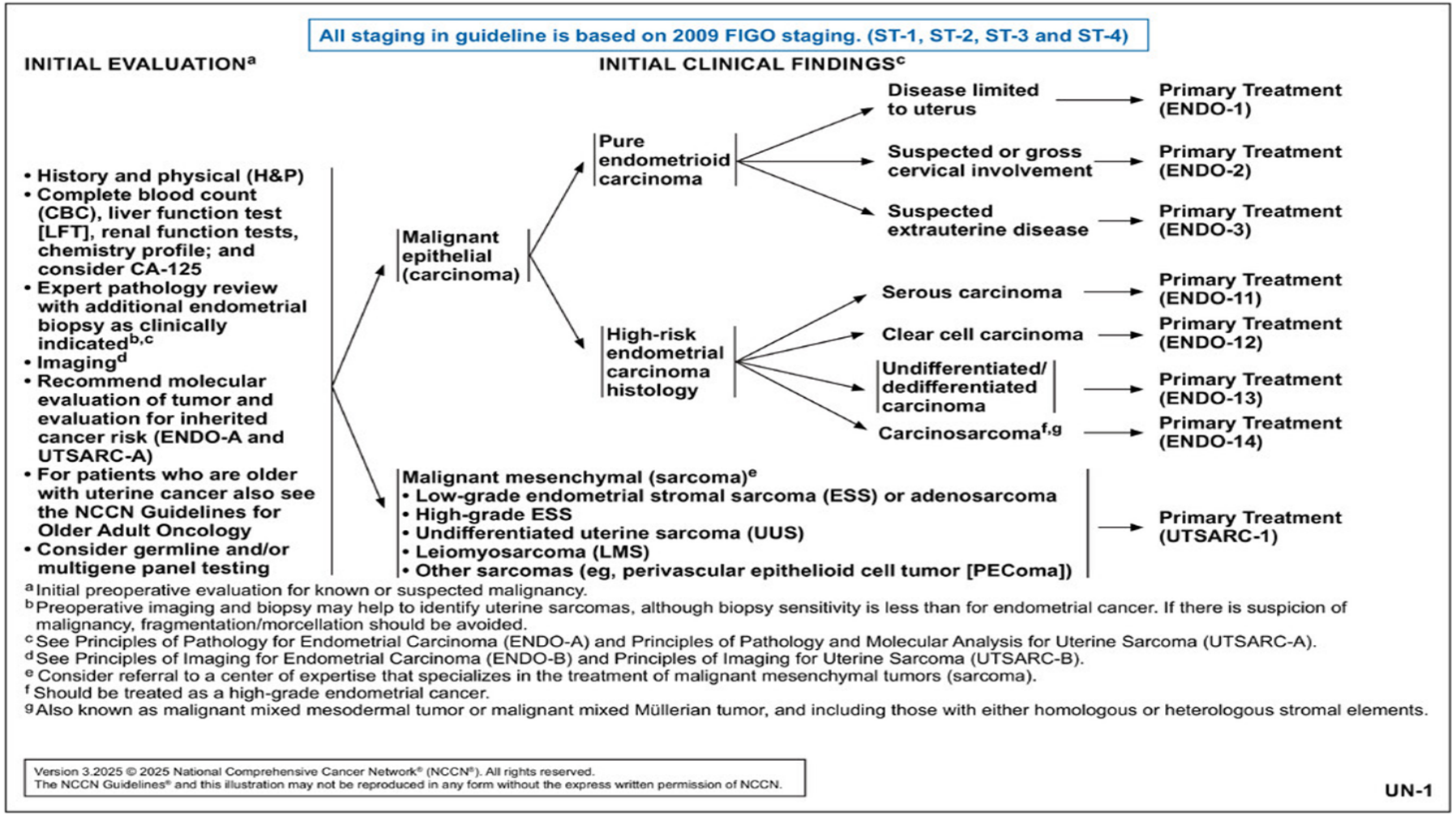
MMRd
Immune-sensitive biology
High-risk setting: strongest rationale for adjuvant ICI

NSMP
Heterogeneous group
Grade and ER status furthe r refine risk

p53abn
Poor-prognosis biology
Systemic therapy particular ly important

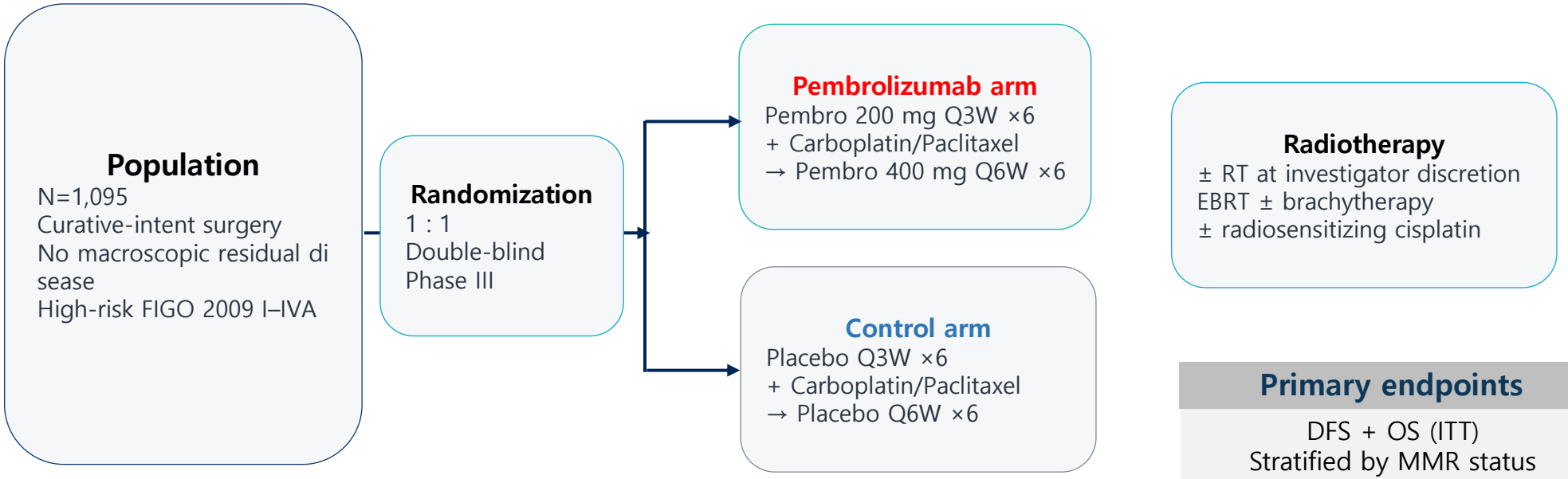
Clinical message
"Stage alone" is no longer sufficient for postoperative risk assessment.

NCCN and FIGO: a practical discrepancy



KEYNOTE-B21 / ENGOT-en11 / GOG-3053

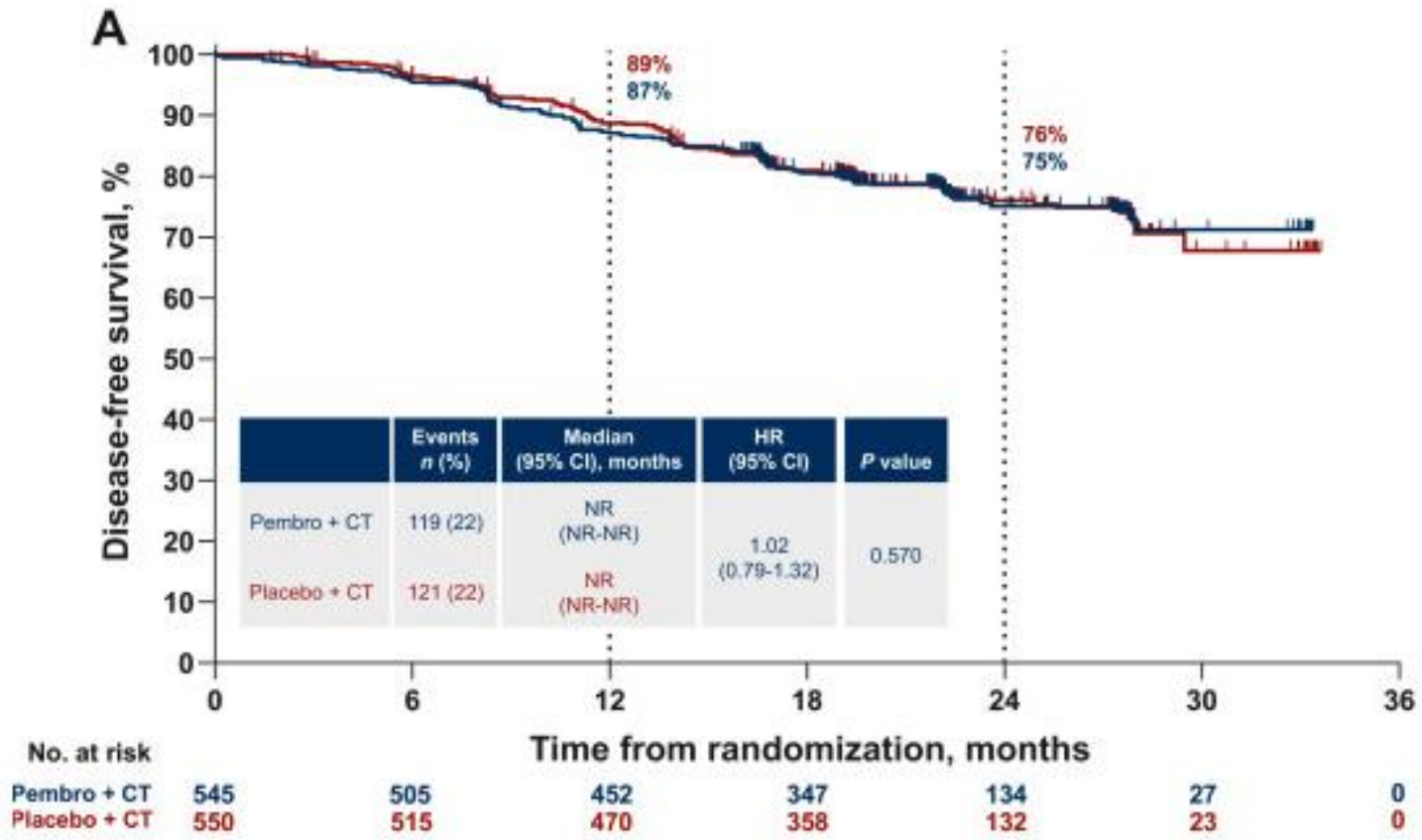
True adjuvant trial: completely resected high-risk EC with no macroscopic residual disease



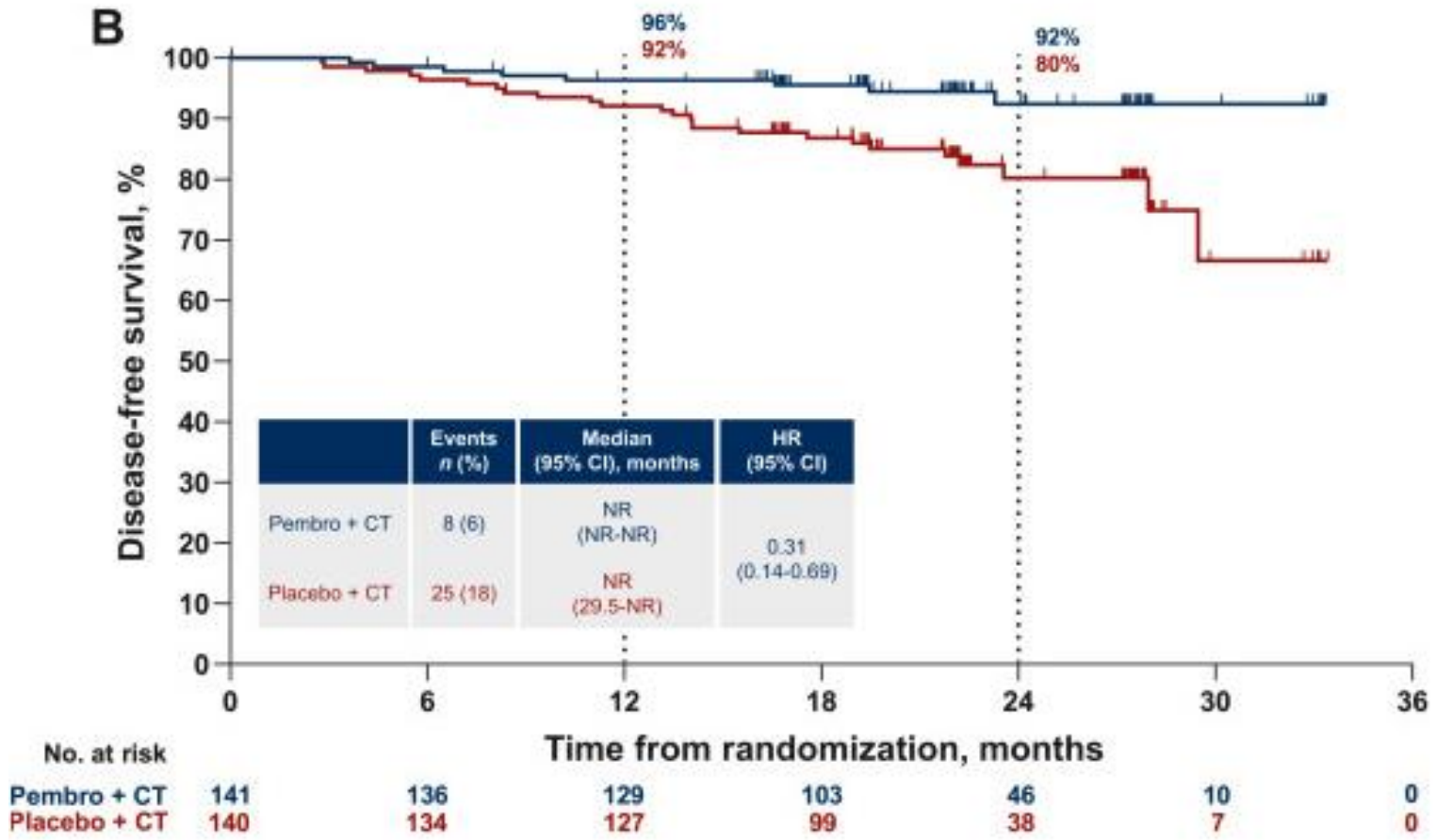
Primary endpoints

DFS + OS (ITT)
Stratified by MMR status
Key question: dMMR vs pMMR?

KEYNOTE-B21 overall DFS

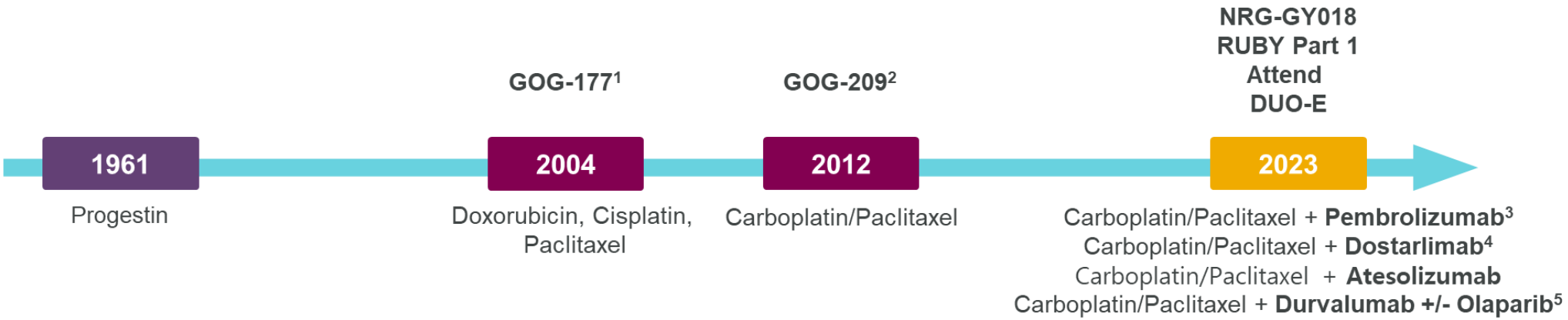


KEYNOTE-B21 dMMR subgroup



Treatment landscape

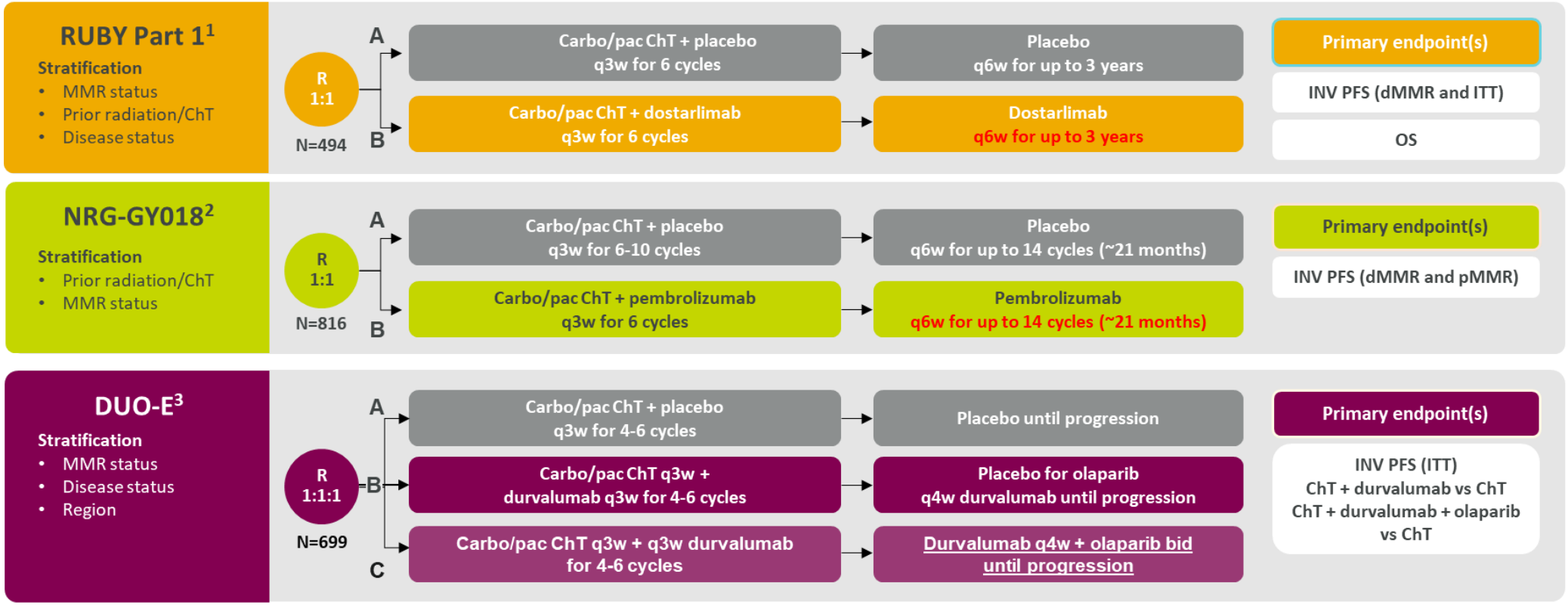
Evolution of the 1L Treatment Landscape for Advanced or Recurrent Endometrial Cancer



1. Fleming GF et al. J Clin Oncol. 2004 Jun 1;22(11):2159-66; 2. Miller DS et al. J Clin Oncol. 2020 Nov 20;38(33):3841-3850; 3. Eskander RN et al. N Engl J Med. 2023 Jun 8;388(23):2159-2170; 4. Mirza MR et al. N Engl J Med. 2023 Jun 8;388(23):2145-2158; 5. Westin SN et al. J Clin Oncol. 2024 Jan 20;42(3):283-299.

Multiple chemo-ICI trials

Please note that head-to-head studies were not conducted between these products.
These data are for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

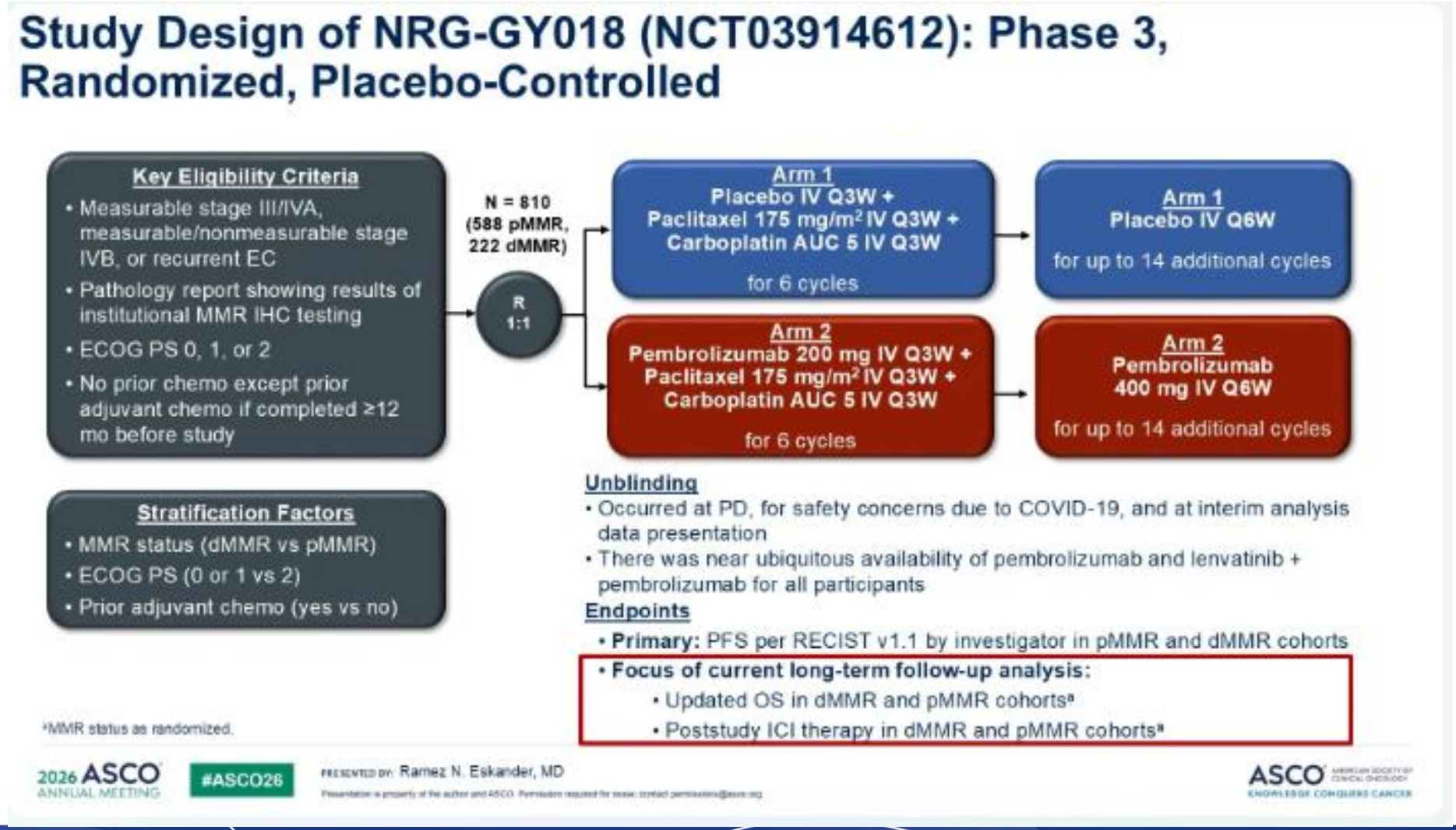


Carbo, carboplatin; chemo, chemotherapy; ChT, chemotherapy; dMMR, mismatch repair deficient; INV, investigator-assessed; ICI, immune checkpoint inhibitor; ITT, intention-to-treat; MMR, mismatch repair; OS, overall survival; pac, paclitaxel; PFS, progression-free survival; pMMR, mismatch repair proficient; q#w, every # weeks; R, randomisation.

1. Mirza MR, et al. *N Engl J Med.* 2023;388(23):2145-2158; 2. Eskander RN, et al. *N Engl J Med.* 2023;388(23):2159-2170; 3. Westin SN, et al. *J Clin Oncol.* 2024;42(3):283-299. 4. ClinicalTrials.gov identifier: NCT03603184. Updated 13 March 2024. Accessed 11 September 2024. https://clinicaltrials.gov/ct2/show/NCT03603184; 5. Colombo N, et al. *J Clin Oncol.* 2019;37(Suppl 15):TPS5608.

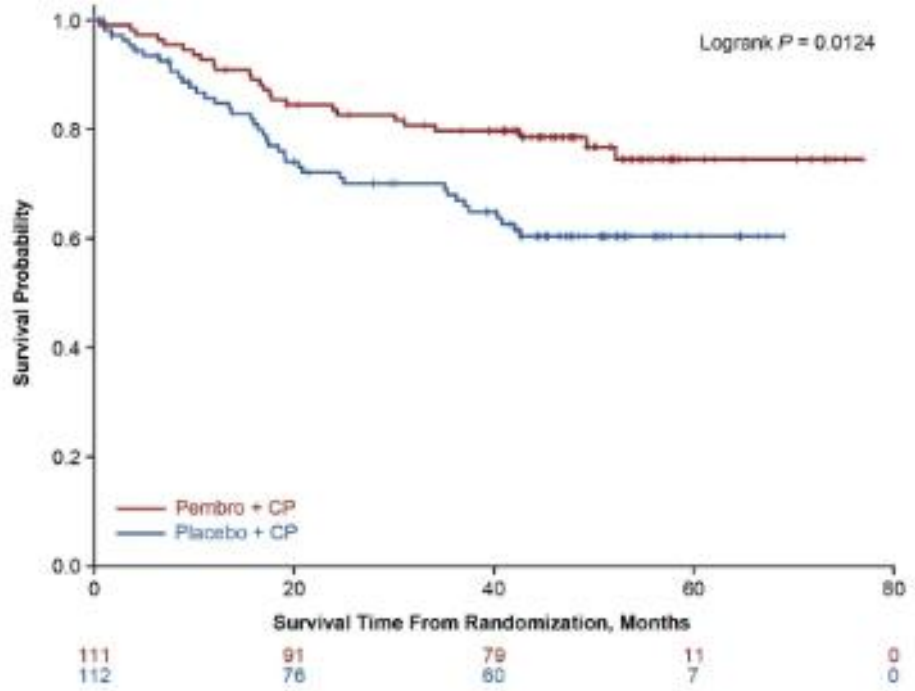
October 2024, Z4-69334

NRG-GY018 study design



NRG-GY018 2026 OS update

Extended Follow-Up Suggests OS Benefit for Pembrolizumab + CP in the dMMR Cohort



	Pembro + CP	Placebo + CP
Events, n/N	25/111	40/112
Median OS	Not reached	Not reached
Survival at 24 mo (95% CI), %	83.5 (75.2–89.3)	72.1 (62.4–79.7)
Survival at 36 mo (95% CI), %	79.7 (70.9–86.2)	68.0 (58.0–76.1)
Survival at 48 mo (95% CI), %	78.6 (69.6–85.2)	60.4 (50.0 – 69.2)
HR (95% CI)[a]	0.56 (0.34–0.92)	

- Information fraction of 43.3%
- Median follow-up across both treatment arms was 49 months
- Amongst participants receiving poststudy therapy, **93.2% of patients in the control arm received an ICI**

[a]Based on Cox regression model stratified by ECOG PS and prior adjuvant chemo.

Proportion of participants who withdrew study consent: Pembro + CP = 5.4%; Placebo + CP = 7.1%

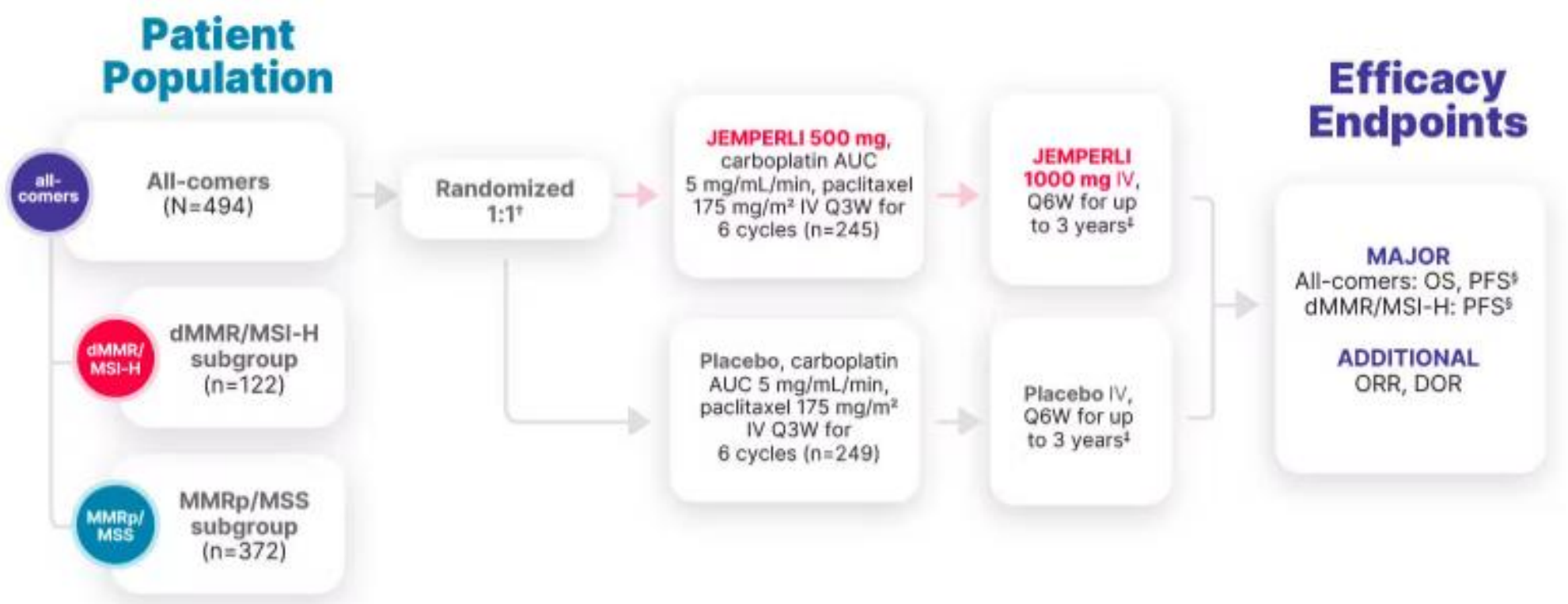
2026 ASCO ANNUAL MEETING #ASCO26

PRESENTED BY: Ramez N. Eskander, MD

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ASCO KNOWLEDGE CONQUERS CANCER

RUBY study design



RUBY: population and key design features

MMR Status

24% dMMR/MSI-H

76% MMRp/MSS

Age

51% 65 Years or Older

Race/Ethnicity

77% White

12% Black

3% Asian

3% Hispanic or Latino



8.9% Carcinosarcoma

20.6% Serous adenocarcinoma

15.8% All other histologies

Clear-cell adenocarcinoma,mucinous adenocarcinoma, undifferentiated carcinoma, mixed carcinoma (≥10% of carcinosarcoma, clear-cell, or serous histologic type) or other

54.7% Endometrioid

Disease Status

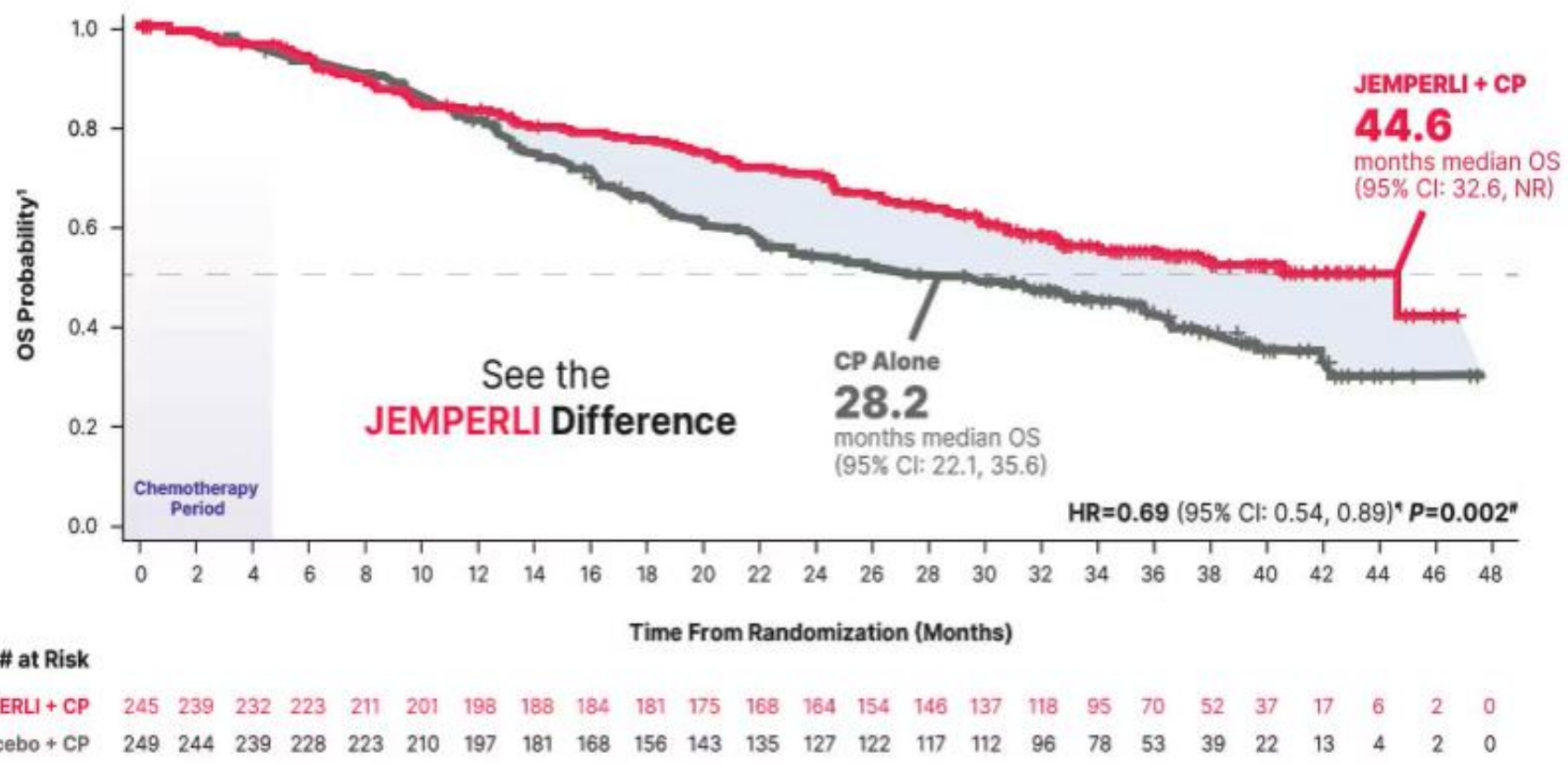


18% Primary FIGO Stage III

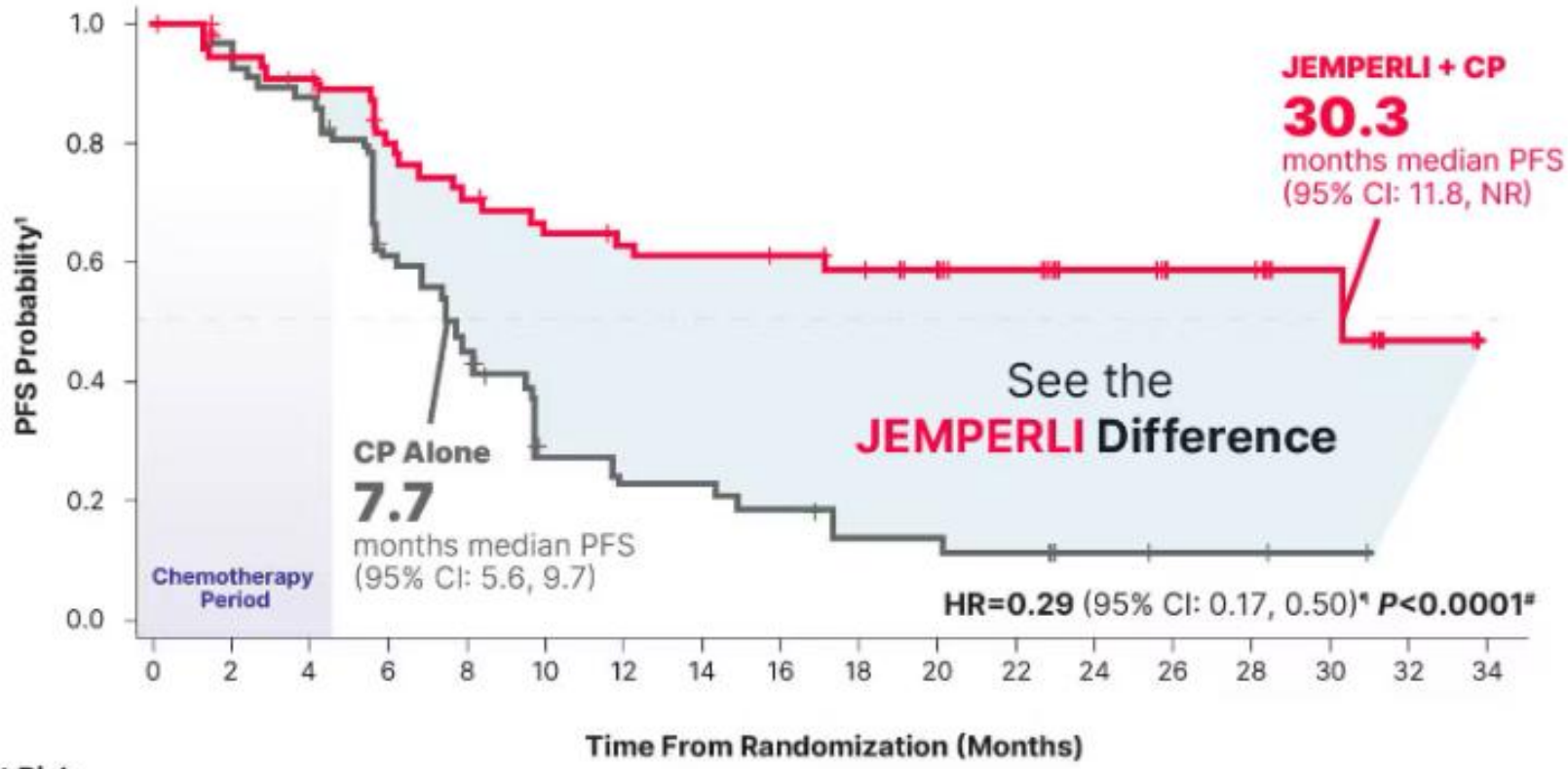
34% Primary FIGO Stage IV

48% Recurrent Disease

RUBY: OS benefit



RUBY: PFS update

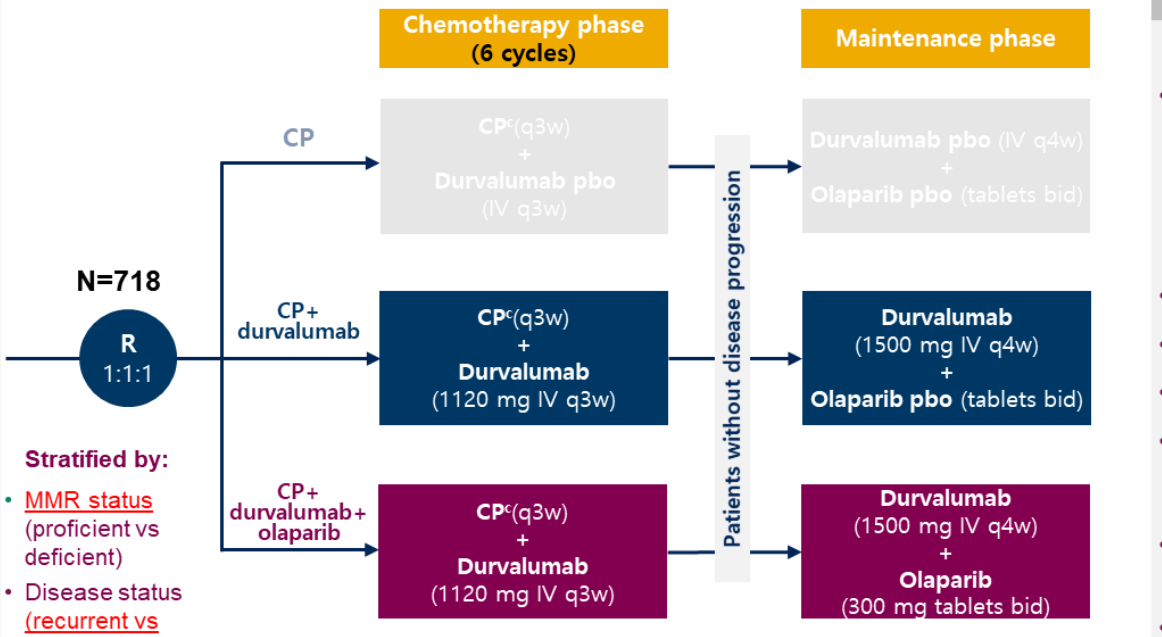


# at Risk																		
JEMPERLI + CP	60	55	52	43	38	34	32	31	30	28	26	20	14	10	10	5	1	0
Placebo + CP	62	54	51	34	25	13	11	11	9	6	6	5	3	2	2	1	0	

DUO-E design

Patients

- **Newly diagnosed FIGO Stage III/IV[a]** or **recurrent endometrial cancer** (measurable disease if newly diagnosed Stage III disease)
- Naïve to first-line systemic anticancer treatment[b]
- Naïve to PARP inhibitors and immune-mediated therapy
- Adjuvant chemotherapy allowed if **≥12 months from last treatment to relapse**
- Known MMR status
- All histologies **except sarcomas**



Endpoints

Primary

- PFS (RECIST per investigator) in
  - CP+durvalumab vs CP
  - CP+durvalumab+olaparib vs CP

Secondary

- OS (key secondary)
- ORR and DoR[2]
- TFST, PFS2 and TSST
- Safety

Exploratory

- PFS in CP+D+O arm vs CP+D arm[3]
- Subpopulation analyses of PFS (prespecified) and ORR and DoR (post hoc) by MMR status[3]
- MMR subpopulation analyses of OS, TFST, PFS2 and TSST (DCO1)[2]

DUO-E is a randomized, multicenter, double-blind, placebo-controlled, Phase III Study.

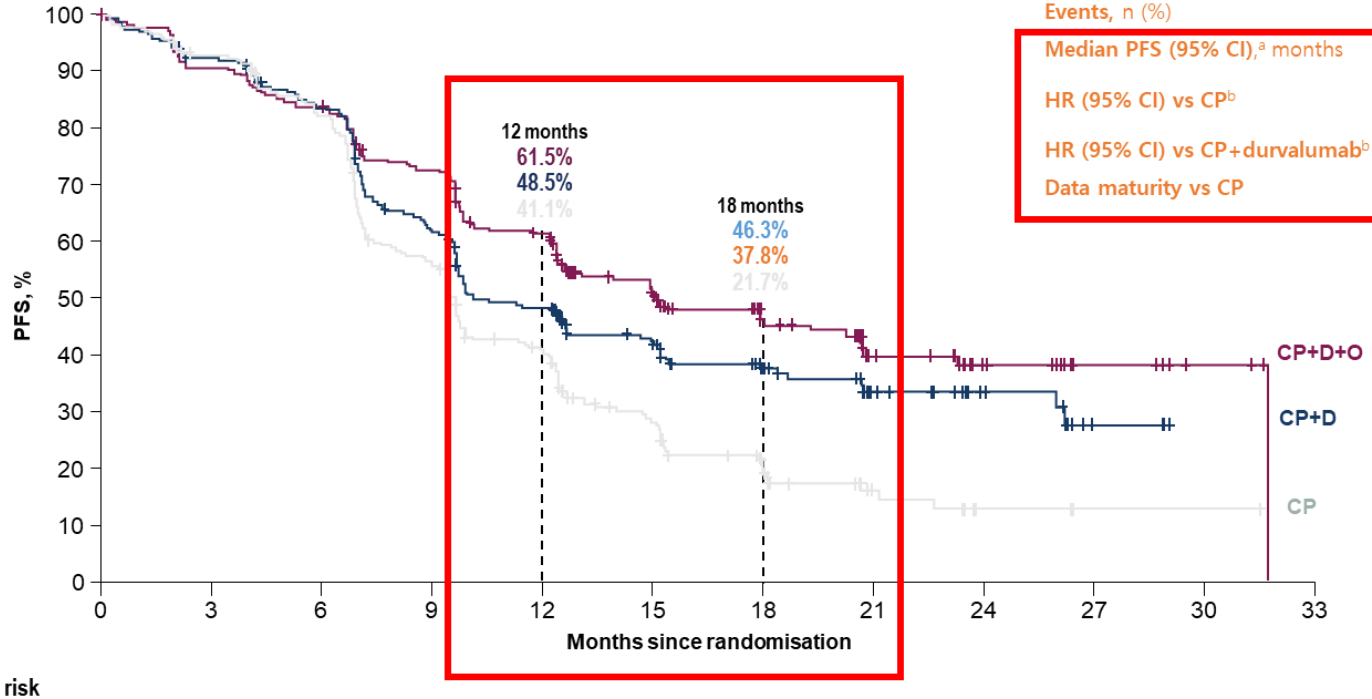
[a]2009 staging system; [b]Prior adjuvant systemic anticancer treatment was permitted for recurrent disease of ≥ 12 months from last dose to subsequent relapse; [c]Six cycles of carboplatin at an area under the concentration-time curve of 5 or 6 mg per mL/min and paclitaxel 175 mg/m^2.

1. Westin SN, et al. *J Clin Oncol.* 2024;42(3):283-299; 2. Baurain JF, et al. Presented at SGO Congress 2024. 16-18 March. San Diego, CA; 3. Chon HS, et al. Presented at: SGO Congress; March 16-18, 2024; San Diego, CA.

DUO-E ITT PFS

Primary Endpoint: Statistically Significant Improvement in PFS

PFS: ITT Population



No. at risk												
CP+D+O	239	214	198	169	139	95	51	30	16	7	3	0
CP+D	238	211	188	138	105	69	45	26	13	5	0	0
CP	241	213	184	125	86	45	26	10	3	1	1	0

	CP N=241	CP+D N=238	CP+D+O N=239
Events, n (%)	173 (71.8)	139 (58.4)	126 (52.7)
Median PFS (95% CI),[a] months	9.6 (9.0–9.9)	10.2 (9.7–14.7)	15.1 (12.6–20.7)
HR (95% CI) vs CP[b]		0.71 (0.57–0.89); *P*=0.003	0.55 (0.43–0.69); *P*<0.0001
HR (95% CI) vs CP+durvalumab[b]			0.78 (0.61–0.99)
Data maturity vs CP		65.0%	62.0%

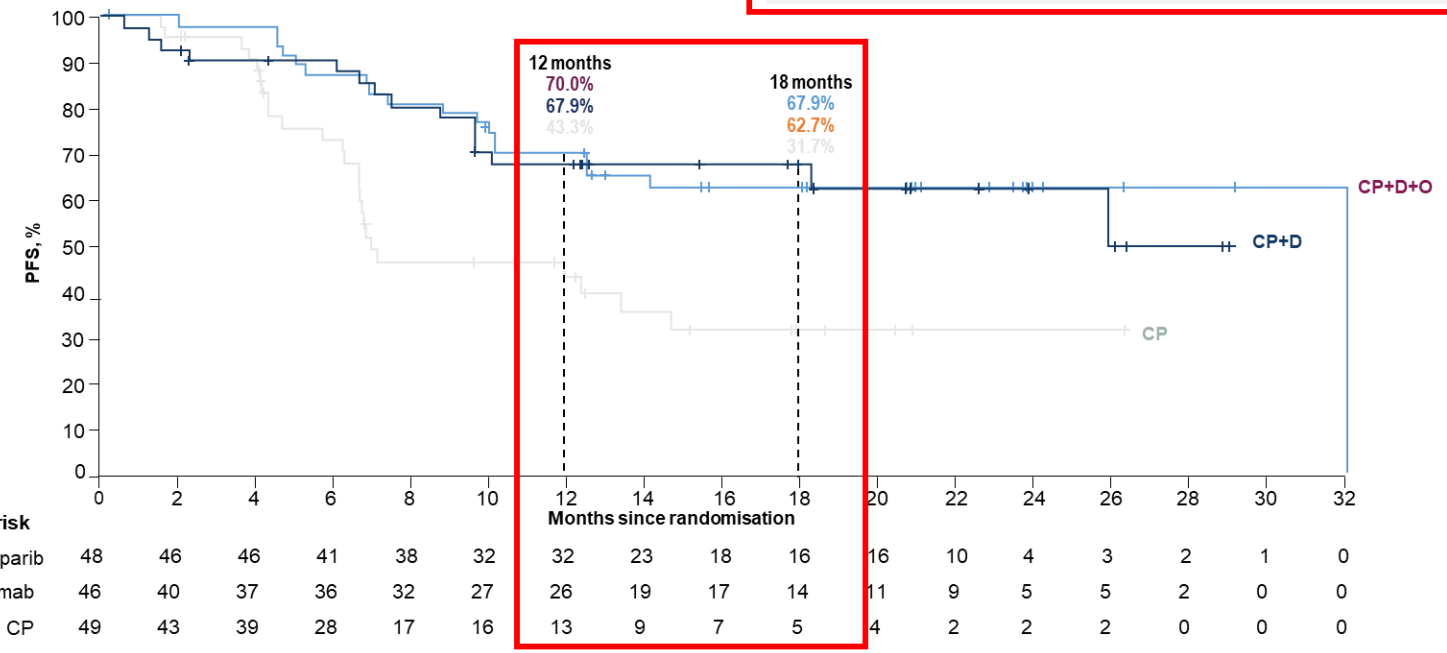
- DCO: April 12, 2023. The median (range) duration of follow-up for PFS was 12.6 (0.0–31.6), 15.4 (0.0–29.1), and 15.4 (0.0–31.7) months in censored patients for the Control, durvalumab, and durvalumab+olaparib arms, respectively. PFS rates were estimated by the KM method. [a]CI for median PFS is derived based on the Brookmeyer–Crowley method; [b]The primary PFS analysis for each comparison was performed separately. The HR and CI were estimated from a Cox proportional hazards model stratified by MMR and disease status. The CI was calculated using a profile likelihood approach. The P value was calculated using a log-rank test stratified by MMR and disease status.
- Westin SN, et al. *J Clin Oncol*. 2024;42(3):283-299.

DUO-E dMMR

dMMR PFS:
Clinically Meaningful Benefit Observed in Both Arms Compared to Control

Prespecified Exploratory Subgroup Analyses
PFS: dMMR (20% of population)

	CP N=49	CP+D N=46	CP+D+O N=48
Events, n (%)	25 (51.0)	15 (32.6)	18 (37.5)
Median PFS (95% CI),[a] months	7.0 (6.7–14.8)	NR (NR–NR)	31.8 (12.4–NR)
HR (95% CI) vs CP[b]		0.42 (0.22–0.80)	0.41 (0.21–0.75)
HR (95% CI) vs CP+durvalumab[b]			0.97 (0.49–1.98)



No. at risk																	
CP+durvalumab+olaparib	48	46	46	41	38	32	32	23	18	16	16	10	4	3	2	1	0
CP+durvalumab	46	40	37	36	32	27	26	19	17	14	11	9	5	5	2	0	0
CP	49	43	39	28	17	16	13	9	7	5	4	2	2	2	0	0	0

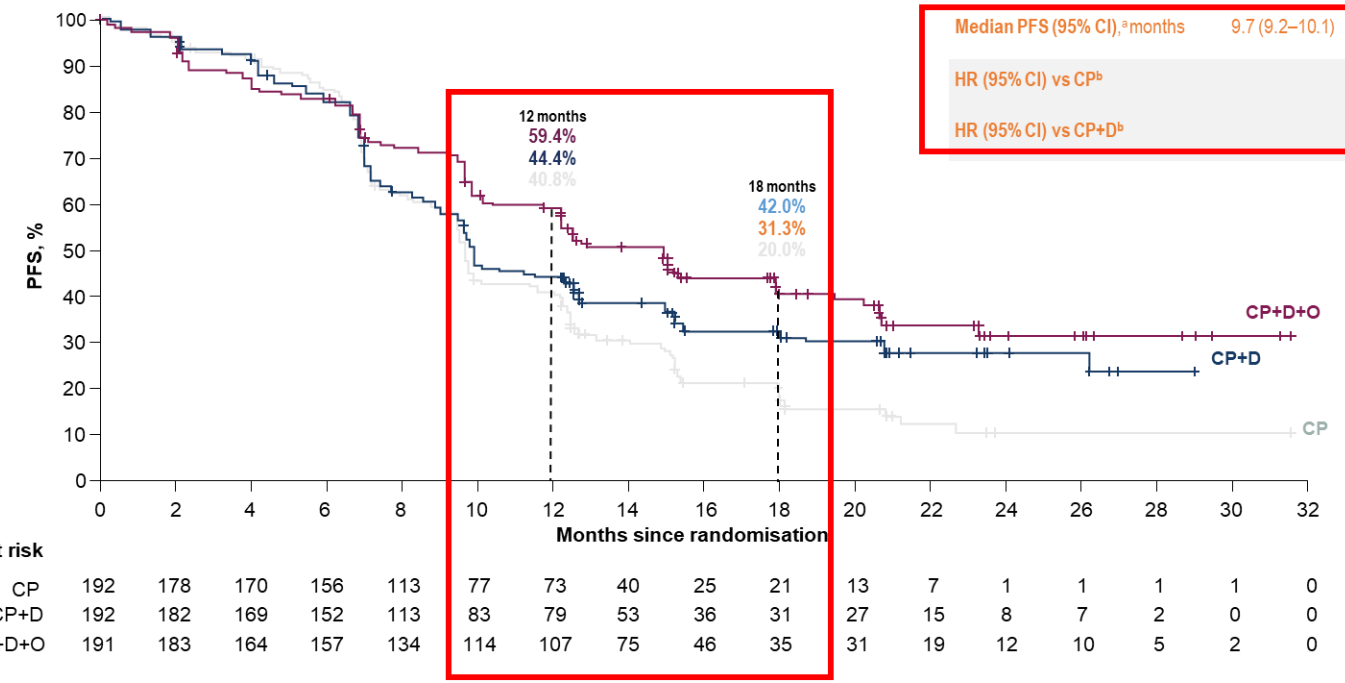
DCO: April 12, 2023. Exploratory subgroup analysis. MMR status evaluated using the Ventana immunohistochemistry MMR panel. Rates were estimated by the KM method. [a]CI for median PFS was derived based on the Brookmeyer–Crowley method; [b]The HR and CI were estimated from an unstratified Cox proportional hazards model.

Westin SN, et al. *J Clin Oncol.* 2024;42(3):283-299.

DUO-E pMMR

pMMR PFS:
Addition of Olaparib Further Enhanced the Treatment Benefit

Prespecified Exploratory Subgroup Analyses
PFS: pMMR (80% of population)



	CP N=192	CP+D N=192	CP+D+O N=191
Events, n (%)	148 (77.1)	124 (64.6)	108 (56.5)
Median PFS (95% CI),[a] months	9.7 (9.2–10.1)	9.9 (9.4–12.5)	15.0 (12.4–18.0)
HR (95% CI) vs CP[b]		0.77 (0.60–0.97)	0.57 (0.44–0.73)
HR (95% CI) vs CP+D[b]			0.76 (0.59–0.99)

DCO: April 12, 2023. Exploratory subgroup analysis. MMR status evaluated using the Ventana immunohistochemistry MMR panel. Rates were estimated by the KM method.
CI for median PFS was derived based on the Brookmeyer–Crowley method; [b]The HR and 95% CI were estimated from an unstratified Cox proportional hazards model.

Westin SN, et al. *J Clin Oncol.* 2024;42(3):283-299.

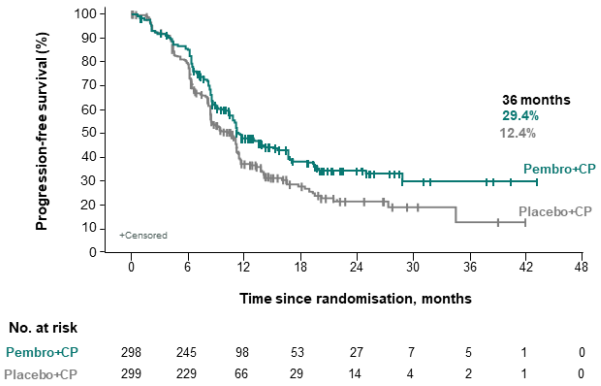
pMMR: no head-to-head comparison

pMMR tumours

Adding ICI to chemotherapy improved PFS, with further gains with the addition of PARPi (updated data)

NRG-GY018 pMMR(DCO: Aug 2023)1*

HR 0.74 (0.60-0.91)
p=0.0022
Data maturity: 58.6%



No. at risk

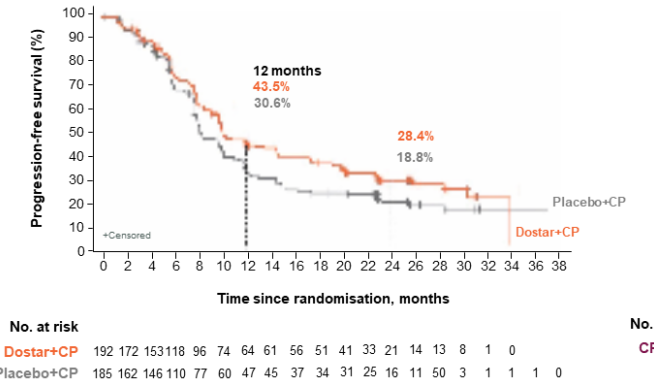
Pembro+CP	298	245	98	53	27	7	5	1	0
Placebo+CP	299	229	66	29	14	4	2	1	0

	Pembro+CP (n=298)	Placebo+CP (n=299)
Events, n (%)	163 (54.7)	187 (62.5)
Median PFS (95% CI), months	11.4 (10.9-15.1)	10.6 (8.7-11.3)

ENGOT-EN6/RUBY Part 1 pMMR-MSS2,3

HR 0.76 (0.59-0.98)

Data maturity: 65.4%



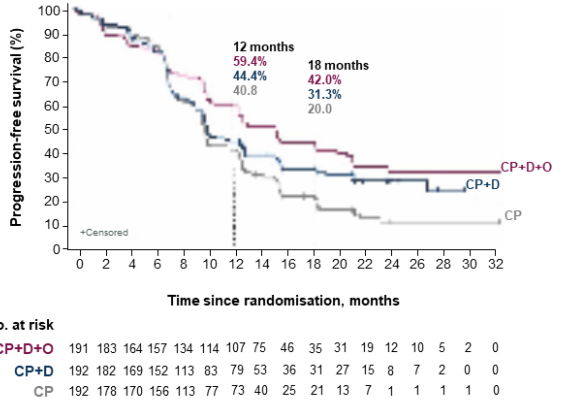
No. at risk

Dostar+CP	192	172	153	118	96	74	64	61	56	51	41	33	21	14	13	8	1	0	
Placebo+CP	185	162	146	110	77	60	47	45	37	34	31	25	16	11	50	3	1	1	1	0

	Dostar+CP (n=192)	Placebo+CP (n=184)
Events, n (%)	116 (60.4)	130 (70.7)
Median PFS (95% CI), months	9.9 (9.0-13.3)	7.9 (7.6-9.8)

ENGOT-EN10/DUO-E pMMR4**

HR: **0.77 (0.60-0.97)** Durva+CP†
HR: **0.57 (0.44-0.73)** Durva+O+CP†
Data maturity: 66.1%



No. at risk

CP+D+O	191	183	164	157	134	114	107	75	46	35	31	19	12	10	5	2	0		
CP+D	192	182	169	152	113	83	79	53	36	31	27	15	8	7	2	0	0		
CP	192	178	170	156	113	77	73	40	25	21	13	7	1	1	1	1	0		

	CP+D+O (n=191)	CP+D (n=192)	CP (n=192)
Events, n (%)	108 (56.5)	124 (64.6)	148 (77.1)
Median PFS (95% CI), months	15.0 (12.4-18.0)	9.9 (9.4-12.5)	9.7 (9.2-10.1)

Please note that head-to-head studies were not conducted between these products. These data are for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

NRG-GY018 *Descriptive analysis. Patients unblinded after primary analysis (Feb 2023). Based on Cox regression model with Efron's method of tie handling with treatment as a covariate stratified by prior chemotherapy. One-sided p-value. Patients were unblinded at primary analysis. Data interpretability is limited due to descriptive analysis and unblinding. Different sensitivity analyses applying different censoring rules results in HRs ranging between 0.58-0.74; DUO-E **Prespecified exploratory subgroup analysis; †HR vs CP+Placebo arm.

Chemo, chemotherapy; CI, confidence interval; CP, carboplatin+paclitaxel; D, durvalumab; HR, hazard ratio; ICI, immune checkpoint inhibitor; O, olaparib; OS, overall survival; pembro, pembrolizumab; PFS, progression-free survival; pMMR, proficient mismatch repair.

1. European Medicines Agency (EMA). EPAR assessment report: pembrolizumab. Last updated: 06/02/2025. Available at: https://www.ema.europa.eu/en/documents/product-information/keytruda-epar-product-information_en.pdf;. 2. Mirza MR, et al. *N Engl J Med*. 2023;388:2145–2158; 3. Powell MA, et al. Presented at: SGO Annual Meeting on Women's Cancer; 16-18 March 2024; San Diego, CA, USA. LBA01; 4. Baurain J, et al. Presented at: Society of Gynecologic Oncology (SGO) Annual Meeting on Women's Cancer; 16-18 March 2024; San Diego, CA, USA. Scientific Plenary V.

Korean reimbursement landscape (2026)

- Dostarlimab + CP → 보험 급여
- Pembrolizumab + CP → Pembrolizumab 본인부담
- Durvalumab + CP ± Olaparib → Durvalumab ± Olaparib 본인부담

*국내 급여 여부는 허가사항 및 HIRA 세부 급여기준을 충족하는 경우에 한함

Current guideline / NCCN

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NCCN Guidelines Version 3.2025
Endometrial Carcinoma

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SYSTEMIC THERAPY FOR ENDOMETRIAL CARCINOMA[a]

Primary or Adjuvant Therapy (Stage I–IV)	
Chemoradiation Therapy	**Systemic Therapy**
Preferred Regimen • Cisplatin plus RT followed by carboplatin/paclitaxel[1,2] **Other Recommended Regimens (if cisplatin and carboplatin are unavailable)** • Capecitabine/mitomycin[3] (category 2B) • Gemcitabine[4] (category 2B) • Paclitaxel[5,6] (category 2B)	**Preferred Regimens** • Carboplatin/paclitaxel/pembrolizumab (for stage III–IV tumors, except for carcinosarcoma) (category 1)[b,c,d,7,8] • Carboplatin/paclitaxel/dostarlimab-gxly (for stage III–IV tumors) (category 1)[c,d,e,9] • Carboplatin/paclitaxel/durvalumab (for stage III–IV dMMR tumors only) (category 1)[c,d,f,10] • Carboplatin/paclitaxel/trastuzumab (for stage III–IV HER2-positive uterine serous carcinoma or carcinosarcoma)[d,g,11] • Carboplatin/paclitaxel/bevacizumab (stage III–IV with measurable disease)[d,12,13] • Carboplatin/paclitaxel[14]

Take-home messages

Endometrial cancer in 2026: staging and treatment are increasingly biology-driven

1 **FIGO 2023**
Histology, LVSI and molecular class now modify anatomic stage.

2 **Adjuvant therapy**
Molecular classification refines escalation/de-escalation; KEYNOTE-B21 signals a distinct dMMR effect.

3 **Advanced / recurrent**
Chemo–ICI is a new backbone; benefit is greatest and most consistent in dMMR.

4 **pMMR**
Benefit is heterogeneous; optimal biomarker selection and PARP-combination strategy remain evolving.



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제31차 추계 심포지엄

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정부세종컨벤션센터 / 세종 코트야드 바이 메리어트

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