Poster code: HSD62

Real-World Treatment Patterns in Commercially Insured Patients With Recurrent or Progressive Endometrial Cancer in the USA

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Objective

- To describe real-world treatment patterns among patients treated with 2 or more lines of therapy (LOTs) in the advanced EC setting

Conclusions

- In this claims-based dataset of commercially insured patients with recurrent or progressive EC, there was considerable comorbidity burden and fragmented 2L+ treatment regimens with limited durability, reflecting the absence of an established standard of care
- Non-platinum–based chemotherapy remains the principal salvage option despite its limited efficacy, highlighting the need for more effective and durable treatment options

Limitations

- Treatment patterns and LOT were identified using claims-based algorithms, which may introduce misclassification of regimens or transitions between lines
- Dataset includes patients who were treated before the change in 1L standard of care, which may have impacted the choice of therapy for 2L and 3L during this period
- The absence of detailed clinical information (eg, tumor stage, biomarker status, disease severity) limits interpretation of treatment selection and outcomes
- Findings are based on a commercially insured population and may not be generalizable to fee-for-service Medicare patients
- Limited sample sizes, particularly for the 3L and 4L datasets, may reduce precision and generalizability of the findings
- As a descriptive analysis, these findings cannot be used to draw causal inferences about the effectiveness of treatment regimens

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Disclosures

Rachel Bhak is an employee of Genmab A/S.

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Abbreviations

1L, first-line; 2L, second-line; 3L, third-line; 4L, fourth-line; a/r, advanced/recurrent; ICI, immune checkpoint inhibitor; EBRT, external beam radiation therapy; EC, endometrial cancer; EGFR, epidermal growth factor receptor; G-CSF, granulocyte colony-stimulating factor; HCPCS, Healthcare Common Procedure Coding System; HRU, healthcare resource utilization; ICD-10, International Classification of Diseases, Tenth Revision; LOT, line of therapy; NDC, National Drug Code; NE, not evaluated; TKI, tyrosine kinase inhibitor; TTD, time to treatment discontinuation; TTNT, time to next treatment; VEGF, vascular endothelial growth factor.

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Introduction

- Endometrial cancer (EC) is the second most prevalent gynecologic cancer globally[1]; in the United States, EC is the most common gynecologic malignancy, with 68,270 new cases projected to occur in 2026[2]
- Approximately 15%-20% of all patients with EC who receive treatment experience a recurrence,[3] after which prognosis is poor with a median overall survival of approximately 12 months[4]
- Guidelines recommend platinum-based chemotherapy (PBC) with or without immune checkpoint inhibitors (ICI) as first-line (1L) treatment for patients with advanced or recurrent (a/r) EC[5]
- Despite advances in the treatment landscape, disease progression following 1L therapy remains associated with limited treatment options and significant unmet need[6–8]
- Accordingly, we aimed to characterize treatment patterns among patients with a/r EC initiating second- to fourth-line (2L–4L) therapy, including treatment regimen distribution, treatment sequencing, time to next treatment (TTNT), and time to treatment discontinuation (TTD)

Methods

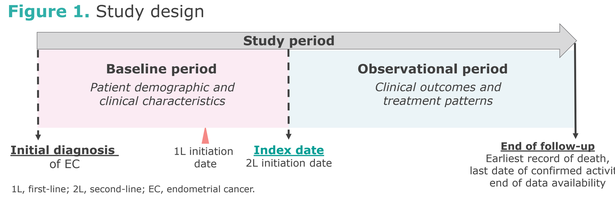
Study design

- A retrospective analysis of de-identified administrative claims data was conducted to characterize real-world treatment patterns among US patients with a/r EC who received ≥2 lines of systemic therapy (**Figure 1**)
- The index date was defined as the start of 2L treatment, with patients followed longitudinally until disenrollment, end of data availability, or loss to follow-up
- A 12-month baseline period prior to 1L treatment initiation was used to assess baseline demographics and clinical characteristics
- The study period spanned January 2018 to December 2024
- Results were summarized overall across the 2L+ period, with patients contributing to each LOT that they received

Study outcomes

- Patient baseline characteristics were summarized with descriptive statistics
- Treatment patterns were assessed from 1L to 4L—including regimen distribution, treatment sequencing, and therapy transitions—and were summarized descriptively
- TTD and TTNT were summarized descriptively

Figure 1. Study design



1L, first-line; 2L, second-line; EC, endometrial cancer.

Data source

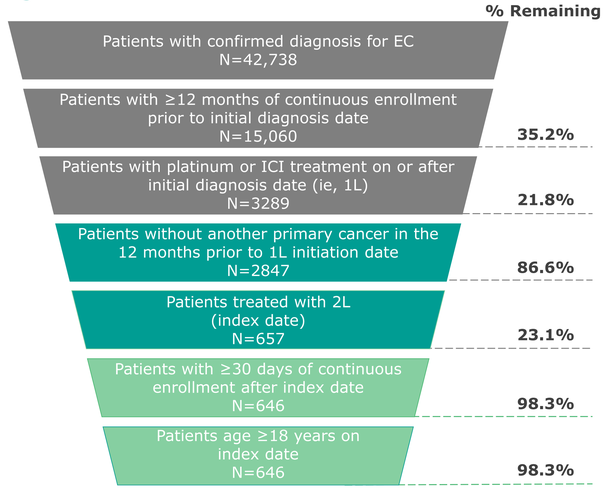
- De-identified claims data were derived from the Merative™ MarketScan® Commercial Claims and Encounters database, capturing longitudinal, patient-level healthcare resource utilization (HRU) and treatment data
- The database includes inpatient, outpatient, and outpatient pharmacy claims linked at the individual patient level, representing a large, commercially insured population and enabling a comprehensive view of HRU and costs
- Treatment regimens were identified using ICD-10, HCPCS, and NDC codes, allowing detailed capture of systemic therapies and regimen composition

Results

Patient selection

- A total of 646 adult female patients were included (**Figure 2**)

Figure 2. Patient attrition flow chart



1L, first-line; 2L, second-line; EC, endometrial cancer; ICI, immune checkpoint inhibitor.

Patient demographics at index date

- Median age was 62 years, with approximately one-third of patients ≥65 years, consistent with the insurance distribution (**Table 1**)
- Patients were geographically well distributed across the US
- In most patients (65.2%), initiation of 2L treatment occurred between 2022 and 2024

Table 1. Patient demographics at index date

Characteristic	2L N=646
Age,[a] median (IQR), years	62 (57, 68)
≥65 years, n (%)	205 (31.7)
Geographic region, n (%)	
Northeast	119 (18.4)
South	241 (37.3)
Midwest	207 (32.0)
West	78 (12.1)
Unknown/not documented	1 (0.2)
Insurance type, n (%)	
Commercial	458 (70.9)
Medicare	188 (29.1)
2L initiation year, n (%)	
2019	22 (3.4)
2020	106 (16.4)
2021	97 (15.0)
2022	140 (21.7)
2023	160 (24.8)
2024	121 (18.7)

[a]Age at advanced diagnosis date. 2L, second-line.

Baseline clinical characteristics

- Patients exhibited a high comorbidity burden, as reflected by elevated Charlson Comorbidity Index scores (**Table 2**)
- Brachytherapy and surgical interventions were common
- Common comorbidities included mild liver disease, diabetes, peripheral vascular disease, and chronic pulmonary disease

Table 2. Therapeutic interventions and comorbidities[a]

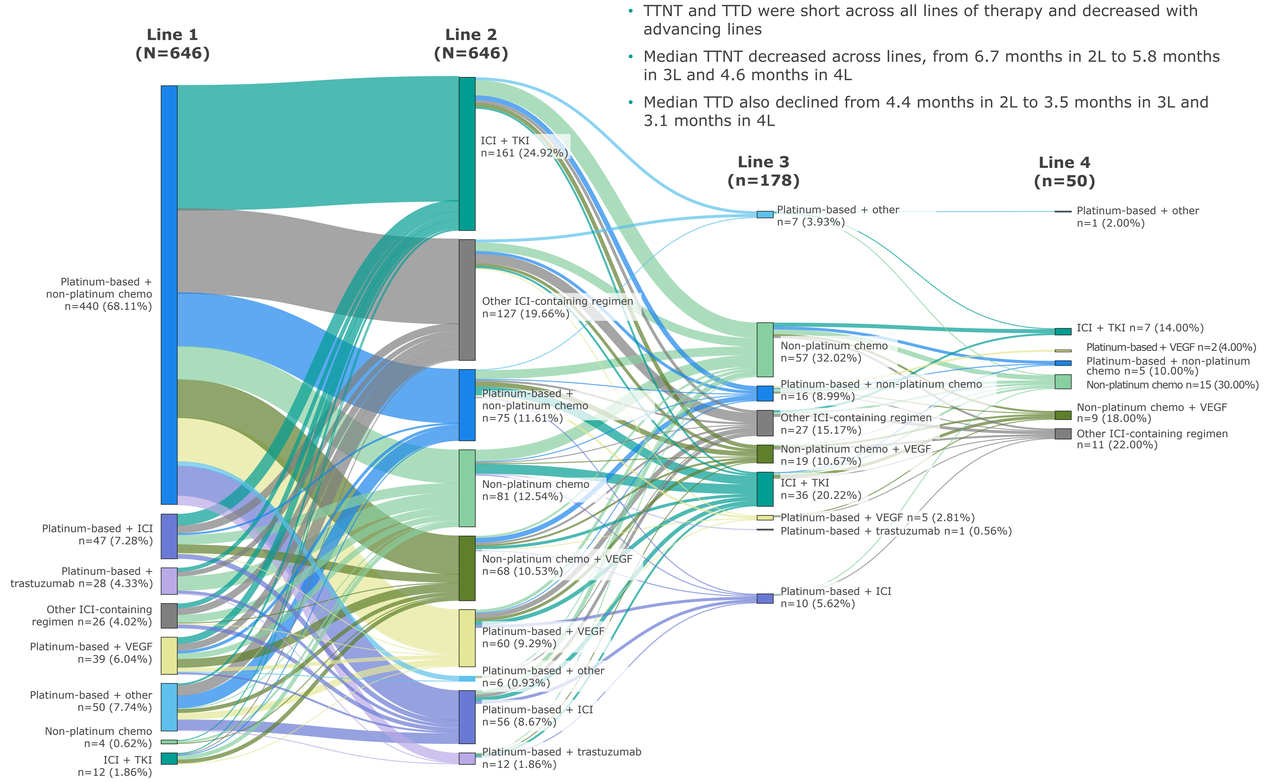
Characteristic	2L N=646	Characteristic	2L N=646
Radiation prior to index date, n (%)		**Quan Charlson Comorbidity Index, mean (SD)**	6.7 (1.9)
EBRT	53 (8.2)	Mild liver disease, n (%)	177 (27.4)
Brachytherapy	141 (21.8)	Diabetes without chronic complication, n (%)	169 (26.2)
Surgery prior to index date, n (%)		Peripheral vascular disease, n (%)	117 (18.1)
Subtotal hysterectomy	196 (30.3)	Chronic pulmonary disease, n (%)	98 (15.2)
Total hysterectomy	318 (49.2)	Diabetes with chronic complication, n (%)	83 (12.9)
Radical hysterectomy	150 (23.2)	Renal disease, n (%)	63 (9.8)
Unilateral salpingo-oophorectomy	21 (3.3)	Cerebrovascular disease, n (%)	48 (7.4)
Bilateral salpingo-oophorectomy	224 (34.7)	Congestive heart failure, n (%)	44 (6.8)
Concomitant G-CSF use, n (%)	125 (19.4)		

[a]Comorbidities occurring in ≥5% of patients are presented. 2L, second-line; EBRT, external beam radiation therapy; G-CSF, granulocyte colony-stimulating factor.

Treatment patterns

- Platinum rechallenge use decreased with advancing lines (32.4% in 2L, 21.9% in 3L, and 16.0% in 4L; **Figure 3**)
- Use of non-platinum chemotherapy increased across lines (23.1% in 2L, 42.7% in 3L, and 48.0% in 4L)
- ICI-containing regimens were most common in 2L and declined in later lines (53.3% in 2L, 41.0% in 3L, and 36.0% in 4L)

Figure 3. Treatment patterns in patients with a/r EC receiving ≥2 LOTs



a/r, advanced/recurrent; EC, endometrial cancer; ICI, immune checkpoint inhibitor; LOT, line of therapy; TKI, tyrosine kinase inhibitor; VEGF, vascular endothelial growth factor.

Time to Next Treatment and Treatment Discontinuation

- TTNT and TTD were short across all lines of therapy and decreased with advancing lines
- Median TTNT decreased across lines, from 6.7 months in 2L to 5.8 months in 3L and 4.6 months in 4L
- Median TTD also declined from 4.4 months in 2L to 3.5 months in 3L and 3.1 months in 4L