abnormal vaginal bleeding requiring intervention had no statistical difference between VP and WVP patients group (p=0.3074) as other complications as well (table 1). Median of related days of vaginal bleeding after the procedure were 7.4 days (SD 8.75) in VP group and 7.34days (SD 8.52) in WVP group, with no statistical difference (p=0.912).

**Conclusions** Insert a vaginal pack or not, after LEEP, do not affect the number of postoperative gynecologic intervention due to vaginal bleeding or the amount of postoperative bleeding days. Previous pregnancies, hormonal status, cytology or LEEP specimen characteristics did not affect the disclosure. We also could not find any risk factor associated to abnormal bleeding. Based on that, the use of vaginal pack can be omitted with no further complications.

## IGCS19-0405

### 382 LATERALLY EXTENDED ENDOPELVIC RESECTION(LEER) AND NEOVAGINE, PATIENT WITH RECTAL ADENOCARCINOMA AND RECURRENCE IN CERVIX, VAGINA AND PELVIC WALL: A PURPOSE OF A CASE

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**Objectives** Exenteration is used to treat cancers of the lower and middle female genital tract in the irradiated pelvis. Höckel described laterally extended endopelvic resection (LEER) as an approach in which the resection line extends to the pelvic side wall.

**Methods** A 49-year-old patient diagnosed with rectal adenocarcinoma 10 years ago, managed with chemotherapy plus radiotherapy. Tumor relapse at 3 years, management with low abdominoperineal resection and definitive colostomy. Second relapse 4 years later, compromising the posterior aspect of the coccyx and right side of the pelvis with irresecability criteria, management was decided with chemotherapy with capecitabine, oxaliplatin and bevacizumab. New relapse at 2 years in the cervix, vagina and pelvic wall. Images without distance disease, type LEER management with extension of pelvic floor margins and resection of muscle pubococcygeus and right lateral iliococcygeus with neovagina (Singapore flap) and non-continent urinary derivation with bilateral cutaneous ureterostomy, achieving adequate lateral margin with curative intent. During follow-up with favorable evolution.

**Results** LEER combines at least two procedures: total mesorectal excision, total mesometrial resection or total mesovesical resection. It may even require resection of the pelvic wall, internal obturator muscle, pubococcygeus, iliococcygeus, coccygeus or internal iliac vessels. In combination with neovagina, it would offer better results in non-gynecological cancer relapses.

**Conclusions** LEER with neovagina can be offered as a new therapy to a selected subset of patients with relapse in adjacent gynecological organs with good oncological, functional and aesthetic results.

# Symptom Management – Supportive Cancer Care

## IGCS19-0706

### 383 PHOTOBIOMODULATION AND MANUAL LYMPH DRAINAGE FOR NIPPLE NECROSIS TREATMENT IN BREAST CANCER: A CASE REPORT

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**Objectives** Recently, breast reconstruction after mastectomy with nipple preservation became an option of breast cancer surgery. Despite its efficacy and aesthetic superiority, the nipple preservation is associated with several complications in the postoperative period.The photobiomodulation therapy, formerly known as low-intensity laser therapy, demonstrated tissue promotion repair by cellular repair biostimulation, angiogenesis and anti-inflammatory effects. These characteristics suggest a potential role for repair of chronic wounds and may be applicable in necrosis treatment. Our aim was to report the effects of the physiotherapeutic intervention through photobiomodulation therapy in a patient with nipple necrosis after risk reducing mastectomy.

**Methods** We report a case of a breast cancer surgery with nipple necrosis treated with low-level laser therapy. The patient was a 36-year-old women who developed skin nipple necrosis in the right breast after bilateral reconstructive mastectomy. She had 6 sessions of low-level laser therapy.

**Results** A female subject developed a nipple necrosis of more than 40% on the right breast after mastectomy and reconstruction. She was referred to Physical Therapy (PT) and the PT sessions were composed by manual lymph drainage, manual therapy for de AWS, exercises of strength and flexibility, followed by LLLT with laser 660 nm, 2 joules per point at every 1 cm. Therapy was implemented for 12 times in total, from May 2016 to June 2016. A re-evaluation was performed monthly from July 13,2016 to November 2017. After 18 months of follow-up, the sustained effects of LLLT were found.

**Conclusions** Low-level laser therapy is effective for the skin cicatrization after nipple necrosis.

## IGCS19-0446

### 384 CONTRACEPTION AND FERTILITY COUNSELING IN PATIENTS RECEIVING CHEMOTHERAPY

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**Objectives** Cancer care advances allow more patients to pursue fertility. Unfortunately, treatments may have detrimental effects on fertility and fetus should pregnancy occur. This study examines physician documentation and patient perceptions of fertility and contraception counseling.

**Methods** IRB approval obtained for a cross-sectional study of men and women, ages 18–50, with newly diagnosed malignancy between May 2017 and 2018. Prior sterilization, secondary or synchronous cancer, or prior chemotherapy were exclusionary. Consented patients received a survey regarding perception on receipt and quality of, counseling. Demographic, sexual, and social information was obtained. Differences were evaluated using chi-square tests.
**Results** Fifty-three of 179 patients identified participated. Majority were women (75 v 25%). Patients were more likely to have perceived counseling for contraception and fertility than documented. The majority perceived counseling as sufficient regarding contraception and fertility.

Men were more likely than women to be perceive counseling regarding fertility (85 v 43%, p=0.010). However, both felt fertility counseling to be sufficient with similar rates of documentation. Caucasians were more likely to perceive receipt of fertility counseling (68 v 29%) and to perceive it to be sufficient (70 v 40%), then African Americans, with the same rate of documentation (35%).
**Conclusions** Significant discrepancies in perception counseling regarding contraception and fertility were seen. Gender and race were important factors for the perception of fertility counseling, while only race was a factor to quality of perceived counseling. These differences occurred despite equal rates of physician documentation, across all groups.

# IGCS19-0430

385 **WHO ARE YOU CALLING OLD? PRACTICE PATTERNS AND MANAGEMENT OF NONAGENARIANS PRESENTING TO A GYNECOLOGIC ONCOLOGIST FOR INITIAL CONSULTATION**

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**Objectives** To describe the practice patterns and treatment of nonagenarians who initiated care with a gynecologic oncologist.
**Methods** Retrospective chart review of women aged 90 or older who presented to a gynecologic oncologist between 10/09 and 12/18 at an urban academic medical center. Descriptive statistics utilized for variables of interest.
**Results** We identified 34 nonagenarians (median age 92, range 90–98): 10 (29%) had benign disease, 8 (24%) pre-malignancy or suspected malignancy, and 16 (47%) malignancy. Of these, 79% had age and/or functional status discussed in the care plan. Of the 8 with suspected malignancy, 5 declined further workup. The cancer distribution revealed 5 (31%) vulvar, 5 (31%) uterine, 4 (25%) ovarian, 1 (6%) vaginal and 1 (6%) cervical cancers. Combined, 37% had stage I disease; 6% stage 3; 6% stage 4; 13% recurrent; and 25% unstaged. All received treatment plans: 7 (47%) with palliative intent and 8 (53%) with curative intent. In the curative group, 7 underwent surgery (1 adjuvant chemotherapy) and 1 chemotherapy/radiation. In the palliative group, 4 underwent radiation, 1 chemotherapy and 2 declined/unknown. Overall, 13 (87%) completed the proposed treatment. Treatment-related complications included 1 superficial skin infection and 1 thirty-day readmission.
**Conclusions** Nonagenarians often presented with vulvar or endometrial cancer and 87% successfully completed treatment with minimal adverse effects or toxicity. Age and/or functional status were considered in the care plan for 79% of women, but it did not preclude treatments that had the potential to preserve meaningful quality of life and/or cure patients of their disease.

# IGCS19-0646

386 **RISK FACTORS COMPREHENSIVE GERIATRIC ASSESSMENT FOR EARLY DEATH IN ELDERLY PATIENTS WITH GYNECOLOGICAL CANCER. A PROSPECTIVE COHORT STUDY**

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**Objectives** To determine risk factors for early death identified the Comprehensive Geriatric Assessment (CGA) in elderly patients with gynecological cancer (EPGC).
**Methods** Prospective cohort study. Participants with a recent diagnosis of cancer were from eight community hospitals and one cancer center in Northeast Brazil and were recruited during their first medical appointment at the outpatient oncologic clinic. A basal CGA was done before the treatment decision (ADL, Charlson Comorbidity Index- CCI, Karnofsky Performance status – KPS, GDS15, IPAQ, MMSE, MNA, MNA-SF, PS, PPS, Polipharmacy, TUG). During the follow up of 12 months, information about the treatments performed, the targeted interventions and early death was collected. Overall survival was estimated using the Kaplan–Meier method, and survival curves were compared using the Log rank test for categorical variables. A multivariate Cox proportional hazards model was used.
**Results** From 2015–2017, 84 EPGC, mean age 69,6±7,9; range 60–96), were enrolled,25% were metastatic disease. tumor site: 40,4% cervical uterine, 36,9%endometrial,20,2% ovary and 2,3 vulva. Nine (10.7%) ECP died in less than 12 months of follow-up.In our multivariate model, controlled by age, site of cancer and cancer stage, the remaining significant risk factors were malnutrition/nonutrition determined by MNA-SF (HR 3.70, 95% CI 1.81–5.99, p<0.001), Katz index (HR 3.60, CI 1.56–3.81, p<0.001) CCI >2 (HR 2,74, CI 1.0.74–10.20, p=0.013) and Polipharmacy (HR 2.65, CI 0.71–9.81, p<0.001).
**Conclusions** The CGA at admission identified risk factors (Nutritional risk, polypharmacy, functionality for Katz index and comorbidity index) for premature death in EPGC. They can help to plan a personalized care.