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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10.1136/ijgc-2019-IGCS.385

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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10.1136/ijgc-2019-IGCS.386

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.