intensive care unit (ICU) admissions, chemotherapy ≤14d of death, PC home visits, and death in hospital. Multivariable logistic regression examined factors associated with aggressive and supportive care.

**Results** There were 16,237 included decedents. Hospital death rates decreased from 47% to 37%, supportive care use rose from 65% to 74%, and aggressive care remained stable (16%). Within 30d of death, 50% were hospitalized, 5% admitted to ICU, and 67% accessed palliative homecare. Within 14d of death, 31% visited the ED and 4% received chemotherapy. Vulvovaginal cancer patients accessed the least resources. Factors associated with aggressive EOL care included younger age, shorter survival, lower income, and rurality. Palliative care was accessed by 93.4% of decedents a median 127d before death, with first contact as outpatients for 68.8% and institutionally for 31.2%. Those accessing PC used median 8 institutional days and 41 community days. While use of community PC gradually increased toward end-of-life, use of institutional PC exponentially increased from 12 weeks until death.

**Conclusion** Over time, fewer women dying with gynecologic cancers in Ontario experienced death in hospital, and more accessed supportive care. However, most were hospitalized and a significant proportion received aggressive care. While >90% of gynecologic cancer decedents accessed PC, median initiation was within the last 4 months of life (late PC), which may result in suboptimal care quality.

**Abstract 2022-RA-747-ESGO Figure 1** Rates of supportive and aggressive end-of-life care received by patients with gynaecologic cancers in Ontario Canada from 2005–2018

**Abstract 2022-RA-747-ESGO Figure 2**

**Conclusion** Over time, fewer women dying with gynecologic cancers in Ontario experienced death in hospital, and more accessed supportive care. However, most were hospitalized and a significant proportion received aggressive care. While >90% of gynecologic cancer decedents accessed PC, median initiation was within the last 4 months of life (late PC), which may result in suboptimal care quality.

**Introduction/Background** Providing prognostic information is considered challenging, and as a consequence, such information is often not discussed. Communication of 3 scenarios to explain survival times has been shown to provide an accurate view of prognosis that leaves room for realistic hope. However, little is known about the preferences for prognostic information among women with gynecological cancer.

**Methodology** This cross-sectional survey recruited women with gynecological cancers at 5 sites in Norway. The survey described 2 formats for explaining life expectancy to a hypothetical patient with advanced cancer—providing either 3 scenarios for survival (best case, worst case, and typical scenario) or just the median survival time.

**Results** A total of 252 women were recruited. 122 (48%) were on current anti-cancer treatment. Participants had primary cancer of the ovaries 110 (44%), corpus 61 (24%), and cervix 52 (21%). Only 35% of responders recalled to have received prognostic information, and out of those that did not, 51% would have liked to receive such information. More participants agreed that explaining 3 scenarios (vs. median survival) would make sense (81% vs. 74%), help to plan for the future (71% vs. 65%), and convey hope (58% vs. 38%), while fewer respondents agreed that explaining 3 scenarios (vs. median survival) would upset people (29% vs. 39%).

Even if the presentation of the worst-case scenario was upsetting (51%), the vast majority felt that it improved their understanding of survival times (72%). 41% would prefer both the median and 3 scenarios to be discussed when prognostic information is given.

**Conclusion** Only a third of women recalled to have received prognostic information. We recommend the 3 scenarios to be included when giving prognostic information, but it seems important to make sure the patient wishes to receive such information.