germ cell cancers in Native Chinese is nearly 2-fold higher compared to US Asians 0.66 vs. 0.36 per 100,000. In Native Chinese, the incidence is increasing with an average annual percent change (AAPC) at 1.4% (p=0.006) whereas in US Asians there is no change (AAPC=-0.10%, p=0.89). To further evaluate the trends in Native Chinese, we found that the incidence (in 2018) of immature teratomas was nearly 3-fold higher compared to dysgerminoma and yolk-sac tumors (0.32 vs. 0.11 vs. 0.10). Moreover, immature teratomas are increasing at 3.46% per year (p<0.001) whereas the dysgerminoma and yolk-sac tumors have remained stable. An intersectional analysis showed Native Chinese at age 10–14 with immature teratoma had the highest annual increase (7.56%, p=0.016).

Conclusions Incidences of germ cell tumors have increased in Native Chinese but remained stable in US Asians. The higher incidence and increasing rates of the immature teratoma type warrants further studies on potential genetic and environmental factors.

### 33/#939 TRENDS IN PHASE 3 CLINICAL TRIALS IN OVARIAN CANCER FROM 2001–2021

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10.1136/ijgc-2022-igcs.77

**Objectives**

To determine the trends and progress of clinical trials on ovarian cancer over the last 20 years.

**Methods**

From 2001 to 2021, all phase 3 clinical trials were identified from clinicaltrials.gov. Demographics and characteristics were analyzed for comparison and trends using chi square analysis.

**Results**

Of 43,641 ovarian cancer patients enrolled in 58 clinical trials, 19 were based in the US and 39 were based internationally. There were 35 (60%) government sponsored trials vs. 23 (40%) industry trials. 18 (31%) trials studied chemotherapy vs. 40 (69%) targeted therapies; 17 (30%) trials incorporated biomarkers. The median number of patients per trial was 581 (range 50–1952), and those using PFS vs. OS was 35 (60%) vs. 14 (24%). To evaluate trends, we studied two time periods, 2001–2010 and 2011–2021. There was an increase in industry sponsored trials (5% (2001–2010) vs. 49% (2011–2021); p-value<0.05), targeted therapy trials (10% to 43%; p-value<0.05), biomarker use (BRCA, HRD, PD-L1) (67% to 89%; p-value<0.05), and incorporation of PFS endpoint (57% to 70%; p-value=0.3). There was a decrease in the median number of patients enrolled per trial (n= 820 to 426) and in the proportion of patients with comorbidities (ECOG>2) (17% to 7%; p-value=0.2).

**Conclusions**

Over the past 20 years, targeted therapy trials incorporating biomarker use has increased, but the number of patients enrolled and those with comorbidities has decreased. These trends in trial design and enrollment are important in understanding the applicability of their results to our patients.

### 34/#806 PATTERNS OF PALLIATIVE CARE UTILIZATION BY WOMEN WITH GYNECOLOGIC MALIGNANCIES IN ONTARIO, CANADA: A 13-YEAR POPULATION-BASED RETROSPECTIVE ANALYSIS

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10.1136/ijgc-2022-igcs.78

**Objectives**

Early palliative care (PC) (≥6–12mo from death) has been associated with improved patient quality-of-life, less aggressive end-of-life care, and prolonged survival, and is understudied in gynecology. We characterized patterns of PC utilization and predictive factors in gynecologic cancer patients.

**Methods**

We conducted a population-based, retrospective cohort study of gynecologic cancer decedents in Ontario from 2006–2018 using ICES-linked administrative healthcare data. Multivariable logistic regression was used to determine factors associated with PC utilization.

**Results**

In this cohort of 16,237 women, 93.4% of decedents accessed palliative care, initially in the outpatient setting for 68.8% and institutionally for 31.2%. Palliative care was initiated a median 127 days before death (IQR 38–361d), and PC users accessed a median 8 institutional days (IQR 0–21d) and 41 community days (IQR 3–174d). While use of community PC gradually increased toward the end of life, use of institutional palliative care exponentially increased from 12 weeks until death. On multivariable analyses, factors significantly associated with an increased likelihood of receiving palliative care were longer cancer-related survival and Deyo-Charlson comorbidity score ≥1. Factors significantly associated with decreased likelihood of palliative care were age ≥80 years, diagnosis of uterine or vulvar-vaginal cancers, initial diagnosis of stage I-III malignancy (vs. stage IV), living rurally or in the third income quintile, or death after 2007.

**Conclusions**

While >90% of gynecologic cancer decedents accessed palliative care, median initiation was within the last 4 months of life (late PC), which may result in suboptimal quality of life and end-of-life care. Access to PC may be inequitable.

### 35/#953 QUANTITY OVER EQUITY: DISPARITIES IN THE DISTRIBUTION OF THE U.S. GYNECOLOGIC ONCOLOGY WORKFORCE

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10.1136/ijgc-2022-igcs.79