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.

**Poster rounds with the professors: Group C5**

**TRENDS IN PHASE 3 CLINICAL TRIALS IN OVARIAN CANCER FROM 2001–2021**

Katherine Cotargco, ²Anya Aliabadi, ³Caitlin Johnson, ¹Amandeep Mann, ¹Ritu Salani, ¹Joshua Cohen, ²Daniel Kapp, ¹John K Chan.

**Objective** 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 were based in the US; 20 (36%) 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, PDL1) (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.

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

Sarah J Mah*, ²Lia Eriksson, ³Daniel Carter Ramirez, ⁴Kara Schnarr, ⁵Hsien Seow.

**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.

**QUANTITY OVER EQUITY: DISPARITIES IN THE DISTRIBUTION OF THE U.S. GYNECOLOGIC ONCOLOGY WORKFORCE**

Nerlyne Desravines*, ²Michael Desjardins, ³Frank Curriero, ¹Amanda Nickles Fader.

**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.

**34/#806**
Objectives Access-to-care disparities are growing as gynecologic oncologist (GON) demand increases amidst rising gynecologic cancer rates. We characterized the geospatial distribution of the U.S. GON workforce relative to at-risk women over 20 years.

Methods We utilized two U.S. physician registries to identify the 2001–2020 GON workforce. Practice locations were aggregated to county levels. Rural/urban were noted based on census designations. Choropleth maps were used to visually assess the spatial variation of the GON workforce relative to the at-risk female population and correlated with patterns in rurality.

Results Between 2001–2020, the GON workforce increased steadily, plateauing circa 2017 (figure 1). By 2020, there were 1,178 active GONs; 51.5% were early-to-mid career and 98.3% practiced in urban areas (representing only 37.3% of all counties). A disparity in practice geography was identified, with 1.09 GONs per 100,000 women in urban areas compared to 0.1 GONs per 100,000 women in rural areas (p < 0.0001). In total, 2,867 counties (representing 57.5 million at-risk women) did not have a GON. Additionally, there was no increase in rural GONs observed over time with only 1.7% in 2016 – 2020 relative to 2.2% in 2001–2005. Of the rural providers, fewer were early-to-mid career (23.5%) compared to late-career (76.5%); this trend persisted throughout all periods (figure 2).

Conclusions Over two decades, the U.S. GON workforce increased substantially, but not equitably, as a widening disparity in rural cancer care was noted over time. Policies and pipeline programs are needed to address this widening disparity in rural gynecologic cancer care.

Abstracts

36/#157 ENHANCED RECOVERY AFTER SURGERY IN OPEN ABDOMINAL HYSTERECTOMY FOR MALIGNANT AND BENIGN DISEASE: A RANDOMISED CONTROL TRIAL

Shalini Rajaram*, Shweta Sharma, Bindiya Gupta, Asha Tyagi, Sandhya Jain. All India Institute of Medical Sciences, Rishikesh, Obstetrics and Gynecology (gynecologic Oncology), Rishikesh, India; UCMS and GTBH, Obstetrics and Gynecology, Delhi India

Objectives Enhanced recovery after surgery (ERAS) is a multidisciplinary protocol that incorporates several perioperative components. To compare perioperative outcomes and patient satisfaction in ERAS versus conventional management in a tertiary care setting.

Methods Sixty women who underwent hysterectomy through the open abdominal route for benign and malignant indications were recruited and randomized to two groups; ERAS vs. conventional. Sample size was calculated after fixing Type I error at 5% and power of study at 95%, assuming a standard deviation of 20%. Postoperative recovery, pain, hospital stay, complications and readmissions and patient satisfaction scores were analysed. Compliance to individual components and overall compliance was calculated (CTRI/2020/02/023431)

Results Duration of hospital stay was shorter in ERAS group: 3.87±1.25 vs 5.60±1.18 days (p-value=0.001) in benign cases and 5.27±2.34 vs 6.33±1.29 days (p-value=0.01) in malignancy. Decreased time to ambulation (p <0.001), time to resumption of enteral feeding (p=0.022 and 0.002), passage of flatus (p=0.002 and 0.028), stool (p< 0.001 and p=0.003) and lower pain scores (p-value<0.001) were seen in benign and malignant cases on ERAS protocol. Complications were comparable in ERAS vs. conventional protocols for Grade 1 (p-value=0.359), Grade 2 (p-value=1.000) and Grade 3 (p-value=0.125). Patient satisfaction scores and readmissions between the two groups were comparable.

Conclusions This trial showed a significant decrease in hospital stay, early ambulation, resumption of oral feeds, bowel motility and lower pain scores with ERAS protocol. Patient satisfaction scores did not differ between ERAS and conventional protocols and adoption of ERAS did not increase postoperative complications and readmissions.