a lower but increasing number of palliative cases are being reviewed. Overall, RTPPR represents an important, though time consuming and costly process. Radical plan review rates were consistently higher in more regimented, higher attendance, higher opportunity cost RTPPR groups, but it remains unclear if error detection rates are superior. Opportunities to measure and increase actionable event detection should be explored. Human health resource time and opportunity costs have been increasing, despite stable or decreasing overall proportion of cases being reviewed. Increasing volumes, and complexity within the case mix of palliative cases (IMRT, SRS for brain metastases, SBRT for oligometastatic disease) will continue to elevate demands on timely and purposeful RTPPR, opening the door for innovation.

170 PREVALENCE OF OLIGOMETASTATIC DISEASE BASED ON THE 2019 INTERNATIONAL CONSENSUS STATEMENT
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Purpose: Increased attention to the oligometastatic state has resulted from improvements in, and availability of, staging modalities, systemic therapy, and ablative treatment approaches. However, what exactly comprises oligometastases (OM) has been inconsistently described, making interpretation of published data challenging and the exact prevalence unknown. A 2019 international consensus statement proposed a definition of a maximum of five metastases involving three organs. We aimed to describe the prevalence of the OM state in an otherwise unselected population according to this definition.

Materials and Methods: Consecutive patients referred to our tertiary cancer centre’s Palliative Radiation Oncology and/or Palliative Care programs were included in an IRB-approved prospectively maintained database within a larger study of survival prediction (06/2010-12/2014). Patient, disease, and treatment information, including number and sites of metastases, were retrospectively reviewed. Stereotactic radiotherapy for OM was not administered. Summary statistics were calculated.

Results: Within this cohort, 980 patients had 9,186 metastases. Median patient age was 65.1 years (range 18.9-91.9 years); 58.2% were male; 36.2% had a lung and 28.2% a genitourinary primary. 50.6% for whom Karnofsky Performance Status was available had a value of >70. The median number of metastases was eight (range 1-105), with 58/980 patients having “innumerable” lesions radiologically. Median number of organ sites involved was two (range 1-10), 255/980 (26.0%) had five or fewer total metastases, and 660/980 (67.3%) had three or fewer organ sites involved. Just over one-third (34.2%) had malignant involvement of an OM exclusion site, such as the bone marrow, leptomeninges, or a pleural effusion. Overall, 209/980 (21.3%) met the International Consensus definition for OM.

Conclusions: Within a historic cohort treated with palliative intent, in retrospect just over 20% had an oligometastatic disease burden based on a recent international consensus statement.

171 THE ROLE OF SOCIOECONOMIC STATUS (SES) IN DISEASE OUTCOMES IN PEDIATRIC CANCER PATIENTS RECEIVING PROTON THERAPY
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Purpose: To describe gender trends in the Canadian radiation oncology (RO) trainee and staffing workforce.

Results: Eight hundred and seventy-six patients with pediatric cancer were enrolled in the PPCR during this time. International patients and those with no address were excluded, leaving 637 patients for analysis. Mean median income was $67,639 at ZC level and $70,906 at CT level. Mean rate of high school graduation was 89.0% at ZC level and 89.1% at CT level. Mean rate below poverty line for the enumeration area was 12.3% at ZC level and 11.7% at CT level. There was no significant difference between data obtained at ZC and CT levels for all metrics. No significant difference was found in OS or PFS (p-value 0.49 and 0.65) as a function of median income, or by poverty status (p-value 0.94 and 0.88). There is no significant difference in OS or PFS with attainment of high school diploma (p-value 0.51 and 0.65). Additional analysis demonstrated no significant difference between OS and PFS with insurance type (p-value 0.59 and 0.73).

Conclusions: Within the population of patients with pediatric cancer treated with proton therapy, population socioeconomic factors including median income, attainment of high school diplomas, rate of poverty and insurance type have not been shown to significantly impact OS or PFS. Importantly, results do not vary when taken at two different enumeration areas.

172 TOWARDS GENDER EQUALITY AND EQUITY IN RADIATION ONCOLOGY: GENDER REPRESENTATION TRENDS IN CANADIAN TRAINEES AND RADIATION ONCOLOGISTS FROM 1994 TO 2019
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Purpose: Social factors are known to play a critical role in disease burden and socioeconomic status (SES) has been associated with severer and health conditions and outcomes. There is strong evidence that SES plays an important role in the incidence, morbidity and mortality of cancer within the adult population, but the impact of SES within the pediatric cancer population is still under debate due to conflicting results. Here we use the large multicenter Pediatric Proton/Photon Consortium Registry (PPCR) to investigate how SES can affect disease control and other outcomes in patients treated for pediatric cancers at proton therapy centers across the United States.
Materials and Methods: Gender data for Canadian RO trainees and radiation oncologists from 1994 to 2019 were collected from the Canadian Post-MD Education Registry and Canadian Medical Association Physician Data Centre. Visa trainees were excluded. Ten Canadian provinces were grouped into five distinct regions for analysis: West Coast, Prairies, Ontario, Quebec, and Atlantic Canada. Gender parity was defined as a 1:1 male-to-female ratio. Descriptive statistics were used to summarize the data.

Results: The number of Canadian RO trainees per year varied between 1994 and 2019, with totals ranging from 41 to 97 males and 25 to 84 females. There were two parallel periods of growth (1994-1996 and 2002-2008), and two periods of regression (1997-2001 and 2009-2016). Gender parity was achieved among trainees from 2012 to 2016. Annual proportion of female trainees increased over time from 38% in 1994 to 51% in 2016, except in 1998-2002 and 2016-2019 when female proportions fell from 43% to 35% and from 51% to 37%, respectively. Female trainee proportions were consistently higher among Francophone training programs (45-90%) compared to Anglophone programs (22-48%). In the Canadian RO workforce, the proportion of female staff increased from 20% in 1994 to 37% in 2019. All regions showed increasing proportions of female staff over time, but proportions differed by region. Quebec was the only region where the RO workforce reached gender parity since 2008. The female workforce in Ontario rose from 22% in 1994 to 31% in 1999, fell to 24% in 2011, and then rose to 30% in 2018. Elsewhere, the proportions of female staff in 2018 were 41% in Atlantic Canada, 35% in the West Coast, and 32% in the Prairies. The proportion of female staff in 2019 was age-dependent: 62% age <35 years, 44% age 35-44 years, 34% age 45-54 years, 30% age 55-64 years, and 25% age ≥65 years. Staff <35 years old were predominantly male from 1994 to 2011, with gender parity in 2012-2016 before females outnumbered males in 2017-2019. Rising female distribution was demonstrated across all age groups with time. The number of male staff aged ≥65 years decreased sharply from 71 to five between 1994 and 1999-2000, while the number of female staff aged ≥65 years dropped from five in 1994 to 0-1 in 1998-2004. By 2019, there was a gradual increase in the age ≥65 cohort to 45 males and 15 females.

Conclusions: Gender representation in the Canadian RO trainee and workforce has changed over time. Gender parity was observed in trainees nationally, staff <35 years old, and in the Quebec workforce. However, gender distribution differences exist with respect to Francophone versus Anglophone training programs, and region and age in the RO workforce. The recent trend of declining female proportion in RO trainees may reflect changing perceptions among medical students and potential gender-based barriers.