

education, duration of marriage, occupation, type of disease, and administration of chemotherapy.

Conclusions Sexuality after cancer affecting the female genital area is altered, age >50 years, illiteracy, length of marriage > 20 years as well as endometrial, vulva and vaginal cancers were predictive factors of sexual dysfunction.

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THE IMPACT OF PATIENT TRAVEL DISTANCE ON QUALITY INDICATORS IN GYNECOLOGIC SURGERY

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Objectives To characterize patient travel distance to a comprehensive cancer center (CC) for gynecologic surgery; to determine the impact of travel distance on perioperative quality indicators.

Methods Patients who underwent first gynecologic surgery at a CC from 1/2000–3/2018 were identified. Travel distance was defined as “close” (≤50 mi) or “far” (>50 mi). Patient demographics, procedural complexity, rates of reoperation, reporting to improve safety and quality (RISQ) events, and postoperative mortality were identified.

Results Of 23,340 patients, 19,246 were included in the close group and 4,094 in the far group. Median distance traveled was 19.25mi (range 0–4963): 14.35mi for close group, 85.21mi far group. Median age was 55 years (range 18–97). There was no difference in age ($p=0.87$) or ASA status ($p=0.16$) between groups. Patients in the far group underwent more complex procedures based on RVUs ($p=0.00$) and case length ($p=0.00$) and had 1-day longer length of stay ($p=0.003$). There were more non-White ($p=0.00$), non-English speaking ($p=0.00$), and unmarried ($p=0.00$) patients in the close group. There was no difference in rate of reoperation ($p=0.95$) or 30-, 60-, or 90-day mortality ($p=0.35$, 0.80 , 0.34) between groups. Patients who traveled farther had 1% more RISQ events ($p=0.003$), but this did not hold on multivariate analysis.

Conclusions We demonstrate that patients who travel for centralized specialty gynecologic surgical care have more complex procedures, more perioperative adverse events, and longer length of stay, without negative impact on perioperative quality of care, reoperation, or postoperative mortality.

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A RETROSPECTIVE STUDY OF DUAL MALIGNANCIES IN A GYNECOLOGICAL ONCOLOGY DEPARTMENT OF A TERTIARY CARE HOSPITAL -A TEN YEAR EXPERIENCE

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Objectives Occurrence of second invasive cancer in a diagnosed case of cancer patient and also in cancer survivors is not uncommon. Advances have been made in diagnostic and therapeutic modalities, leading to improvement in survival of cancer patients, and also, the incidence of second malignancy is on rise. Second malignancy can be synchronous or metachronous. Original studies about dual malignancy are very few. The present study aims to analyze the frequency and types of double malignancies in Gynaec oncology patient.

Methods This is a retrospective analysis of patients with synchronous dual cancers, treated from January 2009 to December 2018. The study included 12 patients with dual malignancies.

Results Out of 12 patients, 4 (33.3%) were of ovarian and endometrium origin and they were the most common in our study, followed by breast and endometrium (16.6%); breast and vulva (16.6%); breast and ovary (16.6%); cancer breast with cancer cervix and cancer endometrium with colon cancer were least common (8.3%). Double malignancies involving the female reproductive tract, like cervix and vulva, can be explained by common etiological factors like Human papilloma virus (HPV). The same association has not been seen in our series which could be explained on the basis of small number of patients reported here.

Conclusions This study puts a light on the fact that oncologists should remain cognizant of the fact that dual cancer of the female genital tract and elsewhere in the body is not an unknown occurrence and a comprehensive workup is desirable at the time of initial presentation.

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HARMONIZATION OPERATIONS FOR GLOBAL TRIALS TO OVERCOME OBSTACLES FROM 2004 – 2017: GYNECOLOGIC CANCER INTERGROUP (GCIG)

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Objectives The Gynecologic Cancer InterGroup (GCIG) is a global consortium consisting of research groups from various countries to facilitate collaboration in clinical trials in gynecologic cancer; founded in 1993 and formalized in 1997. Global clinical trials often have multiple obstacles for operating them. To address such issues, the GCIG established a Harmonization Operations Committee in 2003. Achievements of this Harmonization committee are summarized.

Methods Minutes of GCIG meetings between 2004 and 2017 were reviewed. Participating member groups and Harmonization activities were summarized.