

816

IMPLICATIONS OF THE COVID-19 PANDEMIC: RESULTS OF A GERMAN SURVEY ON PATIENT CARE AND CLINICAL TRIALS IN GYNECOLOGICAL ONCOLOGY (MONITOR-17 SURVEY)

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Introduction/Background* This survey describes the German-wide impact of the COVID-19 pandemic on provision of clinical care and recruitment in clinical trials of patients with gynecologic malignancies from a physician's perspective.

Methodology We performed an online anonymous multicentric prospective survey across clinicians in Germany. The multiple-choice questionnaire was administered at 4-6 weekly intervals from April 2020 to October 2020 for a total of four series.

Result(s)* 483 questionnaires were completed. The majority of participants were gynecological oncologists (83.3%) in certified gynecologic cancer centers (61%) and breast cancer (BC) centers (80.4%). The majority stated a 50% reduction in surgical interventions for gyne-oncological cases. Cases that were prioritized for surgery across all tumors were those with early stage disease, at primary situation and with a good ECOG status. For BC, patients following neoadjuvant chemotherapy treatment and those with high-risk or locally-advanced BC were prioritized. The majority (73%) continued to conduct clinical trials throughout the pandemic. In cases where trials were discontinued, this decision was made by sponsors, and hospital officers. Other reasons for discontinuation included lack of patient-participation (due to fear of attending appointments). Almost 100% of the responders refuted any increased tendency to treat with a neoadjuvant approach (cytotoxic, hormonal, radiation) patients that would qualify for surgery under normal circumstances. This comes in direct contrast to the increased attitude to treat with neoadjuvant anticancer therapy of advanced cancers in other European countries.

Only 18% of the clinicians reported feeling adequately informed about established safety pathways for COVID-19 positive patients with gynecological cancers. More than 43% of the clinicians felt that the COVID-19 pandemic will continue to impact on clinical care for up to 2 years.

Conclusion* Targeted emergency algorithms for patients with gynecological cancers need to be developed to protect and preserve care and treatment options for our patients in future pandemics.

818

COMPLIANCE WITH ENHANCED RECOVERY AFTER SURGERY IN A GYNAECOLOGICAL ONCOLOGY SERVICE IN THE WEST OF IRELAND

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Introduction/Background* Enhanced recovery after surgery (ERAS) protocols aim to improve clinical outcomes and provide a cost benefit to the healthcare system. This approach is widely accepted as the goal in perioperative care, but

implementation varies widely. The ERAS Society updated their guidelines for perioperative care in gynecological oncology in early 2019.

Methodology Retrospective review of implementation of ERAS recommendations in a gynaecological oncology service in the west of Ireland. Data collection through review of patient charts for all major surgeries in the service over 4 months (September-December 2019 inclusive).

Result(s)* Total cohort of patients undergoing surgery during this time period was 41 women. One cervical cancer, 13 endometrial cancers and 27 tubo-ovarian pathologies. No pre-habilitation and verbal education only offered. Successful smoking cessation (>4/52) in 50% of smokers. Bowel preparation used in 2.4% of patients. Length of time fasting; 6-8 hours (10%), 8-12 hours (46%), and 12-16 hours (44%); no carbohydrate loading pre-operatively. Compliance was 100% with anti-microbial prophylaxis, normothermia maintenance, and chlorhexidine based skin preparation at surgery, but no pre-operative chlorhexidine based showers recorded. Peritoneal drains were used in 34% of cases, and there was no strict maintenance of normoglycaemia. There was 100% compliance with intra-operative/post-operative dual mechanical/chemo-thromboprophylaxis, but no pre-operative, nor extended post-operative thromboprophylaxis. General anaesthetic in 100% cases. No sedatives given pre-operatively and 42% underwent minimally invasive surgery. At laparotomy, 92% had a thoracic epidural sited (average use 2.5 days), and 12.5% had patient controlled analgesia. Multi-modal anti-emetics used in 68% of cases and a nasogastric tube placed in 2.4%. Postoperative opiates prescribed in 90%, NSAIDs in 93%, no use of gabapentin recorded. Oral diet resumed in under 24 hours for 61%, with 39% resuming diet in the following 24 hour period. Urinary catheters were removed in under 24 hours for 42% of patients, with 24% and 34% in the following 24 hour periods respectively (71% of which were related to ongoing epidural use). All patients without epidurals mobilised in under 24 hours. Of those with epidurals, 77% mobilised between 24-48 hours.

Conclusion* Mixed compliance is demonstrated with ERAS guidance. There is excellent compliance in the area of surgical-site infection prevention. Improved pre-operative education, reduced fasting times, carbohydrate loading, pre- and post-operative extended thromboprophylaxis and reduced opiate use would improve ERAS compliance rates.

856

AUDIT TO STREAMLINE MULTIDISCIPLINARY TEAM MEETINGS BY IMPLEMENTING STANDARD OF CARE FOR EARLY ENDOMETRIAL CANCER CASES

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Introduction/Background* Multi-disciplinary team (MDT) meetings are the core component of the UK's cancer services. Over the last decade, incidence rates for all cancers combined have increased by a twentieth (5%) in the UK. UK's health services have changed significantly since the introduction of MDT in 1995 and MDT are already under considerable pressure.

In 2020 NHS CANCER ALLIANCES published guidance on how MDTs can streamline to focus time on more complex cases through the introduction of Standards of Care (SoCs)