intimacy. The device we use for the treatment is heated at body temperature and during insertion, a special technique ensures painless tightening and stability in the body.

Results Since the location of the device in the body has an influence on the radiation dose on the adjacent organs, the patient's position results in a reduction of dose to the rectum and bladder and decreases the rate of acute and late toxicity.



Abstract 2022-RA-667-ESGO Figure 1

Conclusion Cooperation of our patients and techniques provide successful treatment planning and delivery while reducing radiotherapy dose to the organs at risk. This approach significantly reduces the level of anxiety, helps patients trust and cooperate with staff, complete treatment without interruptions and an overall better outcome.

2022-RA-683-ESGO

THE ENSURE TRIAL FOR WOMEN WITH EARLY-STAGE ENDOMETRIAL CANCER: A RANDOMIZED CONTROLLED TRIAL COMPARING THE EFFECT OF A REDUCED VERSUS USUAL FOLLOW-UP SCHEDULE ON PATIENT SATISFACTION, HEALTH CARE USE, AND DISEASE PERCEPTIONS

1,2Nicole PM Ezendam, 1,2Belle H de Rooij, 3Carien L Creutzberg, 4Roy F Kruitwagen, 5Luc RCW van Lonkhuijzen, 6Mirjam JA Apperloo, 7Kees Gerestein, 8Astrid Baalbergen, 9Dorry Boll, 10M Caroline Vos, 1,2,11Lonneke V van de Poll-Franse. 1Netherlands Comprehensive Cancer Organisation, Utrecht, Netherlands; 2Tilburg University, Tilburg, Netherlands; 3Leiden University Medical Center, Leiden, Netherlands; 4Maastricht University Medical Center, Maastricht, Netherlands; 5Amsterdam University Medical Centers, location AMC, Amsterdam, Netherlands; 6Medical Centre Leeuwarden, Leeuwarden, Netherlands; 7Universitair Medisch Centrum Utrecht, Utrecht, Netherlands; 8Reinier de Graaf Hospital, Delft, Netherlands; 9Catharina hospital, Eindhoven, Netherlands; 10Elisabeth-TweeSteden Hospital, Tilburg, Netherlands; 11Netherlands Cancer Institute/Antoni van Leeuwenhoek Hospital, Amsterdam, Netherlands

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Introduction/Background Research suggests that most early-stage endometrial cancer patients do not need intensive follow-up. The aim of the ENSURE (Endometrial cancer SURvivors' follow-up care) trial was to compare satisfaction with care between women who received a reduced follow-up (FU) schedule (4 visits) and women who received the usual FU schedule according to the Dutch guideline (8–11 visits) for three years after treatment.

Methodology In this multicentre non-inferiority trial, 316 women from 42 hospitals with FIGO stage IA/B endometrial cancer were randomly allocated to reduced FU (n=160) or usual FU care (n=156). The women completed questionnaires at baseline (after surgery), and after 6, 12 and 36 months. The primary outcome was satisfaction with care (PSQ-III) with a predefined noninferiority margin of 6 points (range 0–100). Mixed linear regressions were used.

Results 299 (95%) women completed the questionnaire at baseline; 291 (92%) at 6-months; 272 (86%) at 12 months and 222 (70%) at 36 months. During three years after treatment, women in the reduced FU group had a median of 3.5 [IQR 3.0–5.0] visits with their specialist/nurse compared to 7.0 [IQR 6.0–9.0] visits for women in the usual FU group. Overall satisfaction with care was similar in the reduced FU (M=82;SD=15) and usual FU (M=82;SD=13) group. At 6, 12 and 36 months, more patients (93/94/90%) in the reduced FU arm were satisfied with their FU schedule than patients in usual FU arm (79/78/82%). Nine women in the reduced FU group and five in the usual FU group developed a recurrence (n.s.).

Conclusion Women receiving reduced follow-up care were just as satisfied with their care as those receiving follow-up care according to Dutch guidelines. Compared to usual care, women in the reduced care group had fewer medical visits and, at the same time, more often reported being satisfied with this reduced frequency.

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PREHABILITATION PROGRAM IN OVARIAN CANCER PATIENTS – TOWARDS MORE OBJECTIVE MEASUREMENT OF COMPLIANCE – PRELIMINARY RESULTS

Krzysztof Nowosielski, Marcin Zębalski, Paula Szostek, Wojciech Szanecki. *Department of Gynecology, Obstetrics and Gynecological Oncology, Medical University of Silesia, University Clinical Center, Katowice, Poland*

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Introduction/Background The aim of the study was to assess the efficacy of prehabilitation program based on six-minute walking test (6MWT) introduced to ovarian cancer patient.

Methodology 52 ovarian cancer patients FIGO III were included in the study. Participants was randomly assigned to controls (n=24) and prehabilitation group (n=28). 3 weeks before surgery, prehabilitation group were tested for Muscle Action Potential (MAP) using LUNA EMG and with 6MWT (to calculate VO2max), and were instructed to perform physical training at home. All patients were assessed one day before surgery – laboratory tests, LUNA, and 6MWT were performed. Changes in MAP and VO2max were used as objective measurement of compliance with physical prehabilitation. Mean time to resume physical activity, hospital duration and peri/postoperative complication rate were analyzed.

Results The mean age in prehabilitation group and controls was 58.2 ± 11.7 vs 59.2 ± 12.1 , respectively. No significant difference between groups in VO2max measured one day before surgery was noted – 15.3 vs 14.8 mL/kg-1·min-1, respectively. The mean maximal MAP (LUNA) was 144.8 mV and 87.4 mV, respectively. The mean hospital stay was 5.89 ± 2.9 and 8.43 ± 3.5 days, respectively (p=0.003). The mean time to start physical activity was 9.9 ± 6.5 vs 16.1 ± 9.1 hours, respectively (p=0.02). 2 patients from prehabilitation group were sent to intensive care unit postoperatively vs 3 in controls.

Readmission to hospital was required in 1 vs 3 women, respectively. All differences were not significant. In prehabilitation group LUNA results and VO2max measured at the beginning of prehabilitation and one day before surgery showed statistically significant improvement: 100.8 mV vs 144.8 mV and 14.7 vs 15.3 mL/kg-1·min-1, respectively (p=0.04 and p=0.01).

Conclusion Introducing the prehabilitation program reduces duration of hospital stay with no major influence on pre and postoperative complications. LUNA and 6MWT (VO2max) may serve as indicator for compliance with physical prehabilitation in ovarian cancer patients.

2022-RA-760-ESGO

PREDICTIVE MODEL OF SEVERE
COMPLICATIONS IN PATIENTS WHO
UNDERWENT AN OPEN GYNECOLOGICAL
CANCER SURGERY ON AN ENHANCED
RECOVERY AFTER SURGERY (ERAS)
PROGRAM

¹Diletta Fumagalli, ²Tommaso Grassi, ²Luca Bazzurini, ¹Tommaso Bianchi, ¹Chiara Procaccianti, ³Mauro Angelo Gilli, ²Giampaolo Di Martino, ²Gaetano Trezzi, ²Francesca Vecchione, ¹Maria Letizia Di Meo, ¹Benedetta Zambetti, ¹Desirée de Vicari, ⁴Valter Torri, ¹Fabio Landoni. ¹University of Milano-Bicocca, Milano, Italy; ²San Gerardo Hospital – Gynecology Unit, Monza, Italy; ³San Gerardo Hospital – Anesthesia and Intensive Care Unit, Monza, Italy; ⁴Department of Oncology, Istituto di Ricerche Farmacologiche Mario Negri IRCCS, Milano, Italy

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Introduction/Background Enhanced Recovery After Surgery (ERAS) is a global multimodal perioperative care initiative designed to achieve early recovery after major surgery. Our primary objective was to analyze the postoperative outcomes after open gynecological cancer surgery on an ERAS program and to design a predictive model of severe complications after surgery.

Methodology We retrospectively reviewed patients undergoing open surgery for suspected gynecological malignancy and managed according to the ERAS guidelines from January 1st, 2019 to December 31st, 2019, at a tertiary-care center in Monza, Italy. Surgical Complexity Score (SCS), Clavien-Dindo Classification (CDC) of complications and a Comprehensive Complication Index (CCI) were applied for each patient. Association between patient-, disease- and surgical-variables and severe postoperative complications (defined as CCI \geq 26.2 events) were estimated using a uni- and multivariable logistic regression model. Factors associated with severe postoperative complications were used to construct a predictive model and nomogram.

Results One hundred and fifty-eight patients who underwent an open surgery were included in the study: 86 ovarian, 28 cervical, 39 uterine and 5 non-gynecological cancers. Overall, 8.2% of patients experienced a CDC grade IIIA-V complication, while 13.3% had a CCI ≥26.2. The median CCI was 8.7 [IQR 0–20.9]. Cancer type, number of comorbidities, blood loss during surgery and SCS were independent predictors of severe postoperative complications after open gynecological cancer surgery.

Conclusion The application of an ERAS program in open gynecological cancer surgery is safe and results in an acceptable complication rate. The risk of severe postoperative complications may be predicted using our risk-model. This may help the clinician in personalizing care for each

patient. Further prospective evaluations of this model are needed.

2022-RA-762-ESGO

IMPLEMENTATION CASE STUDY OF IMAGE GUIDED ADAPTIVE HIGH DOSE RATE BRACHYTHERAPY FOR CERVICAL CANCER: WORKFLOW IMPACT ANALYSIS OF UPGRADING TO IMAGE BASED BRACHYTHERAPY WITHIN NATIONAL CANCER GRID OF INDIA CERVIX CANCER RESOURCE STRATIFIED GUIDELINES

¹Supriya Chopra, ²Varsha Hande, ³Prachi Mittal, ³Satish Kohle, ³Yogesh Ghadi, ²Jaahid Mulani, ²Ankita Gupta, ³Lavanya Gurram, ³Rajesh Kinnhikar, ³Jai Parkash Agarwal. ¹Radiation Oncology, Advanced Centre for Treatment Research and Education in Cancer, Tata Memorial Centre, Navi Mumbai, India; ²Advanced Centre for Treatment Research and Education in Cancer, Tata Memorial Centre, Navi Mumbai, India; ³Tata Memorial Hospital, Tata Memorial Centre, Mumbai, India

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Introduction/Background India has 17% of world's cervical cancer incidence and transition to image guided high dose rate brachytherapy (IGBT) is crucial to improve outcomes. Institutional level activity based costing (ABC) and national impact analysis of transition was undertaken.

Methodology ABC was conducted in a high-volume centre that triaged patients for BT to (A) two dimensional (2D) or B) 3D- point A BT or CT/MR based intracavitary (IC) or D) CT/MR-Interstitial (IS) IGABT). Clinical process mapping (implant and imaging time, delineation, treatment planning, delivery and removal) for workflows A-D was performed. Case scenarios for transition from workflow A to D was constructed at an institutional and national level based on incidence and infrastructure in states and Union Territories (UT) of India. Treatment capacity loss and potential strategies for workflow reorganisation were proposed.



Abstract 2022-RA-762-ESGO Figure 1

Results Based on process mapping in 81 consecutive patients, the total time was 176 minutes (57–208) and 223 minutes (74–260) for 2D and 3D point A, 267 minutes for (101–302) and 348 minutes (232–383) for 3D-IC and 3D IC-IS-IGBT.