

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.

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

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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 $CCI \geq 26.2$. 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.

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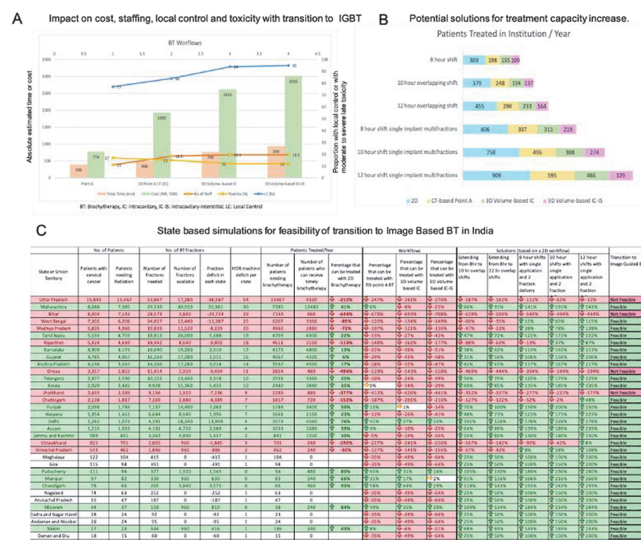
IMPLEMENTATION CASE STUDY OF IMAGE GUIDED ADAPTIVE HIGH DOSE RATE BRACHYTHERAPY FOR CERVICAL CANCER: WORKFLOW IMPACT ANALYSIS OF UPGRADING TO IMAGE BASED BRACHYTHERAPY WITHIN NATIONAL CANCER GRID OF INDIA CERVIX CANCER RESOURCE STRATIFIED GUIDELINES

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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.