2022-RA-1699-ESGO | **ERAS PATHWAY FOR GYNECOLOGICAL** ONCOLOGY - A PRE-POST **IMPLEMENTATION COHORT WITH 1211 PATIENTS**

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Introduction/Background ERAS protocol is expanding through different specialities and gaining importance in gynecology field. This study evaluates the impact of ERAS implementation on gynecological oncological surgery regarding organizational, clinical and compliance outcomes.

Methodology A retrospective cohort study was conducted at the Centre Hospitalier de l'Université de Montréal (CHUM). All consecutive surgical and hospitalized gynecology oncology patients from 2015 (Pre-ERAS implementation) and 2019 (post-ERAS implementation) were included and compared. Exclusion criteria includes general and obstetrical gynecology, same-day discharge and emergency surgeries. Primary end points were: length of stay (LOS), complication rate, and total compliance. Secondary outcomes include total length of stay (TLOS), intensive care unit (ICU), readmission, serious complications, mortality, and compliance per period (pre, intra and post). Statistical significance was p < 0.05.

Results A total of 1211 patients were included, 675 in 2015 and 536 in 2019. A positive impact was present in organizational, clinical and compliance outcomes after ERAS implementation. LOS decreased from 3.9 to 3.1 days (p<0.001), TLOS from 4.4 to 3.4 days (p<0.05), ICU remained stable at 0.7%, readmission went from 5.8% to 4.7%, complications (> G1 Clavien) dropped from 37% to 26.9%, serious complications (> G3 Clavien) from 3.4% to 1.7%(p<0.1) and mortality was stable at 0.4%. Clinical outcomes per diagnosis location are presented in Table 1. Total compliance increased from 56.1% to 64.6% (p<0.01). Compliance changes were greater post-operatively and were the following: pre-op from 81.7% to 88.8%(p<0.01), intraop from 95.4% to 94.1%(p>0.05), post-op 25.1% to 38.4% (p<0.01).

Abstract 2022-RA-1699-ESGO Table 1												
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Conclusion Benefits of ERAS implementation were demonstrated through smaller LOS and lower complications rates. While institutional and clinical impact of ERAS protocol are evident, some disease locations benefit more from ERAS protocol. Implementation challenges remains, mainly through compliance documentation, nevertheless efforts

continue to raise compliance for greater impact on clinical and organizational outcomes.

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OPIOID PRESCRIPTION ADEQUACY IN **ENDOMETRIAL CANCER PATIENTS** UNDERGOING HYSTERECTOMY UNDER **ERAS PROTOCOL**

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Introduction/Background Medical prescriptions contribute to the opioid crisis. Recent literature suggests opioids' discharge prescriptions should be personalised based on patients' opioid consumption during the last 24h of hospitalisation. Enhanced Recovery After Surgery (ERAS) guidelines recommend multimodal analgesia approach and limited opioid prescription. This study compares the opioid discharge prescription to last 24h consumption in endometrial cancer patients.

Methodology A retrospective cohort study was conducted and included endometrial cancer patients undergoing hysterectomy under ERAS protocol in 2019 at Centre hospitalier de l'Université de Montréal(CHUM). Exclusion criteria were patients with sarcoma, chronic opioid use, same-day discharge. As a significant number of patients undergoing primary surgery for endometrial cancer spend less than 24h at the hospital, post operative opioid and co-analgesia consumption in the last 24h pre discharge was adjusted from the consumption in the last 12h pre discharge. Adjusted 24h opioid and co-analgesia pre discharge consumption was compared with prescription daily posology. Patients were controlled by surgical approach. Statistical significance was 0.05.

Results 186 patients were analysed: 26.34% laparotomy, 41.40% laparoscopy, and 32.26% robotic surgery. Histological types were 76.35% endometrioid adenocarcinoma, 19.35% serous carcinoma, 3.23% clear-cell carcinoma, and 1.08% mixed carcinoma. 89.25% stayed at least 12h at care unit. 94.62% of analgesia logs and 88.17% of prescription logs were available. Last 24h opioid consumption was 14.80, 11.09, and 10.35 morphine milligram equivalent(MME) and prescription daily posology was 39.53, 34.60, and 29.80 MME respectively for laparotomy, laparoscopy and robotic surgeries. Often prescribed co-analgesia were acetaminophen and naproxen. Ibuprofen, celecoxib, and ketorolac were also prescribed.

Conclusion The amount of opioid prescribed at discharge were significantly greater than the posology required according to last 24h opioid consumption. Co-analgesia prescription did not meet ERAS guidelines recommendations. Auditing practices is essential for better awareness. Education and standardisation of opioids' discharge prescriptions could help control the opioid crises.