

Abstracts

performed in 15 of the cases and the other 77 patients were submitted to a Laparotomic (Abdominal) Surgery. Median surgical time was 199 minutes (60- 370). The average hospital stay was 3.33 days (1-13). Combined anesthesia was performed in 34 of the laparotomic surgeries. NGT was left in 6 patients. NGT and BC were withdrawn in 89 cases within 24 hours. Only 10 out of the 92 patients required rescue medication for postoperative pain management. Only 3 patients required bowel resection without any complications. Five patients required blood transfusions. In 23 patients intraabdominal drainage was placed and in 20 of them it was removed within 24 hours. Nobody presented emesis in the postoperative period. One patient developed bilateral DVT. The average value of postoperative glycemia was 150 (91 - 289). There were no readmissions.

Conclusions It was very difficult to implement the ERAS guidelines. Our patients had a good postoperative outcome. This allowed early institutional discharge. The ERAS protocol did not increase the costs of hospitalization.

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OUTCOMES OF OBESE PATIENTS UNDERGOING GYNECOLOGIC SURGERY ON AN ENHANCED RECOVERY AFTER SURGERY (ERAS) PROGRAM

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Objectives To compare perioperative outcomes of obese vs. non-obese patients undergoing gynecologic surgery on an ERAS program.

Methods We retrospectively reviewed patients undergoing open surgery 11/2014–11/2018. Patients were classified into three categories based on body mass index (BMI) and obesity class: normal/overweight [BMI 18.0–29.9 kg/m²], class I [BMI 30.0–34.9 kg/m²], class II [BMI 35.0–39.9 kg/m²], and class III or greater [BMI ≥40.0 kg/m²]. Obese patients were matched to non-obese patients by age, procedure date, and surgical indication. Standard statistical methods were utilized. Primary outcome was postoperative length of stay [LOS].

Results After matching, 696 patients were included in the analysis [normal/overweight, n=348; class I, n=163 class II, n=88; class III or greater, n=97]. All groups had a median postoperative LOS of 3 days. Obese patients had longer procedure times [median OR time: 218 min vs. 192.5 min, p<0.001] and greater estimated blood loss [median EBL: 300 mL vs. 200 mL, p<0.001]. Compliance with individual program elements was not different overall [70.1% vs. 69.8%, p=0.3262], although lower early mobilization was observed among obese patients [89.9% vs. 94.5%, p=0.023]. No differences were observed in severe [grade III-IV] perioperative complications [10.9% vs. 6.6%, p=0.06], reoperation [2.3% vs. 1.4%, p=0.577], and readmission [11.8% vs. 8.0%, p=0.128]. Mild complications [grade I-II] were more frequent in obese patients [62.4% vs. 48.3%, p<0.001], influenced by more wound complications in this group [4.9% vs. 17.8%, p<0.001].

Conclusions Even after longer operative time and greater blood loss, obese ERAS patients had comparable compliance, perioperative complications, and length of stay to non-obese patients.

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INCIDENCE OF POST-OP URINARY TRACT INFECTIONS AFTER ROUTINE CYSTOSCOPY IN MINIMALLY INVASIVE ROBOTIC GYNECOLOGIC CANCER SURGERY

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Objectives The aim of this study is to investigate the incidence of post-op infections after routine cystoscopy in robotic-

Abstract 374 Table 1 Comparison of presence and absence of post-op UTI within 30 days of surgery

	(+) UTI (N=10)	(-) UTI (N=40)	p value
Age, y	52.2 (33 – 88)	64 (35 – 91)	
≤ 60	8 (80.0)	14 (35.0)	0.0111
> 60	2 (20.0)	26 (65.0)	
Comorbidities ¹			
≤ 1	4 (40.0)	9 (22.5)	0.2639
> 1	6 (60.0)	31 (77.5)	
Histologic grade			
I	3 (30.0)	15 (37.5)	0.6617
II - III	7 (70.0)	25 (62.5)	
Operating room time ² , hr:min	3:02 (2:31 – 3:45)	2:45 (1:43 – 4:00)	
≤ 2:00	0 (0.0)	4 (10.0)	0.3030
> 2:00	10 (100.0)	36 (90.0)	
Surgery start time			
Before 3 pm	8 (80.0)	32 (80.0)	1.0000
After 3 pm	2 (20.0)	8 (20.0)	
Estimated blood loss (EBL), cc	66 (10 – 200)	34.5 (10 – 100)	
≤ 30	6 (60.0)	28 (70.0)	0.5483
> 30	4 (40.0)	12 (30.0)	
Surgical complexity			
Simple ³	3 (30.0)	33 (82.5)	0.0011
Complex ⁴	7 (70.0)	7 (17.5)	
Surgical stage			
I	7 (70.0)	36 (90.0)	0.1066
II-IV	3 (30.0)	4 (10.0)	
Length of stay ⁵ , hr:min	38:49 (0:29 – 11:47)	24:29 (2:03 – 168:25)	

Data are noted as median (range) or N (%).

¹Comorbidities indicate chronic medical conditions other than endometrial cancer.

²Operating room time is from the time the patient enters the room to when she leaves the room.

³Simple procedure indicates the inclusion criteria: robotic-assisted total hysterectomy with bilateral salpingo-oophorectomy and total pelvic lymphadenectomy.

⁴Complex procedure includes the simple procedure in conjunction with any of the following: aortic lymphadenectomy, or other lymph node removal.

⁵Length of stay is from the time that patient leaves the operating room to the time of discharge.

Significant p values (<0.05) are emboldened.

Abstract 374 Table 2 Bivariate correlation analysis of factors associated with UTI occurrence after routine cystoscopy

	Pearson correlation	95% Confidence interval	p value
Age	-0.333	-0.559, 0.060	0.018
Comorbidities	-0.222	-0.471, 0.060	0.122
Histologic grade	0.099	-0.185, 0.367	0.495
Length of surgery	0.143	-0.141, 0.405	0.323
Estimated blood loss (EBL)	0.360	0.091, 0.580	0.010
Later start time	0	-0.278, 0.278	1
Surgical complexity	0.220	-0.072, 0.470	0.124
Surgical stage	0.291	0.014, 0.527	0.040
Length of stay	0.194	-0.090, 0.448	0.178

Significant p values (<0.05) are emboldened.

assisted gynecologic cancer surgery and to compare the rate to reported incidence of similar surgeries without the use of routine cystoscopy.

Methods Retrospective study utilizing a single gynecologic oncologist's database (July 1, 2017 to January 30, 2019) in which routine cystoscopy was performed to detect urinary tract injury following robotic total hysterectomies (RTH) for surgical treatment of endometrial cancer (N=50). Data was analyzed using Chi-square test, unpaired t-test, and bivariate correlation.

Results None of the patients with a known, treated pre-op UTI presented with a post-op UTI within 30 days of surgery. Additionally, the routine cystoscopy did not find urinary tract injuries in any of the patients. Out of 50 patients, 20 (10%) has post-op UTIs within 30 days of routine cystoscopy. Patients with post-op UTIs had higher median operating room time, more complex surgeries, and higher surgical stage compared to the patients without post-op UTIs (table 1). Increased incidence of UTIs were also statistically significantly associated with younger age, higher estimated blood loss (EBL), and higher surgical stage, $p<0.05$ (table 2).

Conclusions Younger patients with an increased EBL and higher surgical stage endometrial cancer were associated with a higher rate of post-op UTI occurrence after routine cystoscopy in robotic-assisted gynecologic surgery. UTIs are common in women undergoing gynecologic surgery; however, the rate appears to be higher with routine cystoscopy in this small cohort. Consideration of a larger sample size merits further investigation.

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LAPAROSCOPIC COMPLETE DISSECTION OF PARA-AORTIC LYMPH NODE(PALND) UP TO RENAL VEIN THROUGH 5-PORT LAPAROSCOPIC APPROACH IN CASES OF GYNECOLOGIC MALIGNANCIES: SINGLE SURGEON'S EXPERIENCE

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Objectives To introduce the technique of laparoscopic complete dissection of para-aortic lymph nodes up to renal vein

level, high level with easy performing and approaching position during laparoscopic operation in patients with gynecologic malignancies.

Methods From March, 2014 to September 2017, The forty-nine patients with gynecologic malignancies (endometrial and ovarian malignancy), who required a laparoscopic staging operation or laparoscopic cytoreductive surgery of metastatic nodules on para-aortic area suspected by abdomino-pelvic computed tomography (AP-CT) and Positron emission tomography-computed tomography (PET-CT). The data was analyzed retrospectively with medical records. All laparoscopic PALND was performed up to renal vein level through 5-ports laparoscopic approach by a single surgeon (Y.S K.).

Results Laparoscopic complete dissection of para-aortic lymph node up to level of renal vein (PALND) were performed in 14 patients with endometrial cancer and 35 patients with ovarian cancer. The mean operation time of PALND was 31.5 ± 4.6 minutes. The mean number of dissected para-aortic lymph nodes was 9.6 ± 2.7 proven by pathologic reports. There were only 2 cases of conversion to laparotomy, which included one of left renal vein injury and one of left gonadal vein. The two cases occurred at early time of running 5-ports laparoscopic PALND up to renal vein. The two cases of laparotomic conversion due to vessel injury was cured by the assistant a vascular surgeon.

Conclusions If it is indicated for PALND in gynecologic malignancies, laparoscopic 5-ports approach of PALND up to level of renal vein is fine and safe approaching technique with reasonable operation time.

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DUAL MECHANICAL AND PHARMACOLOGICAL THROMBOPROPHYLAXIS SIGNIFICANTLY DECREASES RISK OF PULMONARY EMBOLUS AFTER LAPAROTOMY FOR GYNECOLOGIC MALIGNANCIES

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Objectives Patients with gynecologic malignancies have high rates of postoperative venous thromboembolism. Currently, there is no consensus for perioperative thromboprophylaxis. The Gynecologic Oncology division at Sunnybrook Health Sciences Centre in Toronto, Canada, implemented a dual thromboprophylaxis strategy for laparotomies in 12/2017. We aimed to compare rates of pulmonary embolus(PE) within 30 days postoperatively, and to identify risk factors for PE.

Methods Prospective study of laparotomies for gynecologic malignancies from 12/2017–10/2018, with comparison to historical cohort from 01/2016–11/2017 using the institutional National Surgical Quality Improvement Program database (NSQIP).

Preintervention, patients received low molecular weight heparin(LMWH) during admission and those deemed high-risk continued 30-day prophylaxis. Postintervention, all patients received both mechanical thromboprophylaxis with sequential compression devices during admission and 30-day prophylaxis with LMWH.