

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

	Pearson correlation	95% Confidence interval	<i>p</i> 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.