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.

IGCS19-0020

375 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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10.1136/ijgc-2019-IGCS.375

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.

IGCS19-0073

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

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10.1136/ijgc-2019-IGCS.376

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.

Results There were 371 and 163 laparotomies pre-and post-intervention.

After implementation, PE rates decreased from 5.1% to 0% (p=0.001). PEs were diagnosed by CT scan prompted by symptoms, at a median of 2 days postoperatively.

Patient characteristics (age, BMI, diabetes, smoking, tumor stage), rate of malignant cases, operative blood loss and duration, and length of stay(LOS) were similar between groups. There were more cytoreductive procedures preintervention (p ≤0.0001).

Univariate analysis revealed that surgery preintervention (OR:4.25, 95%CI 1.04–17.43, p=0.04), LOS≥5 days (OR:11.94, 95%CI 2.65–53.92, p=0.002), and operative blood loss ≥500mL (OR:2.85, 95%CI 1.05–7.8, p=0.04) increased risk of PE. On multivariable analysis, surgery preintervention remained associated with more PEs(OR:4.16, 95% CI 1.03–16.79, p=0.05), when adjusting for operative blood loss.

Conclusions Aggressive dual thromboprophylaxis after laparotomy appears to significantly reduce PE in this high-risk patient population.

IGCS19-0393

377 SENTINEL NODE DETECTION IN GYNECOLOGY ONCOLOGY: OUR EXPERIENCE WITH INDOCYANINE GREEN (ICG)

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10.1136/ijgc-2019-IGCS.377

Objectives Sentinel node (SLN) technique has been able to reduce full lymphadenectomy associated morbidity. The introduction of indocyanine green (ICG) has shown improved SLN detection rates. The purpose of this study was to examine the feasibility of SLNs detection in Gynecologic Cancers: Cervical (UCC) Endometrial(EC) and Vulvar Cancer(VC); using ICG, patent blue(PB) and tc99 radiocolloid (tc99m). We evaluated overall and bilateral detection rate for each tracer.

Methods Between January 2017 and March 2019, 21 patients were scheduled for SLN detection (16 CCU, 2 VC and 3 EC). For CCU and EC 500μCi of tc99m were injected at each quadrant of the cervix and lymphoscintigraphy were performed the day before surgery. VC injections were preformed around the tumor. Immediately before surgery 2ml of patent blue and 2ml of ICG were injected at the same positions. SLNs were identified using a NIR fluorescence, radioactive guidance and direct vision.

Results Three tracers were used in 76% of the cases, all had at least two. Detection rate was 100% for 3 methods combined: ICG 100%, Tc99m 100%, PB 77%. Bilateral detection was 100% for 3 methods combined: ICG 88%, Tc99m 88%, PB 38%. No adverse effects related to either tracer were shown.

Conclusions Our study is the first reported experience in Argentina to compare ICG to gold standard tc99m for the detection of SLN in Gynecologic Cancers. ICG sensibility rate is comparable to tc99m, adding the possibility of direct visualization during the procedure. The later facilitates surgeons' task reducing morbidity and surgical duration.

IGCS19-0060

378 SALPINGECTOMY AT THE TIME OF HYSTERECTOMY FOR BENIGN GYNAECOLOGIC DISEASE: A COMPARISON OF SURGICAL APPROACHES

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10.1136/ijgc-2019-IGCS.378

Objectives Due to a growing body of evidence demonstrating the involvement of the fallopian tubes in serous ovarian malignancies, prophylactic salpingectomy has been recommended to be discussed with or offered to patients undergoing hysterectomy for benign indications. This study aimed to compare rates of bilateral salpingectomy at the time of hysterectomy for benign indications across different surgical approaches.

Methods This study was performed through a retrospective review of data collected for clinical audit via SurgicalPerformance, a web-based audit project which collects data from individual surgeons. Of 11477 hysterectomy records available, 6608 were eligible for analysis.

Results During hysterectomy, salpingectomy was performed in in 3856 of 6608 cases (58%) overall. Based on surgical approach, salpingectomy occurred in 65% of cases using an open approach, 70% with laparoscopic approach, 78% with laparoscopic assisted vaginal hysterectomy, 73% with robotic, 73% with conversion to open and 13% with vaginal. There was a significant difference in the rates of salpingectomy during vaginal hysterectomy compared to other approaches (p≤0.001). When adnexal surgery was performed at the time of hysterectomy, those under the age of 50 more frequently underwent salpingectomy alone, whereas those over the age of 50 more frequently underwent bilateral salpingo-oophrectomy.

Conclusions Salpingectomy at the time of hysterectomy for benign indication occurred significantly less frequently when the operation occurred using a vaginal approach, compared to other approaches. While the data presented here are hypothesis generating, they justify further prospective research into barriers to salpingectomy when a vaginal hysterectomy approach is performed.

IGCS19-0339

379 THE EFFECT OF EARLY POSTOPERATIVE URINARY CATHETER REMOVAL ON PATIENT SATISFACTION IN GYNECOLOGIC ONCOLOGY

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10.1136/ijgc-2019-IGCS.379

Objectives Patient satisfaction is an important aspect of quality health care. A urinary catheter is routinely maintained for the first night following major surgery on a gynecologic oncology