irinotecan. This study aimed to evaluate the efficacy of SG in primary EOC cell lines and xenografts.

Methods Trop-2 expression was evaluated in 90 formalin-fixed-paraffin-embedded (FFPE) tumors and 9 primary tumor cell lines by immunohistochemistry and flow cytometry, respectively. Trop-2 expression and cell viability after exposure to SG in primary tumor cell lines, non-targeting control-ADC (h679-CL2A-SN-38), and SG-parental antibody hRS7 IgG were evaluated using flow-cytometry-based-assis. Antibody-dependent-cell-cytotoxicity (ADCC) against Trop-2+ and Trop-2- EOC cell lines was evaluated in vitro using 4-h Chromium-release-assays. In vitro activity of SG was tested against Trop-2+ EOC xenografts.

Results Moderate-to-strong staining was seen in 47% (42/90) of ovarian tumors while 89% (8/9) of the primary EOC cell lines overexpressed Trop-2. EOC overexpressing Trop-2 were significantly more sensitive to SG compared to control ADC (p<0.05). Both SG and hRS7 mediated high ADCC activity only against Trop-2+ cell lines. SG also induced bystander killing of Trop-2+ tumor cells. In vitro experiments with SG in EOC xenografts demonstrated greater antitumor effects and increased survival compared to ADC controls (p<0.05). SG was well tolerated by the animals.

Conclusions SG has shown remarkable preclinical activity against biologically aggressive EOC and it is endowed with significant bystander effect against tumors with heterogenous TROP-2 expression. Clinical trials are warranted.

Abstracts

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IMPACT OF ERAS PROGRAM IMPLEMENTATION IN GYNECOLOGIC SURGERY ON HEALTHCARE COSTS

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Objectives To evaluate differences in hospital charges and healthcare utilization for gynecologic surgery patients managed before and after ERAS implementation.

Methods We retrospectively reviewed women undergoing open gynecologic surgery before and after ERAS implementation. Consecutive patients from 5/2014–10/2014 and 11/2014–11/2015 comprised the pre-ERAS and ERAS cohorts, respectively. Patients were excluded if they had a multidisciplinary surgical team or underwent minimally invasive surgery. All technical and professional charges were ascertained for healthcare services from procedure date until postoperative day 30. Adjuvant treatment charges were excluded. Charges were categorized by the type of clinical service provided. The primary outcome was the difference in total charges between the two groups.

Results A total of 271 patients were included with 58 and 213 patients in the pre-ERAS and ERAS cohort, respectively. 70,177 technical charges and 6,775 professional charges were identified and classified. The median hospital charge decreased 15.6% from the pre-ERAS to ERAS groups [95% CI 0–39%; p=0.008]. ERAS patients had lower charges for laboratory services [20% decrease; 95% CI 0–39%; p=0.04], pharmacy services [30% decrease; 95% CI 14–41%; p<0.001], room-and-board [25% decrease; 95% CI 20–47%; p=0.005], and material goods [64% decrease; 95% CI 44–81%; p<0.001]. No differences in charges were observed for perioperative services, diagnostic procedures, emergency department care, transfusion-related services, interventional radiology procedures, physical/occupational therapy, or outpatient care.

Conclusions Hospital charges and healthcare service utilization were lower for ERAS patients compared with patients receiving conventional perioperative care. ERAS may be considered high value as it provides improved outcomes while lowering resource utilization.