

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-assays. 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 vivo* 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 Trop2+ cell lines. SG also induced bystander killing of Trop-2- tumor cells. *In vivo* 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.

IGCS19-0605

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IMPACT OF ERAS PROGRAM IMPLEMENTATION IN GYNECOLOGIC SURGERY ON HEALTHCARE COSTS

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10.1136/ijgc-2019-IGCS.52

Objectives To evaluate differences in hospital charges and healthcare service 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.

Asia/Australia Regional Plenary

IGCS19-0452

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THE IMPLEMENTATION OF A STANDARDIZED SURGICAL TRAINING PROGRAM FOR SPECIALIST GYNAECOLOGISTS TO DECREASE THE RATE OF OPEN, ABDOMINAL HYSTERECTOMY

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10.1136/ijgc-2019-IGCS.53

Objectives Hysterectomy is the most common major gynaecological procedure in Australia. Evidence suggests that Total Abdominal Hysterectomy (TAH) is associated with longer hospital stay, protracted recovery and worse postoperative quality of life and increased cost. Despite this evidence, the decline TAH is slow in Australia compared to internationally.

Methods We developed a prototype of training specialist gynaecologists in Total Laparoscopic Hysterectomy (TLH). The pillars of training include Baseline assessment of surgical outcomes; Identification of trainee surgeons and institutions; Development of a governance and support structure; Preceptorship; Proctorship; Comparison of surgical outcomes with baseline. Data collection includes intraoperative and postoperative complications from the trainee surgeons as well as from surgeons who do not receive the surgical training intervention.

Results Four public hospitals received approval for surgical training and three of these commenced training. A total of 46 surgical training cases have been completed to date. One hospital completed all 10 training days with all three gynaecologists passing their TLH training. These gynaecologists currently offer TLH to their patients and have been successfully converted from “open” surgeons to “laparoscopic” surgeons. Another two hospital units totalling 6 gynaecologists completed most of their training days, one is about to start.

Conclusions A standardized surgical outreach training program for specialist gynaecologists seems to be of interest to hospitals and surgeons, and may be a future way to roll out surgical innovations to practising surgically orientated gynaecologists. Future data analyses will assess whether the program results in reduced hospital stay, surgical complications, better postoperative quality of life and reduced cost.