Study Design Enrolled patients were randomly allocated in two groups according to the use (Group A) or no use (Group B) of the uterine manipulator.

The variables collected included baseline demographic characteristics, perioperative data, final pathology report, adjuvant treatment, and follow-up.

Results 154 patients were randomly allocated in Group A (n=78) and Group B (n=76). A statistically significant difference was found in OT for the laparoscopic staging (p=0.005), while no differences were reported for the robotic procedures.

The EBL was significantly lower in Group B (p=0.030). Only one conversion to laparotomy (1.3%) occurred in Group A. Comparable results were recorded in terms of peritoneal cytology, LVSI (p=0.584), and pattern of lymphovascular spread (p=0.790).

With a median follow-up of 38.7 months, no differences were detected in terms of OS and DFS, and in the number of recurrences. The uterine manipulator had no impact on DFS both at univariate and multivariable analysis.

Conclusions The intrauterine manipulator does not affect the perioperative and oncological outcomes of presumed low-risk endometrial cancer patients undergoing laparoscopic/robotic staging.

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9 FRAILTY IS INDEPENDENTLY ASSOCIATED WITH WORSE OUTCOMES AND INCREASED RESOURCE USE FOLLOWING PROCEDURES TO TREAT ENDOMETRIAL CANCER

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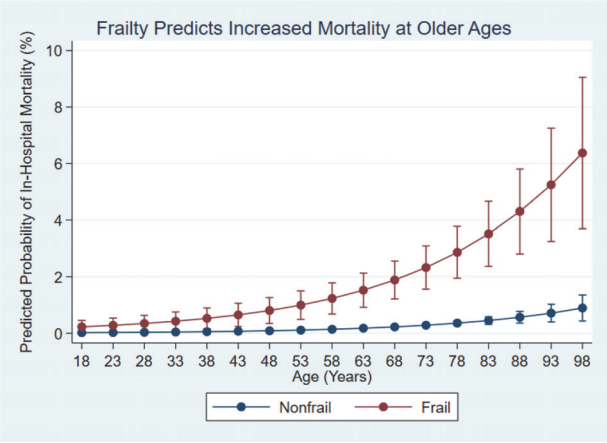
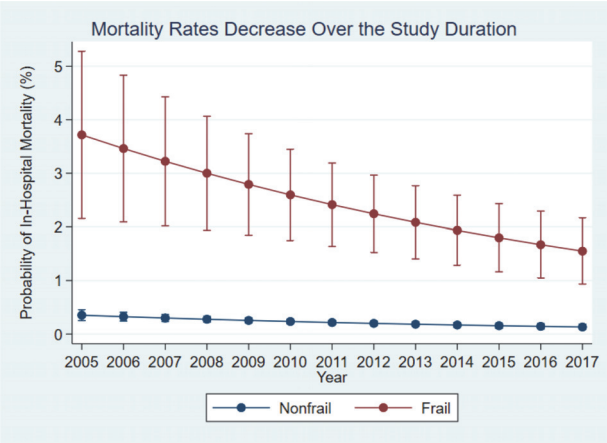
Introduction Frailty has been associated with poorer surgical outcomes and is a critical factor in procedural risk assessment. The objective of this study is to validate surgical outcomes in patients undergoing surgery for endometrial cancer (EC).

Methods Patients undergoing inpatient gynecologic surgery for EC were identified using the 2005–2017 National Inpatient Sample database. The Johns Hopkins Adjusted Clinical Groups (ACG) frailty-defining diagnosis indicator was used to designate frailty. Multivariate regression models were used to assess the association of frailty with post-operative outcomes and resource use.

Results Of an estimated 339,846 patients, 2.9% (9,868) were considered frail. After adjusting for patient and hospital characteristics, frailty was associated with a four-fold increase in inpatient mortality (adjusted odds ratio [AOR]:4.1; p<0.001) and non-home discharge (AOR:5.2; p<0.001), as well as increased respiratory (AOR:2.6; p<0.001), neurologic (AOR:3.3; p<0.001), renal (AOR:2.0; p<0.001), and infectious (AOR:3.2; p<0.001) complications. While frail patients exhibit increased mortality with age (figure 1), the rate of mortality in this cohort decreased significantly over time (figure 2). Compared with non-frail counterparts, frail patients also had longer lengths of stay (7.6 days vs. 3.4 days; p<0.001) and increased hospitalization costs ($25,093 vs. $13,405; p<0.001).



Abstract 9 Figure 1



Abstract 9 Figure 2

Conclusion/Implications Frailty is independently associated with worse surgical outcomes, including mortality, and increased resource use in women undergoing surgery for EC. Though there have been improvements in mortality in more recent years, further efforts to mitigate the impact of frailty should be explored.

Plenary III

IGCS20_1420

10 THE LEARNING CURVE OF ROBOT-ASSISTED LAPAROSCOPY HAS IMPACT ON THE ONCOLOGICAL OUTCOMES OF EARLY STAGE CERVICAL CANCER PATIENTS

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Introduction Previous learning curve studies are focused on short term surgical outcomes of robot-assisted surgery. We are