Conclusion* Although TEA is not included in ERAS protocols in gynaecological oncology, in experienced hands, it would be a beneficial tool related to decreased need of opioid use and nausea rates with no impact to hospital stay and PO complications, aiming to improve the perioperative quality of patient's care.

505 LYMPH NODE STATUS AS A PREDICTOR OF VENOUS THROMBOEMBOLIC RISK POSTOPERATIVELY IN GYNAE-ONCOLOGY

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Introduction/Background* Gynaecological cancer surgery carries a high risk of venous thromboembolism (VTE). In the absence of thromboprophylaxis, 34.5% of women with gynaecological cancer develop VTE post operatively compared to 2% in benign gynaecological surgery patients. Lymph node dissection (LND), an integral part of any gynaecological procedure, carries therapeutic benefit in some cancers but also increases the complications of cancer surgery. An association of LND with VTE has been suggested.

The aim of this study is to investigate the role of LND and lymph node (LN) metastasis on the incidence of VTE following both open and laparoscopic surgery for gynaecological cancer.

Methodology This is a retrospective cohort study analysing data from 1084 patients who underwent gynaecological cancer surgery between 2006-2019 in St James Hospital, Dublin, Ireland (Tertiary referal centre). 1018 patients with complete follow up were included in the study.

Patients with previous VTE, history of significant haemorrhage outside of a surgical setting within the last 5 years, familial bleeding diathesis and patients receiving anticoagulant therapy were excluded. Univariate analysis was used to determine the effects of LND and LN metastasis on the rate of VTE 90 days post surgery.

Result(s)* Forty three patients developed VTE in 90 days post-surgery (4.3%). VTE rate was significantly higher following open surgery (5.4%) compared with laparoscopic approach (2.3%) ($P<0.02$). The total number of para aortic LN retrieved significantly increased the rate of VTE ($P<0.008$). VTE risk within 90 days was 14.3% in patients with >10 para-aortic LN removed , 5.9% in patients <10 paraaortic LN retrieved, compared with 4.4% who had no paraaortic LN removed. Pelvic LN metastatic status significantly influenced VTE risk. 5.2% of patients <5 LN positive for metastasis had VTE, which increased 4 fold (20%) in patients with > 5 LN positive for metastasis ($P<0.042$). Lymphovascular space invasion(LVSI) had no effect on VTE risk postoperatively. Overall survival was reduced in patients who developed VTE($P<0.0001$).

Conclusion* Gynaecological cancer surgery increases VTE risk. The number of paraaortic LN and pelvic LN metastatic status is associated with increased VTE risk and may be useful in predicting VTE post surgery.

510 AN OVERVIEW OF COMPLICATIONS IN MAJOR GYNAECOLOGICAL ONCOLOGY SURGERY AT A TERTIARY CENTRE

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Introduction/Background* We aim to assess the complication rates across different operative modalities and surgeons. Provide information on patient co-morbidities and tissue diagnosis. This information is important for patient counselling and to provide evidence for ongoing unit accreditation.

Methodology We identified all major gynaecology oncology cases performed at our tertiary centre in 2019, assigned to the 4 oncology surgeons. Cases were assessed for operation type, diagnosis and co-morbidities. Complications then assessed using Clavien-Dindo classification. Data about complications obtained from EDN and follow up clinic letters. Standard used was the UK Gynaecological Oncology Surgical Outcomes and Complications audit of 25.9% on inclusion of all patient-reported complications.

Result(s)* Our major complication rate (Clavien-Dindo 3-4) was **1.61%.** Our overall complication rate (Clavien-Dindo 1-4 was **29.8%** . 11 deaths recorded, with only 1 death within 28 days of surgerym unrelated to surgery. Of complications, 1 case of intra-abdominal & retroperitoneal collection, 2 cases wound dehiscence requiring surgical management, 2 cases of haemorrhage requiring relook laparotomy and 1 case returned to theatre for vaginal wall tear after specimen removal.

Conclusion* Our major complication rate is below the national average. Different surgeons have different specialist interests, this may reflect complication rate and allows super specialisation e.g. in robotic surgery. We reported largely similar rates of rare major complications across surgeons and operation type. This knowledge is helpful when consenting patients for procedures, as it gives real life numbers at a local level.

591 PERIOPERATIVE CARE IN GYNAECOLOGICAL CANCER SURGERY DURING THE COVID PANDEMIC IN A LOW RESOURCE CENTRE – ROLE OF ENHANCED RECOVERY PROTOCOLS

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Introduction/Background* ERAS (Enhanced Recovery after Surgery) is a multimodal perioperative care pathway designed to achieve early recovery after surgical procedures. This study aimed to analyse the feasibility of ERAS in the era of pandemic and to find its effect on the post-operative outcome of patients undergoing surgery for gynaecological cancer during the COVID pandemic

Methodology This observational study was done on patients who underwent gynaecological cancer surgery during COVID pandemic in a tertiary cancer centre in South India. Data was collected including patient demographics, nature of surgery, adherence to each of the components of ERAS programme

and outcomes. Post operative complications were graded according to the Clavien–Dindo classification

Result(s)* 152 patients were included in the study period from June to December 2020. 85 patients had cancer ovary, 59 cancer endometrium, 6 cancer cervix and 1 cancer vulva and 7 patients had benign tumours. In the pre operative component of ERAS protocols,82% patients received pre surgery counselling, 97% received thromboembolic prophylaxis, 94% received carbohydrate loading and none of the patients received mechanical bowel preparation. 8% received blood components during and after surgery. In the post operative phase on Day 1, 62% patients had urinary catheter removed, 88% received normal diet and 92% had early ambulation. The complication rate was 26%, but majority 79% had grade 1 and 2 complications. There was one postoperative mortality due to sepsis. The mean hospital stay was 6.6 days.

Conclusion* The study confirms the feasibility and benefits of following ERAS pathway in enhancing patient recovery during COVID pandemic.

596 CLINICIANS' VIEWS ON ENDOMETRIAL CANCER FOLLOW-UP STRATEGIES

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Introduction/Background* The introduction of telephone or patient-initiated follow-up schemes for endometrial cancer (EC) follow-up across the UK has been primarily clinician-led. This has resulted great variation in the structure and management of such schemes, as well as the population of EC patients enrolled. The aim of this study was to investigate clinicians' views on the existing schemes and guidance for EC follow-up, and to determine the interest in the development of a national UK-wide stratified EC follow-up scheme.

Methodology The views of clinicians involved in the follow-up of patients who have undergone treatment for EC were explored through semi-structured telephone interviews. Purposeful sampling was applied to ensure that the views gathered spanned diverse clinical backgrounds, experience and geography throughout the UK. Interviews were audio recorded, transcribed verbatim and analysed using framework analysis.

Result(s)* Interviews were conducted with gynaecological oncologists, cancer unit gynaecologists, oncologists and clinical nurse specialists (CNS). There was overwhelming interest to move towards patient initiated follow-up schemes, although there was variation in the extent of implementation of such schemes between cancer centres and units across the UK. There was also variation in the structure and patient populations clinicians felt should be included in the schemes. The concept of a national protocol for EC follow-up was of interest to the participants, although it was felt that the addition of biomarker monitoring would increase the confidence in transferring patients with high-risk or advanced disease to such a scheme.

Conclusion* There is a move towards risk-stratified follow-up schemes for EC, in particular patient-initiated follow-up. Clinicians reported interest in the development of a national follow-up strategy in order to reduce variation in practice and enable equality of access to innovative schemes across the UK.

633 HEALTH CARE ASSOCIATED INFECTION IN GYNECOLOGIC ONCOLOGY: CLINICAL AND ECONOMIC IMPACT. LARGE RETROSPECTIVE SINGLE-INSTITUTION STUDY

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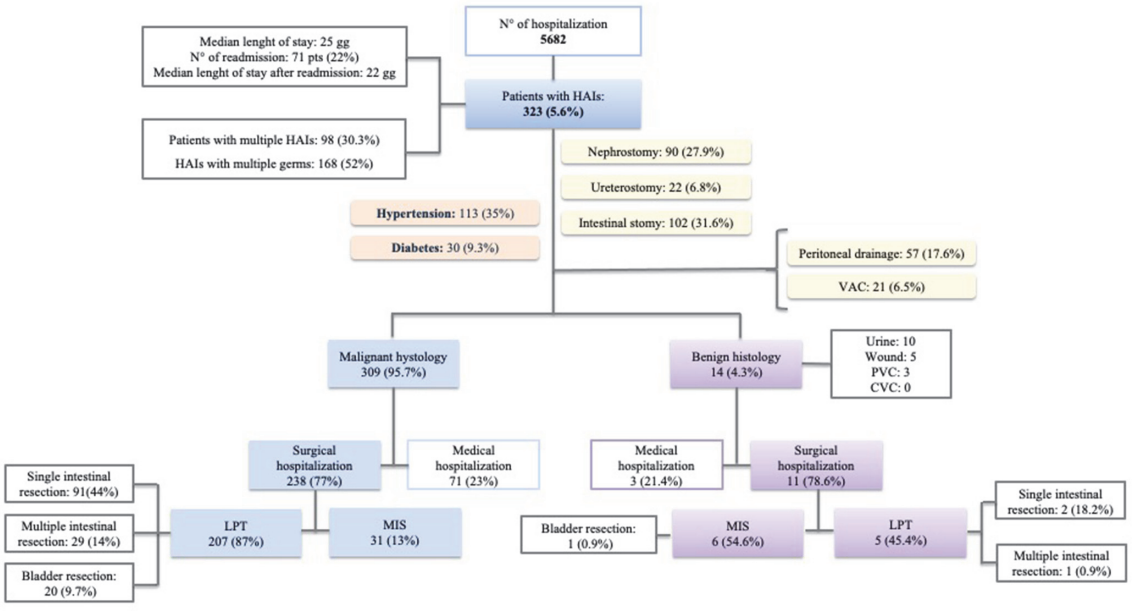
Introduction/Background* The purpose of this paper is to analyze data related to infections of patients suffering from



Abstract 633 Figure 1