December 2019 were invited to participate in the study in April 2021 by post. Under supervision of EORTC, the authors translated the disease specific EORTC QLQ-EN24 questionnaire to the Slovene language in accordance with EORTC guidelines. Demographic and clinical treatment data was evaluated and correlated with the QLQ-EN24 dimensions. Correlations were performed using the Spearman rank test, continuous data was compared using the Mann-Whitney U test. Data were evaluated using the SPSS for Mac version 23.0

Result(s)* Seventy-nine women participated in this study (response rate 51%). Cronbach's alpha for items in the Slovenian version of the EORTC QLQ-EN24 scale was 0.72. Median age of women was 64 years (36-85). Follow up time was 4 years (2-5). Sexual activity in the last 4 weeks prior to filling out the questionnaire was reported in 26 women (32%). Median body mass index (BMI) was 31 (19-52). BMI was correlated with worse reported outcomes in lymphoedema (r_s=-.246, p<.045) and urological symptoms (r_s=-.246, p<.044). Age was correlated only with items regarding poor body image (r_s=-.350, p<.002), sexual interest (r_s=-.408, p<.001) and sexual activity (r_s=-.506, p<.001). No other symptoms assessed were correlated with age. No patient recorded symptoms were correlated with surgery type (minimally invasive or open surgery) nor with lymph node treatment.

Conclusion* Our pilot study using a Slovenian version of the EORTC QLQ-EN24 showed adequate internal consistency. An initial analysis of the treatment mode did not impact patient reported health symptoms. There is a need for further understanding and support to women to prevent health symptoms post treatment and improve PROs.

103 INDIVIDUALIZING SUPPORT TO IMPROVE QUALITY OF LIFE IN DIFFERENT PHASES OF BREAST CANCER TREATMENT

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Introduction/Background* Due to the improved prognosis of patients with breast cancer, health-related quality of life has become increasingly important. The aim of the study is to evaluate the potential impact of different epidemiological, oncological and treatment parameters on the quality of life at different stages of diagnosis, treatment and follow-up in order to help improve and individualize the support for patients with breast cancer.

Methodology Between January 2019 and January 2021, 189 breast cancer patients were included. The quality of life was assessed using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC-QLQ-C30) and a German questionnaire quantifying psychological distress (FBK-R10) at three distinct time points: At initial diagnosis as well as after six and 12 months. Sociodemographic and clinical data were also included.

Result(s)* Both the subjective quality of life and the perceived health condition differed significantly between the three time points (p<0.01). After six months, the reported quality of life was significantly lower in all age groups. However, there was a significant improvement in the quality of life after 12 months. There was a trend to full rehabilitation in women age 50 to 69. Further, quality of life was significantly lower in patients undergoing treatment compared to patients in follow-up (p=0.01). Moreover, these patients suffered significantly more frequently from psychological distress (p=0.035) and sexual dysfunction (p<0.05). There was a significant correlation between the EORTC and FBK-R10 questionnaires (p<0.05), suggesting a correlation between quality of life and psychological distress.

Conclusion* The quality of life decreased significantly during the first six months after diagnosis, identifying this time as a period of particular need for a multidisciplinary support system. In addition, patients undergoing treatment should receive special attention given their lower quality of life, greater psychological distress and substantially more sexual dysfunction. A significant improvement in quality of life can be observed 12 months after the initial diagnosis. Future studies should focus on how to regain an improved quality of life earlier and how to implement support systems based on the patients' different needs at different times during the course of the disease.

220 ENHANCED RECOVERY AFTER SURGERY IS FEASIBLE, BENEFICIAL AND SHOULD BE THE STANDARD IN MAJOR GYNECOLOGICAL SURGERIES

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Introduction/Background* Enhanced recovery after surgery (ERAS) protocols are evidence-based protocols designed to standardize medical care, improve outcomes, and lower health care costs. Our objective was to evaluate the implementation of the ERAS protocol, and its effect on recovery during the hospitalization period after gynecological laparotomy surgeries.

Methodology In this retrospective cohort study we compared demographic and clinical data of consecutive patients at a single institute who underwent open gynecological surgeries before (August 2017- December 2018) and after (January 2019- March 2020) the implementation of the ERAS protocol. Eighty women were included in each group.

Result(s)* The clinical and demographic characteristics were similar between the women operated before and after implementation of the ERAS protocol. Following implementation of the protocol, decreases were observed in post-surgical hospitalization (from 4.89±2.56 to 4.09±1.65 days; p=0.01), in patients reporting nausea symptoms (from 18 (22.5%) to 7 (8.8%); p=0.017), and in the use of postoperative opioids (from 77 (96.3%) to 47 (58.8%); p<0.001). No significant changes were identified between the two periods regarding vomiting, 30-day re-hospitalization and postoperative minor and major complications.

Conclusion* Implementation of the ERAS protocol is feasible and was found to result in less postoperative opioid use, a faster return to normal feeding and a shorter postoperative hospital stay. Implementation of the protocol implementation was not associated with an increased rate of complications nor with re-admissions.

Abstract 220 Table 1 Comparison of postoperative ERAS protocol interventions before and after its implemention

	Before ERAS N=80	After ERAS N=80	P-value
Opioid analgesic use	77 (96.3%)	47 (58.8%)	<0.001
Postoperative nasogastric tube	23 (28.7%)	7 (8.8%)	0.001
Intraoperative surgical drain administration	23 (28.7%)	18 (22.5%)	0.365
Duration of surgical drain postoperative [a]	1.11±1.97	0.74±1.54	0.292
First postoperative day indwelling urinary catheter removement	64 (80.0%)	75 (93.8%)	0.01
Duration of indwelling urinary catheter postoperative [a]	1.64±2.05	1.1±0.43	0.009
Ambulation within 6 hours from return to department	1 (1.3%)	25 (31.3%)	<0.001
Duration until ambulation from return to department (hours) [a]	21.42±8.59	13.93±6.56	<0.001
Fluid drinking within one day postoperative	17 (21.3%)	48 (60.0%)	<0.001
First postoperative day feeding	3 (3.8%)	73 (91.3%)	<0.001
Duration until feeding from surgery (days) [a]	2.24±1.05	1.08±0.34	<0.001
First postoperative day intravenous fluid cessation	48 (60.0%)	77 (96.3%)	<0.001

Abstract 220 Table 2 Comparison of postoperative clinical outcomes before and after implementation of the ERAS protocol

		Before ERAS N=80	After ERAS N=80	P-value
Hospitalization after surgery duration (days) [a]		4.89±2.56	4.09±1.65	0.01
Nausea [a]		18 (22.5%)	7 (8.8%)	0.017
Vomiting	No	73 (91.2%)	75 (93.8%)	0.225
	First-day postoperative	2 (2.5%)	0 (0%)	
	Second-day postoperative and beyond	3 (3.8%)	5 (6.2%)	
	Bowel obstruction requiring a nasogastric tube	2 (2.5%)	0 (0%)	
Postoperative complications		12 (15.0%)	10 (12.5%)	0.646
Re-hospitalization within 30 days of surgery		11 (13.8%)	8 (10.0%)	0.463

244 THE IMPACT OF URINE BLADDER CATHETERIZATION AFTER RADICAL HYSTERECTOMY – UNDERSTANDING PATIENTS' EXPERIENCE

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Introduction/Background* Postoperative bladder dysfunction is a common phenomenon after radical hysterectomy (RH) in patients with cervical cancer. Post-operatively, women receive a transurethral or suprapubic catheter.

The objective of our study was to evaluate patients' experience of urine bladder catheterization after RH.

Methodology A questionnaire with 19 items was sent to 62 women who underwent RH between January 2017 and July 2020 at the Erasmus MC Cancer Institute in Rotterdam, the Netherlands. Questions regarding information received, catheter-related problems, and emotional distress were surveyed using a four-point Likert scale. For analysis, the two lowest and two highest outcomes were combined. Further, women were encouraged to share any comments. The study was approved by the ethical board of the Erasmus MC.

Result(s)* Forty- seven women responded (75%). Insufficient information on catheter use was reported by approximately 20%. A high or very high score was given for frustration by 36%, shame by 21%, fear by 11%, and movement restrictions by 28%. Overall, these were more common in women with a transurethral (n = 29) compared to a suprapubic catheter (n = 18). Additional information in the free text box made it clear that postoperative micturition and catheter- relates problems have a significant impact on quality of life.

Conclusion* Women in this study reported more sorrow and problems related to postoperative catheterization after radical hysterectomy than expected. These results emphasize the need to discuss these issues with our patients pre- and postoperatively, to learn more about their needs, and ultimately to improve the perioperative protocol and thereby reduce the patients' perceived discomfort.