misinterpreted as a lymphatic trunk. For both, although nerve correction was done during surgery by suturing, rehabilitation was necessary. For open surgery, we have never experienced obturator nerve injury during the pelvic lymphadenectomy in the same period.

Conclusions Obturator nerve injury during pelvic surgery is possibly frequent in laparoscopic surgery.

EPV254/#148 SEPTUAGENARIANS AND OCTOGENARIANS UNDERGOING GYNECOLOGIC ONCOLOGY LAPAROTOMY: IS THERE A ROLE FOR ROUTINE POSTOPERATIVE CARDIAC BIOMARKER MONITORING?

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Objectives Accumulating evidence correlates myocardial injury after noncardiac surgery(MINS), even when asymptomatic, with increased cardiac and non-cardiac morbidity and mortality. There is no literature on MINS specific to Gynecologic Oncology. We sought to evaluate the incidence and risk factors of MINS in patients aged ≥70.

Methods Elective laparotomies between 01/2016–09/2020 for patients aged≥70 at a tertiary hospital in ON, Canada, were reviewed using prospectively-collected National Surgical Quality Improvement Program(NSQIP) data. MINS was defined as peak serum high-sensitivity troponin-T concentration≥0.04ng/mL within 30 days postoperatively. Logistic regression analysis was performed.

Results In this cohort of 258 patients, of 242(93.8%) who underwent postoperative troponin screening, 40(16.5%) experienced MINS without exhibiting ischemic symptoms or ECG changes. The diagnosis of MINS led to a change in cardiovascular medications for 35 patients(87.5%). On univariate analysis, Revised Cardiac Risk Index(RCRI) of 3–5 (p=0.002), history of coronary artery disease(p=0.003) or insulin-dependent diabetes(p=0.006), preoperative use of antiplatelets(p=0.009), beta-blockers(p=0.02), ACE-inhibitors(ACEI) or angiotensin-receptor blockers(ARB)(p=0.020) and frailty as defined by the NSQIP modified frailty index-5(p=0.02), were associated with greater risk of MINS. Factors reflecting surgical complexity including surgical complexity score, operative duration, blood loss and advanced oncologic stage, were not predictive. Multivariable analysis using backward selection procedure identified elevated RCRI and preoperative ACE/ARB as significant risk factors (OR5.93,95%CI 1.52–23.31,p=0.01 and OR2.3,95%CI 1.18–5.06,p=0.02).

Conclusions One in 6 patients in our cohort experienced asymptomatic MINS, irrespective of surgical complexity. MINS may be underdiagnosed after Gynecologic Oncology surgery in the absence of systematic troponin screening. Our analysis highlights a possible opportunity to optimize cardiac risk factors and potentially reduce morbidity and mortality.

EPV255/#120 TISOTUMAB VEDOTIN VS INVESTIGATOR'S CHOICE CHEMOTHERAPY IN SECOND- OR THIRD-LINE RECURRENT OR METASTATIC CERVICAL CANCER (INNOVATV 301/ENGOT-CX12/GOG-3057, TRIAL IN PROGRESS)

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Objectives Doublet chemotherapy (paclitaxel plus either platinum or topotecan) with bevacizumab (if eligible) is recommended for first–line treatment of recurrent/metastatic cervical cancer (r/mCC; Tewari 2014). In the second–line setting, there are limited data for available treatment options. Tisotumab vedotin (TV) is an investigational antibody–drug conjugate directed to tissue factor. In the phase 2 pivotal trial (innovaTV 204/ENGOT-cx6/GOG-3023) in r/mCC patients with disease progression on or after chemotherapy, TV demonstrated clinically meaningful and durable activity (objective response rate [ORR]: 24%; median duration of response [DOR]: 8.3 months) with a manageable and tolerable safety profile. Most adverse events associated with TV were mild to moderate. These findings support further investigation of TV in patients with r/mCC who progress on first–line treatment.

Methods innovaTV 301/ENGOT-cx12/GOG-3057 (NCT04697628) is a global, randomized, open-label, phase 3 trial evaluating efficacy and safety of TV in patients with previously treated r/mCC. Eligible patients are ≥18 years, have r/mCC, and have progressed after 1–2 prior lines of therapy (either standard of care systemic chemotherapy doublet or platinum-based therapy with bevacizumab, if eligible). Approximately 482 patients will be randomized 1:1 to receive 21–day cycles of TV (2.0 mg/kg IV once every 3 weeks) or investigator's choice of chemotherapy: topotecan, vinorelbine, gemcitabine, irinotecan, or pemetrexed. The primary endpoint is overall survival. Key secondary endpoints are progression-free survival, ORR, time to response, DOR, safety, and quality of

life outcomes. The study is enrolling and will have sites in the USA, Europe, Japan, Latin America, Taiwan, Singapore, and South Korea.
Results Not applicable.
Conclusions Not applicable.

EPV256/#150 PREOPERATIVE FRAILTY ASSESSMENT IN PATIENTS UNDERGOING GYNECOLOGIC ONCOLOGY SURGERY: A SYSTEMATIC REVIEW

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Objectives The aim of the present article was to discuss currently available evidence on the impact of frailty assessment on adverse postoperative outcomes and survival in patients undergoing surgery for gynecological cancer.
Methods Systematic search of Medline (PubMed) and Embase databases until September 30, 2020. Key inclusion criteria were: (1) randomized or observational studies; (2) patients undergoing non-emergent surgery for gynecological malignancies; (3) preoperative frailty assessment.
Results Through the process of evidence acquisition, twelve studies including 85,672 patients were selected and six tools were evaluable: 30-item frailty index, 40-item frailty index, modified frailty index (mFI), John Hopkins Adjusted Clinical Groups index, Fried frailty criteria, Driver's tool. The prevalence of frailty varied roughly from 6.1% to 60% across different series included. The mFI was the most adopted and predictive instrument. Pooled results underlined that frail patients were more likely to develop 30-day postoperative complications (OR, 4.16; 95% CI, 1.49–11.65; p=0.007), non-home discharge (OR, 4.41; 95% CI, 4.09–4.76; p<0.001), ICU admission (OR:3.99; 95% CI, 3.76–4.24; p<0.001) than the non-frail counterpart. Additionally, frail patients experienced worse oncologic outcomes (disease-free and overall survivals) than non-frail patients.
Conclusions The present systematic review demonstrated that preoperative frailty assessment among gynecologic oncology patients is essential to predict adverse outcomes and tailor a personalized treatment. The mFI appeared as the most used and feasible tool in daily practice, suggesting that tailored therapeutic strategies should be considered for patients with 3 or more frailty-defining items.

EPV257/#152 SURGICAL SITE INFILTRATION VERSUS TRANSVERSUS ABDOMINIS PLANE BLOCK OF LIPOSOMAL BUPIVACAINE AFTER MIDLINE VERTICAL LAPAROTOMY FOR GYNECOLOGIC MALIGNANCY: A PROSPECTIVE RANDOMIZED CONTROLLED TRIAL

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Objectives Surgical site infiltration (SSI) and transversus abdominis plane (TAP) block are postoperative analgesic techniques. Liposomal bupivacaine may prolong analgesic effects. We hypothesize that surgical site infiltration of liposomal bupivacaine will reduce opioid consumption in the 48-hour postoperative period compared to TAP block.
Methods A single blind randomized controlled trial comparing surgical site infiltration of liposomal bupivacaine versus TAP block with liposomal bupivacaine after midline vertical laparotomy in patients with suspected or known gynecologic malignancy. Negative binomial regression was used to estimate the differences in total morphine milligram equivalent (MME) use between groups. Multivariable linear regression of pain scores on visual analog scale 0–10 was used at each time interval (2, 6, 12, 24, and 48 hours postoperatively) while controlling for medication use and age.
Results Of 43 patients, 22 received SSI and 21 received TAP block. Mean age was 57.8 (SD = 11.50). There were no significant differences in demographics, incision length, surgery duration or pathology between groups. After controlling for age and BMI, there was not a statistically significant difference in total MME between the treatment groups (β = -0.17, 95% CI = -0.77, 0.43, p = 0.59). There were no statistically significant differences in pain scores (both resting and exertion) at all time points after controlling for age and pain medication utilization.
Conclusions Surgical site infiltration of liposomal bupivacaine did not reduce opioid use and did not decrease pain scores within 48 hours after surgery compared to TAP block after midline vertical laparotomy for gynecologic cancer.

EPV258/#285 IMPROVING THE RATES OF SAME DAY DISCHARGE IN ROBOTIC SURGERY PATIENTS – A GYNECOLOGIC ONCOLOGY QUALITY IMPROVEMENT PROJECT

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Objectives In appropriately selected gynecologic oncology (GO) patients, robotic or laparoscopic surgery is a preferred approach (faster recovery, fewer complications, shorter hospital stay). Furthermore, same day discharge (SDD) is safe and effective in these patients. Evidence suggests no increased rates of readmission, or complications for SDD compared with overnight observation. We pursued a Quality Improvement (QI) project aimed at increasing our rate of SDD by 50% by June 2021 in GO robotic surgery patients.
Methods This QI initiative is based upon the Institute for Healthcare Improvement's Model for Improvement. The study is an interrupted time series study. Baseline data assessment determined the rate of SDD and potential root causes for failed SDD. For each intervention (addressing a root cause), Plan-Do-Study-Act cycles were conducted. Outcome, process, and balancing measures were collected prospectively.
Results Four simple interventions were selected for implementation: 1) setting SDD as the default discharge plan, 2) providing a physician discharge order on the patient chart, 3) removing the foley catheter in the OR, 4) developing comprehensive standardized perioperative patient education materials. The rate of SDD was improved from 28.8% (baseline) to