

69.4% following the changes. There was no increased 30-day rate of readmission (0% SDD vs 1.3% all robotic cases) or presentation to the emergency department (1.9% SDD vs 3.8% all robotic cases) following implementation of the interventions.

Conclusions Local rates of SDD can be improved with simple interventions targeting disposition planning, foley catheter removal and managing patient expectations. These interventions may be easily applicable to other GO programs.

EPV259/#288

PATIENT OUTCOMES AND ADHERENCE TO AN ENHANCED RECOVERY PATHWAY FOR OPEN GYNECOLOGIC ONCOLOGY SURGERY: A 5-YEAR SINGLE CENTER EXPERIENCE

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Objectives This study evaluates compliance with Enhanced Recovery After Surgery (ERAS) protocol for open gynecologic oncologic surgery at a tertiary center and relationship between levels of compliance and perioperative outcomes.

Methods Our retrospective cohort study included 1879 patients between November 2014 and December 2020. Two groups were identified based on compliance level (<80% versus ≥80%). Our primary outcomes were 30-day readmission, reoperation, length of stay, and postoperative complications. We also assessed compliance with each ERAS item over time (P1: 2014–2016, P2: 2017–2018, P3: 2019–2020) categorizing patients according to date of surgery. Values were compared between P3 and P1. Multivariable logistic regression analyses were performed to evaluate associations between high compliance and perioperative outcomes.

Results Overall compliance was 74% (95% CI 71.9–78.2). Compliance with ERAS >80% was associated with lower Clavien-Dindo grades II (OR 0.74, 95%CI 0.59–0.93), III (OR 0.55, 95%CI 0.33–0.93), and V (OR 0.08, 95%CI 0.01–0.60) complication rates, readmission rates (OR 0.61; 95%CI 0.43–0.88) and shorter length of stay (OR 0.59; 95%CI 0.47–0.75). Preoperatively, there was increased adherence to counseling (50%, p=0.01), optimization (21%, p=0.02), and carbohydrate-loading (74%, p=0.02). Intraoperatively, use of short-acting anesthetics and adherence to avoiding abdominal drainage (7%, p=0.04) increased. Compliance with goal directed fluid therapy (16%, p=0.04) and normothermia (8%, p=0.03) decreased. Postoperatively, there was increased compliance with avoiding saltwater overload (8%, p=0.02) and multimodal analgesia (5%, p=0.02).

Conclusions Compliance (>80%) with ERAS is associated with lower complication rates, 30-day readmissions, and shorter length of stay without impacting reoperation rates and postoperative opioid use.

EPV260/#451

SCHWANNOMA OF THE PUDENDAL NERVE – ANATOMICAL CONSIDERATIONS IN THE APPROACH TO SURGICAL MANAGEMENT OF THIS RARE PATHOLOGY

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Objectives Schwannomas are uncommon, benign, indolent, nerve sheath tumours with low malignant potential; commonly affecting the nerves of the head, neck, mediastinum and extremities. Two pudendal cases have been reported. Their deep, complex location challenges resection - via the ischio-rectal fossa in our case.

Methods A 24-year-old female reported an enlarging left perineal mass over eight years; associated with numbness and sexual dysfunction. This was 7x5cm on examination, distal to Alcock's canal, with no vaginal, rectal or anal sphincter involvement. It was defined and mildly FDG-avid on imaging. Biopsies confirmed schwannoma. She reports no neurological deficit or evidence of recurrence following resection.

Results Alcock's canal is directly accessed via the ischio-rectal fossa with minimal pelvic muscle and ligament disruption. The pudendal nerve arises from the S2–4 sacral nerve and travels forward laterally in the pelvis within this obturator internus fascial sheath. It has both motor and sensory functions. The ischio-rectal fossa is a pyramidal space lateral to the anal canal and below the pelvic diaphragm. It contains the internal pudendal and inferior rectal vessels and nerves.

Conclusions Pudendal nerve schwannomas are rare, arising from a single non-functioning sensory fascicle. Following



Abstract EPV260/#451 Figure 1