groups more predisposed to PTSD. Distress was highest in emergency admissions, reinforcing the need for earlier diagno-
sis through improved diagnostic pathways. Psychological sup-
port may improve patient experience, especially for younger,
less educated unemployed women.

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**CLINICOPATHOLOGICAL FEATURES AND TREATMENT OUTCOMES OF OVARIAN CLEAR CELL CARCINOMA: THE PAN-BIRMINGHAM GYNAECOLOGICAL CANCER CENTRE EXPERIENCE**

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Introduction/Background To evaluate clinico-pathological fac-
tors and oncological outcomes in ovarian clear cell carcinoma (OCCC).

Methodology Retrospective cohort study, spanning the period
2000–2022. One-hundred women with OCCC were enrolled. Clinico-pathological, and treatment data were analysed to identify plausible predictors. Survival analysis was performed via the Kaplan-Meier method, log-rank test and Cox-regres-
sion. The census day was 1st April 2022.

Results The median age at diagnosis was 59.6 years. The majority of women were diagnosed with stage I 55/100 (55%). Of these, 28/55 (50.9%) were stage IA, 16/55 (20.1%) stage IC on the basis of rupture-only, and 11/55 (20%) stage IC on the basis of surface involvement and/or positive cytology. 45/100 (45%) of women were stage III-IV. 51/100 (51%) of women had concomitant diagnosis of endometriosis. The median PFS and OS in women with stage I was 58.00 (95% CI 29.00 – 68.00) and 189.00 (95% CI 60.00 – 189.00) months, respectively. There was statistical difference in PFS/OS in women with stage IA and IC. In the subgroup analyses, women with stage IC on the basis of surface involvement and/or positive cytology demonstrated a statistically significant decrement in both PFS (HR 3.79, 95% CI 1.12 – 22.6) and OS (HR 5.32, 95% CI 1.25–26.2). The median PFS and OS in women with stage III-IV was 24.00 (95% CI 14.00 – 47.00) and 44.00 (95% CI 19.00 – 65.00) months, respec-
tively. The presence of residual disease was found to be a prognosticator for survival, whilst adjuvant chemotherapy or presence of endometriosis were not significantly associated with poorer outcomes.

Conclusion OCCC usually presents in young women and at early-stage. Stage IA has an excellent prognosis compared to stage IC and III/IV. Surface involvement and/or positive cytology are seemingly independent prognosticators vis-à-
vis endometriosis or adjuvant chemotherapy. Owing to high chemoresistance novel treatment paradigms are warranted.

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**FIRST EXPERIENCES OF IMPLEMENTING ‘ENHANCED RECOVERY AFTER SURGERY’ (ERAS) AT TWO GERMAN ESGO CENTERS OF EXCELLENCE – KORE-INNOVATION: THE FIRST PROSPECTIVE CLINICAL TRIAL TO ASSESS A PERIOPERATIVE PATHWAY TO REDUCE POSTOPERATIVE COMPLICATIONS IN OVARIAN CANCER PATIENTS**

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Introduction/Background The perioperative ERAS pathway
has been established in many surgical fields and has shown to improved health care quality and costs. We report our first experiences implementing the ERAS pathway as part of the KORE INNOVATION trial in patients with ovarian cancer.

Methodology KORE INNOVATION is an ongoing clinical trial to assess the effects of an innovative perioperative care path-
way to reduce complications for patients undergoing surgery for ovarian cancer by implementing a prehabilitation strategy combined with an ERAS pathway. The trial is conducted at two study sites in Germany, both ESGO centers of excellence for ovarian cancer surgery: Charité Universitätsmedizin Berlin and Evangelische Kliniken Essen Mitte. ERAS guidelines were adapted for the clinical settings, and multiple training sessions for all staff were conducted. An interdisciplinary ‘KORE-team’ consisting of physicians, nurses, nutritionists, and physiothera-
pists was established to aid implementation, monitor staff adherence, follow the patients throughout the entire care process, and function as interface managers. We report our first experiences with the staff’s adherence to ERAS items at both study sites.

Results The following ERAS items showed good adherence: omission of bowel preparation, carboloding, disinfection using chlorhexidine, use of opioid-sparing anesthesia and epidurals, early postoperative mobilization, and feeding. In contrast, the following items showed decreased adherence: omission of pre-
operative sedatives, omission of drains, goal-oriented fluid management during the postoperative phase, and the omission of postoperative antibiotic treatment. Adherence increased through monitoring through daily rounds and active staff engagement administered by the KORE team.

Conclusion Continuous training and adherence monitoring are by multi professional and interdisciplinary KORE team are key factors for the successful implementation of the ERAS pathway.