Methodology In this multicentre non-inferiority trial, 316 women from 42 hospitals with FIGO stage IA/B endometrial cancer were randomly allocated to reduced FU (n=160) or usual FU care (n=156). The women completed questionnaires at baseline (after surgery), and after 6, 12 and 36 months. The primary outcome was satisfaction with care (PSQ-III) with a predefined noninferiority margin of 6 points (range 0–100). Mixed linear regressions were used.

Results 299 (95%) women completed the questionnaire at baseline; 291 (92%) at 6-months; 272 (86%) at 12 months and 222 (70%) at 36 months. During three years after treatment, women in the reduced FU group had a median of 3.5 [IQR 3.0–5.0] visits with their specialist/nurse compared to 7.0 [IQR 6.0–9.0] visits for women in the usual FU group. Overall satisfaction with care was similar in the reduced FU (M=82;SD=15) and usual FU (M=82;SD=13) group. At 6, 12 and 36 months, more patients (93/94/90%) in the reduced FU arm were satisfied with their FU schedule than patients in usual FU arm (79/78/82%). Nine women in the reduced FU group and five in the usual FU group developed a recurrence (n.s.).

Conclusion Women receiving reduced follow-up care were just as satisfied with their care as those receiving follow-up care according to Dutch guidelines. Compared to usual care, women in the reduced care group had fewer medical visits and, at the same time, more often reported being satisfied with this reduced frequency.

Introduction/Background Research suggests that most early-stage endometrial cancer patients do not need intensive follow-up. The aim of the ENSURE (Endometrial cancer SURvivors’ follow-up care) trial was to compare satisfaction with care between women who received a reduced follow-up (FU) schedule (4 visits) and women who received the usual FU schedule according to the Dutch guideline (8–11 visits) for three years after treatment.

Conclusion Cooperation of our patients and techniques provide successful treatment planning and delivery while reducing radiotherapy dose to the organs at risk. This approach significantly reduces the level of anxiety, helps patients trust and cooperate with staff, complete treatment without interruptions and an overall better outcome.
Readmission to hospital was required in 1 vs 3 women, respectively. All differences were not significant. In prehabilitation group LUNA results and VO2max measured at the beginning of prehabilitation and one day before surgery showed statistically significant improvement: 100.8 mV vs 144.8 mV and 14.7 vs 15.3 mL/kg-1·min-1, respectively (p=0.04 and p=0.01).

Conclusion Introducing the prehabilitation program reduces duration of hospital stay with no major influence on pre and postoperative complications. LUNA and 6MWT (VO2max) may serve as indicator for compliance with physical prehabilitation in ovarian cancer patients.

**Abstract 2022-RA-760-ESGO**

**PREDICTIVE MODEL OF SEVERE COMPLICATIONS IN PATIENTS WHO UNDERWENT AN OPEN GYNECOLOGICAL CANCER SURGERY ON AN ENHANCED RECOVERY AFTER SURGERY (ERAS) PROGRAM**

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**Introduction/Background** Enhanced Recovery After Surgery (ERAS) is a global multimodal perioperative care initiative designed to achieve early recovery after major surgery. Our primary objective was to analyze the postoperative outcomes after open gynecological cancer surgery on an ERAS program and to design a predictive model of severe complications after surgery.

**Methodology** We retrospectively reviewed patients undergoing open surgery for suspected gynecological malignancy and managed according to the ERAS guidelines from January 1st, 2019 to December 31st, 2019, at a tertiary-care center in Monza, Italy. Surgical Complexity Score (SCS), Clavien-Dindo Classification (CDC) of complications and a Comprehensive Complication Index (CCI) were applied for each patient. Association between patient-, disease- and surgical-variables and severe postoperative complications (defined as CCI ≥26.2 events) were estimated using a univ- and multivariable logistic regression model. Factors associated with severe postoperative complications were used to construct a predictive model and nomogram.

**Results** One hundred and fifty-eight patients who underwent an open surgery were included in the study: 86 ovarian, 28 cervical, 39 uterine and 3 non-gynecological cancers. Overall, 8.2% of patients experienced a CDC grade IIIA-V complication, while 13.3% had a CCI ≥26.2. The median CCI was 8.7 [IQR 0–20.9]. Cancer type, number of comorbidities, blood loss during surgery and SCS were independent predictors of severe postoperative complications after open gynecological cancer surgery.

**Conclusion** The application of an ERAS program in open gynecological cancer surgery is safe and results in an acceptable complication rate. The risk of severe postoperative complications may be predicted using our risk-model. This may help the clinician in personalizing care for each patient. Further prospective evaluations of this model are needed.

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**Abstract 2022-RA-762-ESGO**

**IMPLEMENTATION CASE STUDY OF IMAGE GUIDED ADAPTIVE HIGH DOSE RATE BRACHYTHERAPY FOR CERVICAL CANCER: WORKFLOW IMPACT ANALYSIS OF UPGRADING TO IMAGE BASED BRACHYTHERAPY WITHIN NATIONAL CANCER GRID OF INDIA CERVIX CANCER RESOURCE STRATIFIED GUIDELINES**

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**Introduction/Background** India has 17% of world’s cervical cancer incidence and transition to image guided high dose rate brachtherapy (IGBT) is crucial to improve outcomes. Institutional level activity based costing (ABC) and national impact analysis of transition was undertaken.

**Methodology** ABC was conducted in a high-volume centre that triaged patients for BT to (A) two dimensional (2D) or (B) 3D- point A BT or CT/MR based intracavitary (IC) or D) CT/MR-Interstitial (IS) IGABT). Clinical process mapping (implant and imaging time, delineation, treatment planning, delivery and removal) for workflows A-D was performed. Case scenarios for transition from workflow A to D was constructed at an institutional and national level based on incidence and infrastructure in states and Union Territories (UT) of India. Treatment capacity loss and potential strategies for workflow reorganisation were proposed.

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**Abstract 2022-RA-762-ESGO Figure 1**

**Results** Based on process mapping in 81 consecutive patients, the total time was 176 minutes (57–208) and 223 minutes (74–260) for 2D and 3D point A, 267 minutes for (101–302) and 348 minutes (232–383) for 3D-IC and 3D IC-IS-IGBT.