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-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 brachytherapy (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) IGBT). 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.
Transition from workflow A to D could lead to 64% reduction in capacity and reduce throughput to 1/3rd. Solutions to increase treatment capacity: i.e 10 or 12 hour overlapping shifts increased capacity by 25% and 50%, whereas performing 1 implant and delivering 2 fractions lead to 100% increase. These simulations were extrapolated to national scenario. Based on these simulations 23 states and UT will be able to transition to IGABT whereas 4 states will not meet treatment capacity. (Figure 1A-C). Additional 8 states/UT have no BT access. Further financial investment is needed in these 12 states/UT.

Conclusion Capacity upscale should be considered for IGBT implementation to prevent treatment delays. Further financial investment is needed at national level. The data is subject to implementation to prevent treatment delays. Further financial investment is needed in these scenarios. Based on these simulations 23 states and UT will be able to transition to IGABT whereas 4 states will not meet treatment capacity. (Figure 1A-C). Additional 8 states/UT have no BT access. Further financial investment is needed in these 12 states/UT.

Conclusion Capacity upscale should be considered for IGBT implementation to prevent treatment delays. Further financial investment is needed at national level. The data is subject to implementation to prevent treatment delays. Further financial investment is needed in these 12 states/UT.

**2022-RA-876-ESGO**

**HYSTERECTOMY, PELVIC OR PARAORTIC LYMPHADENECTOMY: RESULTS OF AN OUTPATIENT PATHWAY FOR SURGERY IN GYNECOLOGIC ONCOLOGY**

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**Introduction/Background** The development of outpatient surgery and ERAS protocols have led to apply it to more complex oncologic procedures such as hysterectomy and lymph node staging. Such an attitude implies to ensure high success rates of same-day discharge, identify possible limits and aim to improve modifiable weaknesses. The objective of this study was to evaluate the success rate of an outpatient pathway that is routinely used in our center for hysterectomy, pelvic lymphadenectomy (PLND) and paraaortic lymphadenectomy (PALND).

**Methodology** This retrospective study included all consecutive patients scheduled in the outpatient unit of a Comprehensive Cancer Center for a surgery including at least simple hysterectomy, pelvic lymphadenectomy (PLND) and paraaortic lymphadenectomy (PALND).

**Results** From 2015 to 2020, 232 patients were included: 22 PLND (9%), 76 PALND (33%), and 134 hysterectomies (58%). All surgeries were performed by laparoscopy, except one vaginal hysterectomy. Robotic assistance was used in 70 (30%) cases. The global outpatient success rate was 77.6% with a same-day admission rate of 15.5% and a 30-day admission rate of 7.3%. In multivariate analysis, the following factors were significantly predictive of failure: ASA score at 3 (OR, 2.74; CI95, 1.05–7.16, p = 0.04), end-of-surgery time after 2 pm (OR, 4.98; CI95, 2.03–12.3; p<0.001) and operative time of more than 90 minutes (OR, 7.23; CI95, 2.10–24.8; p = 0.002).

**Conclusion** The success rate of an outpatient strategy for hysterectomy, PLND or PALND is high when a clear outpatient pathway has been established. Preoperative identification of comorbidities, early surgery scheduling and optimization of the duration of surgery are key issues.