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.

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 uni- 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.

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 brachotherapy (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.

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-IGBT.
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 IGBT 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 infrastructure and skilled personnel to deliver IGBT.

**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 oncogynecologic 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** A total of 93,218 patients with gynecological cancer were evaluated between January 2004 and December 2017. Among them, total 10,451 (11.2%) developed lymphedema. Incidences of lymphedema were 11.4%, 13.1%, and 9.16% in cervical cancer, endometrial cancer and ovarian cancer respectively. Age and multimodal treatment are considered to be possible risk factors for lymphedema in patients with gynecological cancer (p < 0.001), while residence and income quartile were not associated with lymphedema in gynecologic cancer patients. The expands of health care resources for the treatment of lymphedema has increased over the years.

**Conclusion** Lymphedema is a common complication affecting women with gynecological cancer. This is the first population-based study to identify risk factors for lymphedema in gynecological cancer patients. National healthcare costs for lymphedema treatment are increasing in Korean society. Health care providers should give attentions for high-risk lymphedema group during and after cancer-related treatment.

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**LYMPHEDEMA IN GYNECOLOGICAL CANCER SURVIVOR; A NATIONWIDE COHORT STUDY**

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**Introduction/Background** Lower extremity lymphedema after gynecological cancer treatment is common complication and negatively affects the quality of life and function of patients. This study investigated the cumulative incidence and risk factors of lymphedema in patients with gynecological cancer, as well as utilization of health care resources for post-treatment lymphedema.

**Methodology** Using the Korean National Health Insurance Service (NHIS) database, we conducted a nationwide, retrospective cohort study of patients with cervical, endometrial, and ovarian cancer with cancer-direct treatment. The patients were categorized by age, region, income, and treatment modality. To analyze the incidence and risk factors of lymphedema, cox proportional hazards regression models were used. We also analyzed diagnostic and treatment claim codes to find out trend or costs of utilization of health care resources for lymphedema treatment.

**Results** A total of 93,218 patients with gynecological cancer were evaluated between January 2004 and December 2017. Among them, total 10,451 (11.2%) developed lymphedema. Incidences of lymphedema were 11.4%, 13.1%, and 9.16% in cervical cancer, endometrial cancer and ovarian cancer respectively. Age and multimodal treatment are considered to be possible risk factors for lymphedema in patients with gynecological cancer (p < 0.001), while residence and income quartile were not associated with lymphedema in gynecologic cancer patients. The expands of health care resources for the treatment of lymphedema has increased over the years.

**Conclusion** Lymphedema is a common complication affecting women with gynecological cancer. This is the first population-based study to identify risk factors for lymphedema in gynecological cancer patients. National healthcare costs for lymphedema treatment are increasing in Korean society. Health care providers should give attentions for high-risk lymphedema group during and after cancer-related treatment.

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**WAIT TIME UNTIL SURGERY IN GYNECOLOGICAL ONCOLOGY: PATIENT PREFERENCE AND EXPERIENCE**

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**Introduction/Background** Patient perspective on treatment and aftercare in gynecological oncology has been getting more attention. However, there are no studies on patient’s experience of wait time before surgery, which is especially relevant...