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 revision after 2023. 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.

**Introduction/Background** The development of outpatient surgical and ERAS protocols has 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 included in this study. 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.

**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. The expansion of health care resources for the treatment of lymphedema has increased over the years.

**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.

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