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 infrastructure and skilled personnel to deliver IGBT.

2022-RA-876-ESGO HYSTERECTOMY, PELVIC OR PARAAORTIC 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, PLND or PALND. The success was defined by same-day discharge and no admission in the 30 days after surgery. Multivariate logistic regression was used to determine prognostic factors associated with success. Odds ratios (OR) with 95% confidence interval (CI95) were estimated.

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.

2022-RA-917-ESGO 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 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.

2022-RA-960-ESGO 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

as wait times have increased during the COVID pandemic. In this patient preference study we investigated 1)how patients experience wait time; 2)what wait time is acceptable; 3)how it impacts quality of life.

Methodology Mixed methods study design; combining a qualitative interview study with a questionnaire among women with gynecological cancer. We performed semi-structured interviews with 20 women about their experiences with and preferences regarding wait time. Using thematic analysis we found factors that impact wait time acceptability and based on this developed a questionnaire. The questionnaire was administered to 100 women who had undergone surgery for gynecological cancer in two tertiary hospitals in the Netherlands.

Results Wait time between first appointment and surgery was more than 4 weeks for 61% of patients. Wait time was considered too long by 77% of these patients compared to 39% of patients who waited less than 4 weeks *(p=0.01)*. 31% of patients scored above the threshold for either anxiety or depression on the Hospital Anxiety and Depression Scale (HADS), 63% of patients had sleeping problems and 37% of patients experienced pain frequently or most of the time. Patients spent less time on working (38%) and exercise (46%) and more time on time on relaxation (38%), with friends (27%) and educating themselves on their illness (40%).

Conclusion Waiting for surgery is often stressful for gynecological oncology patients. Waiting over 4 weeks for surgery is considered too long by most patients. Patients reduced time working and exercising and increased time finding information on their illness. This study provides directions on how to improve quality of care the weeks before surgery from the patient's perspective.

2022-RA-1039-ESGO FACTORS PREDISPOSING TO MORE SEVERE PAIN AND A SIGNIFICANT INFLUENCE OF PATIENTS' ANXIETY PRIOR TO THE PROCEDURE – A STUDY ON A PERIOPERATIVE CARE IN GYNECOLOGIC ONCOLOGY

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Introduction/Background The attitude towards perioperative care in gynecology is continuously evolving. A necessity of an implementation of a holistic approach is highlighted by the Enhanced Recovery After Surgery Society guidelines. The study performed by the Students' Scientific Group at the University Oncology Center in Bialystok aimed to determine which factors have an impact on the more severe postoperative pain.

Methodology The survey involved patients undergoing gynecologic surgery from XI 2020 to III 2022. A psychosocial condition was assessed by the original questionnaire at admission. Information about pain level was provided by patients themselves using the Numeric Rating Scale (0–10) 3 times per day for 3 days. A study examined the relationship between gathered variables and pain level.

Results From a total of 115 patients (median age 50), 63 completed all the questionnaires. Approximately a half of them (n=30) was diagnosed with a malignancy. Patients who declared greater anxiety related to the procedure experienced significantly more severe pain (p=0,041). Majority of patients declared an active lifestyle, albeit most of them discontinued it before surgery. Additional application of regional anesthesia provided a significant reduction of pain (p=0,017). The severity of a postoperative pain was not associated with: age, BMI, type of incision, indication (malignant or non-malignant) and a scope of an operation. Averagely, the most severe pain was experienced in the evening the next day after the surgery.

Conclusion Reduction of patients' anxiety should be considered a priority assignment in the process of qualifying to the surgery. Desirable actions include e.g. psychological support, education and detailed information on the course of the hospitalization. To reduce the postoperative pain and the administered doses of systemic drugs, regional anesthesia should be considered. Medical staff must be aware that perioperative care begins much earlier than on the day of admission to the hospital.

2022-RA-1057-ESGO OUTCOMES OF GYNAECOLOGICAL CANCER SURGERY DURING THE COVID-19 PANDEMIC: RESULTS FROM THE INTERNATIONAL, MULTICENTER, PROSPECTIVE COVIDSURG-GYNAECOLOGICAL CANCER STUDY

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Introduction/Background The magnitude of adverse outcomes caused by the disrupted surgical cancer care during the COVID-19 pandemic is unclear. The aim of CovidSurg-Gynaecological Cancer study was to evaluate the changes in care and short-term outcomes of surgical patients with gynecological cancers during the initial phase of the COVID-19 pandemic internationally.

Methodology A multicenter, international prospective cohort study including consecutive patients with gynecological cancers who were initially planned for non-palliative surgery.

Primary outcome The incidence of pandemic-related changes in care

Secondary outcomes 30-day postoperative morbidity and mortality rates

A composite outcome of unresectable disease or disease progression, emergency surgery and death