

numbers of RS between December 2020 and April 2022 and COVID-19 infections (CI) amongst patients.

**Results** There was no delay in the simulation training. Wet lab training was delayed due to temporary center closure. The surgeon's learning curve was slower at the beginning of the program. This was attributed to the lower influx of patients as a result of prioritization, lesser operative sessions, and delays in the mandatory training completion. 41 RS procedures were done in the first 8 month following a COVID-19 free pathway and were operated in an elective surgery hub with no visitors allowed. There were no cancellations due to CI during this period. Following the return to NHS hospital, 102 patients underwent RS in the subsequent 8 months. Pre-operative isolation was gradually reduced then cancelled. One patient had a CI and was rescheduled accordingly.

**Conclusion** Covid pandemic has impacted the learning curve for RS with significant improvement noted after the gradual release of Covid related restrictions.

**2022-RA-1197-ESGO** **'IAVAZZO SCORE', AN EFFORT TO PREOPERATIVELY PREDICT THE DURATION OF ROBOTIC ASSISTED GYNECOLOGICAL SURGERIES**

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**Introduction/Background** In the last decades the rate of robotic-assisted gynecological surgeries has increased exponentially. The main reason for this increase is the less postoperative pain, the immediate patients' mobilization, and the evidence-based safety of these procedures. However, the prolongation of robotic-assisted gynecological surgeries compared to the open or even the laparoscopic remains the biggest disadvantage. A recent publication of our team tried to stratify robotic-assisted surgeries' duration using several preoperative patients' parameters.

**Methodology** We retrospectively analyzed all the robotic-assisted gynecological surgeries that have been conducted in our institution from January 2020 until May 2021. Preoperative values such as BMI, size of the uterus, previous abdominal surgeries, prior vaginal deliveries, and cause of surgical procedure were evaluated and were used in order to create a predictive score of difficulty and duration of surgery.

**Results** Overall, 57 cases were included in our analysis. The mean value of 'Iavazzo score' was calculated at 7.96., while median surgery time was 136 minutes. 'Iavazzo score' was found to be statistically correlated with operative time. Moreover, a cut-off value of 7.5 for our predictive score was found to be indicative of surgical duration more than our median surgical duration.

**Conclusion** Our predictive score can be a useful tool for pre-operative planning. An international multicenter trial is soon about to be launched in order to investigate the utility of our score and confirm our results on a larger scale

**2022-RA-1258-ESGO** **PATIENT WALK TO THE OPERATING THEATRE AS A NEW TOOL FOR PATIENT EMPOWERMENT – KORE-INNOVATION: THE FIRST PROSPECTIVE CLINICAL TRIAL TO ASSESS A PERIOPERATIVE PATHWAY TO REDUCE POSTOPERATIVE COMPLICATIONS IN OVARIAN CANCER PATIENTS**

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**Introduction/Background** Patient empowerment is an essential, yet neglected resource of the patient's health journey. Through a patient-centered approach, patients are encouraged to take on an active role in their health and recovery. We report our first experiences of the patient walk intervention as part of the patient empowerment module, which is embedded in the KORE-INNOVATION trial as a subpopulation analysis.

**Methodology** The KORE-INNOVATION trial is an ongoing clinical trial to assess an innovative perioperative care pathway to reduce complications for patients undergoing surgery for ovarian cancer. We implemented the patient walk intervention to encourage patients' autonomy before surgery. Patients were given the option to walk to the operation room instead of being pushed in their bed as part of the standard patient care pathway. The only requirement for walking was to omit sedating pre-medication. To evaluate patients' and staff's experiences, we administered a questionnaire between the 2nd-5th postoperative day.

**Results** Of the 65 patients offered to walk to the operating room, 48 participated. All patients reported that the experience was either better than expected or as expected; nobody reported that it was worse than expected. Patients reported that if given the choice would walk again. Patients also stated that they felt strengthened in their autonomy. Reasons for not walking were refusal to omit sedatives or anxiety before the operation. The main barriers from the staff's perspective were logistical difficulties, which decreased over time.

**Conclusion** Providing patients with the option to walk to the operating theatre is a simple but effective method of increasing patients' autonomy and engagement. Furthermore, it promotes the active patient role in their health and recovery. This easily implementable no-cost intervention should be routinely integrated in the context of ERAS protocols.