Abstracts

Methods A retrospective study including all cases of SH performed in a tertiary referral center in Israel during 2014–2021. We searched all surgeries performed by Senior gynecological surgeons in the Gynecologic department and extracted data of surgeries coded as SH in the surgical notes. Further, the rate of minimally invasive surgery (MIS) was evaluated across years of study.

Results Overall, we included 143 SH surgeries of women with a median age of 52 years. Symptomatic myoma was the indication in 75.5% of cases. MIS SH was completed in 33 (23.1%) of cases. The rate of MIS SH decreased from 46.7% in 2014 to 8.3% in 2021. Importantly, in 5 (3.5%) SH, malignancy was evident in the final pathological report. Reoperation was performed in 5 (3.5%) of cases in a median time of 71 months with 3 cases (2.1%) of malignancy as the indication.

Conclusions Although performed, SH carries a non negligible risk of performing an incomplete surgery in gynecologic unsuspected malignancy and the necessity of future gynecological oncological surgery.

Objectives A perioperative quality improvement initiative for minimally invasive (MIS) gynecologic oncology surgery at our centre improved the rate of same day discharge (SDD) from minimally invasive (MIS) gynecologic oncology surgery at our institution, with the addition of implementation cost in the post-intervention group.

Results The total cost per patient was 10 357.41$ post-intervention compared to 12 122.88$ pre-intervention (p=0.01). The mean costs for readmission and outpatient clinical visits were 221.93$ vs. 157.53$, and 140.56$ vs. 133.44$ for post- and pre-intervention respectively.

Conclusions A quality-improvement ERAS initiative in gynecology oncology MIS led to a 17% total cost reduction per patient for a total saving of 2063.24$ per patient.

Objectives Traditional Groin node dissection techniques are associated with significant local wound related morbidity and lymphedema. Sentinel node techniques are not available widely in many LMICs and are not applicable due to tumour size at presentation or multifocal disease. Novel techniques for morbidity reduction and training is required for implementation.

Methods A technique was developed comprising of the following: Small incision above groin crease- 1 cm lateral to pubic tubercle not extending beyond pulsation of femoral artery, Saphenous-sparing, Subfasial dissection, Closure of subcutaneous fat in 2 layers to obliterate dead space, suction drains to stay according to output, early ambulatory care. Success was measured using: Would complication rates- breakdown/lymphedema, Vulval QOL, Surgeon’s/trainee satisfaction, implementation as a new standard of care, pathology , groin recurrence.

Results Since June 2019, this technique was implemented in 3 centres: 1.NGOCC, Gateshead, UK 2. JCUH, Middlesbrough UK 3. CNCI, Kolkata, India Both RCOG subspeciality fellows and IGCS fellows ( India/Nepal) were trained. > 25 cases have been performed. Trainees found this technique easy to learn/implement. It has been a regarded as a change of practice in all 3 institutions including plan for surgical QA . Average length of incision was 5–6 cm without compromising depth of dissection, removal of nodes medial to femoral artery/vein and visibility of the femoral triangle. There was significant reduction in local wound-related morbidity. In CNCI Kolkata, IGCS fellow has started audit on QOL . No groin recurrences have been detected till date.

Conclusions Surgical techniques to reduce morbidity in cancer surgery is a priority.