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.

Abstracts

EP384/#926 COST-ANALYSIS OF AN ENHANCED RECOVERY PROGRAM AFTER MINIMALLY INVASIVE GYNECOLOGIC ONCOLOGY SURGERY

1Cristina Mitric*, 2Soyoun Rachel Kim, 3Gregg Nelson, 4Stephane Lafortune, 5Stuart Mcluskey, 6Lisa Avery, 7Stuart Mccluskey, 8Aysha Zia, 9Genevieve Bouchard-Fortier. 1University of Toronto, Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Toronto, Canada; 2Princess Margaret Cancer Centre/University Health Network/Majid Health Systems, Gynecology Oncology, Toronto, Canada; 3University of Toronto, Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Toronto, Canada; 4University Health Network, University of Toronto, Anesthesia, Toronto, Canada; 5University Health Network, University of Toronto, Gynecologic Oncology, Toronto, Canada; 6University Health Network, University of Toronto, Laboratory Medicine & Pathobiology, Toronto, Canada

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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 29% to 75%. The current study aims to estimate the project implementation costs and compare costs between the pre-intervention and post-intervention cohorts.

Methods Our Early Recovery After Surgery (ERAS)-based perioperative program enrolled 102 consecutive patients undergoing MIS hysterectomy at a single cancer centre during a 12-month period, and their SDD rates were compared to a historical cohort of 100 consecutive patients. Surgical admissions and readmissions were collected from the case-cost department. Postoperative and unplanned clinic visits, and emergency room visit costs were estimated from average visit cost. Total costs were calculated from the surgical visits, readmissions, and all 30 days postoperative visits 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 12420.65$ pre-intervention (p=0.01), resulting in a 17% total hospital cost reduction per patient, specifically 2063.24$. The total cost for the program implementation was 134.34$ per patient for a total cost of 13 106.52$. The average surgical admission cost per patient post-intervention was 9859.80$ 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 gynecologic oncology MIS led to a 17% total cost reduction per patient for a total saving of 2063.24$ per patient.

EP385/#1176 IMPLEMENTATION OF A MODIFIED MEDIAL INGUINALFEMORAL GROIN TECHNIQUE TO REDUCE MORBIDITY IN VULVAL CANCER SURGERY: AN UK- INDIA EXPERIENCE

1, 2Aasma Mukhopadhyay*, 3Chittaranjan National Cancer Institute, Kolkata Gynecological Oncology Trials and Translational Research Group, Kolkata, India; 2James Cook University Hospital, Gynaecological Oncology, Middlesbrough, UK; 3Newcastle University, Population Health Sciences Institute, Newcastle Upon Tyne, UK

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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. NGOC, Gateshead, UK 2. JCUH, Middlesbrough UK 3. CNCI, Kolkata, India Both RCOG subspecialty 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.

EP386/#184 MOBILE APP POST-OPERATIVE HOME MONITORING AFTER GYNECOLOGIC ONCOLOGY AND BREAST RECONSTRUCTION SURGERY ASSOCIATED WITH IMPROVED QUALITY OF RECOVERY: RESULTS OF A RANDOMIZED CLINICAL TRIAL

1Gregg Nelson*, 2Spencer Yakaback, 3Carmen Webb, 4Claire Temple-Oberle. 1University of Calgary, Obstetrics & Gynecology, Calgary, Canada; 2University of Calgary, Surgery, Calgary, Canada

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Objectives Smartphone applications have been shown to positively impact patient experience. Our aim was to compare post-surgical care using conventional in-person follow-up with smartphone app assisted follow-up.

Methods Patients undergoing gynecologic-oncology (GO) or breast-reconstruction (BR) surgery were randomized into a parallel two-arm clinical trial comparing smartphone app-assisted follow-up (App) with conventional follow-up (Conv). Patients were managed according to Enhanced Recovery After Surgery protocols. Post-discharge, the App group utilized a surgeon-monitored smartphone app, in which patients recorded Quality of Recovery 15 (QoR15) scores, EORTC selected adverse events and surgical site photographs over six weeks. The Conv group were seen in-person at standard intervals. Patient satisfaction scores were assessed in both groups using Patient Satisfaction Questionnaire (PSQ)-III subscales at two and six weeks post-operatively, while the Conv group also completed the QoR15 questionnaire at these intervals.

Results Seventy-one patients (36 GO; 35 BR) were enrolled. Compared to Conv, the App group had significantly higher QoR15 scores post-operatively (two weeks: 127.58 vs 117.68, p=0.02; six weeks: 136.64 vs 129.76, p=0.03). Patients were equally satisfied between groups in all subsets of the PSQ-III, including overall care (two weeks: 23.18 vs 22.88, p=0.79; six weeks: 23.23 vs 24.94, p=0.10), communication with their surgeon (two weeks: 21.71 vs 21.74, p=0.78; six weeks: 21.43 vs 21.65, p=0.59) and access to care (two weeks: 43.75 vs 43.30, p=0.74; six weeks: 42.45 vs 44.62, p=0.16). Surgeons appreciated early complication identification with the app.

Conclusions Post-operative follow-up using app-assisted monitoring led to high satisfaction with care for patients and surgeons.

EP387/#661  PELVIC EXENTERATION IN GYNECOLOGIC CANCERS: A SINGLE CENTER STUDY FROM INDIA

Objectives This study aimed to assess the perioperative and oncologic outcomes of pelvic exenteration (PE) for advanced, recurrent, or persistent gynecologic cancers in a contemporary cohort from a resource-limited setup.

Methods A review was conducted of patients excluding ovarian carcinoma who underwent PE over 10 years (2012 – 2021) at Tata Medical Center. Clinical information including baseline patient and disease characteristics, surgical details, and survival data were extracted from electronic medical records. Survival analysis was done using Kaplan-Meier and life-table methods.

Results Twenty-four patients (age 32–72) underwent PE with local recurrence (70.8%) as the most common indication. Ten patients (41.7%) had cervical cancer, while 29.2%, 20.8%, and 8.3% patients had uterine, vaginal, and vulval cancers respectively. Twelve patients (50%) underwent anterior exenteration, 9 (37.5%) total, and 3 (12.5%) posterior. Urinary diversion was required in 21 (87.5%) patients, colostomy in 12 (50%) patients, and reconstruction in 11 (45.8%) patients. The median estimated blood loss was 1000 mL (250–2700), and the median hospital stay was 16 days (7–44). Seventeen patients (70.8%) had infectious complications, and urinary tract (58.3%) was the most frequent focus. Clavien-Dindo grade ≥ 3 30-day complication rate was 20.8%, and the 30-day mortality rate was 4.2% (1 patient). Three-year locoregional control rate was 87% while the median overall survival (OS) was 33.9 months (95% CI 9.7–58.1). The estimated 5-year OS rate was 35%. No factor had a significant association with survival.

Conclusions Exenteration for gynecologic cancers had acceptable early morbidity and mortality, albeit a high postoperative infection rate. Survival was comparable to prior studies.