Objectives This study compared the surgical outcomes of patients with benign disease who underwent laparoscopic assisted vaginal hysterectomy (LAVH) to determine the association of surgical outcomes with resident participation in the gynecological field.

Methods We performed a single center retrospective study of 683 patients diagnosed with gynecological benign disease from January 2010 to December 2015 who underwent the LAVH procedure. Clinicopathological characteristics and surgical outcomes were compared between the resident involvement group and attending physician alone group. The primary endpoint was 30-day postoperative morbidity.

Results In total, 165 patients underwent LAVH with resident involvement and 518 patients underwent surgery without resident involvement. The mean age of the patients was 49 years and 48 years in the resident involvement group and attending alone groups, respectively. There was 30-day postoperative morbidity in 8 (3.5%) and 18 (4.8%) patients in the resident involvement group and attending alone group (P = 0.422), respectively. Operative time was significantly different between the two groups, 131 minutes in resident involvement group and 101 minutes in attending alone groups (P < 0.001). On multivariate analysis, Charlson comorbidity index > 2 (OR 1.001, 95% CI: 2.7–24.0, P < 0.001), operation time (OR: 1.018, 95% CI: 1.008–1.028, P < 0.001) and EBL (OR: 1.002, 95% CI: 1.001–1.003; P < 0.001) were significantly associated with 30-day morbidity, but resident involvement was not statistically significant.

Conclusions The operation time was longer when the resident involvement in LAVH, but was no significant difference in morbidity at 30 days. Therefore, resident involvement in LAVH is a reasonable way to meet both resident training and patient safety.

E-poster viewing: Survivorship


Objectives There is paucity of data regarding self-reported lower extremity lymphedema (LEL) and quality of life after surgery for endometrial cancer. Questionnaires are emerging, however translated and validated Norwegian versions are not available. Cross-cultural adaptation is important to reduce the risk of introducing bias into a study. The purpose of this pilot study was to translate and culturally adapt the Gynecologic Cancer Lymphedema questionnaire (GCLQ) and Lower-extremity Lymphedema Screening Questionnaire (LELSQ).

Methods Permissions were obtained to use the original English versions of the GCLQ and LELSQ for translation into Norwegian. The questionnaires were translated using a procedure based on standard guidelines including forward translation by native speakers of the target language, synthesis, back translation and review. Sixteen patients from the Radium Hospital gynecological cancer outpatient ward, all expected to have stable disease, were invited for questionnaire test-retest by completing the same questionnaires twice at 3–4-week intervals. Internal consistency was assessed by Cronbach’s alpha. Test-retest was assessed by intra-class correlation coefficient (ICC).

Results Twelve (75%) patients responded to the invitation and completed all items in the questionnaires. Cronbach’s alpha was 0.75 for the GCLQ and 0.89 for LELSQ. The ICC was 0.86 for GCLQ and 0.91 for LELSQ.

Conclusions Translation and cross-cultural adaptation of these internationally validated patient reported outcomes questionnaires for LEL in gynecological cancer survivors was feasible. The Norwegian translation of GCLQ and LELSQ showed acceptable internal consistency and the test-retest reliability was excellent.