Objectives Access-to-care disparities are growing as gynecologic oncologist (GON) demand increases amidst rising gynecologic cancer rates. We characterized the geospatial distribution of the U.S. GON workforce relative to at-risk women over 20 years.

Methods We utilized two U.S. physician registries to identify the 2001–2020 GON workforce. Practice locations were aggregated to county levels. Rural/urban were noted based on census designations. Choropleth maps were used to visually assess the spatial variation of the GON workforce relative to the at-risk female population and correlated with patterns in rurality.

Results Between 2001–2020, the GON workforce increased steadily, plateauing circa 2017 (figure 1). By 2020, there were 1,178 active GONs; 51.5% were early-to-mid career and 98.3% practiced in urban areas (representing only 37.3% of all counties). A disparity in practice geography was identified, with 1.09 GONs per 100,000 women in urban areas compared to 0.1 GONs per 100,000 women in rural areas (p < 0.0001). In total, 2,867 counties (representing 57.5 million at-risk women) did not have a GON. Additionally, there was no increase in rural GONs observed over time with only 1.7% in 2016 – 2020 relative to 2.2% in 2001–2005. Of the rural providers, fewer were early-to-mid career (23.5%) compared to late-career (76.5%); this trend persisted throughout all periods (figure 2).

Conclusions Over two decades, the U.S. GON workforce increased substantially, but not equitably, as a widening disparity in rural cancer care was noted over time. Policies and pipeline programs are needed to address this widening disparity in rural gynecologic cancer care.

Objectives Enhanced recovery after surgery (ERAS) is a multidisciplinary protocol that incorporates several perioperative components. To compare perioperative outcomes and patient satisfaction in ERAS versus conventional management in a tertiary care setting.

Methods Sixty women who underwent hysterectomy through the open abdominal route for benign and malignant indications were recruited and randomized to two groups; ERAS vs. conventional. Sample size was calculated after fixing Type I error at 5% and power of study at 95%, assuming a standard deviation of 20%. Postoperative recovery, pain, hospital stay, complications, and readmissions and patient satisfaction scores were analysed. Compliance to individual components and overall compliance was calculated. Results Duration of hospital stay was shorter in ERAS group: 3.87±1.25 vs 5.60±1.18 days (p-value=0.001) in benign cases and 5.27±2.34 vs 6.33±1.29 days (p-value=0.01) in malignancy. Decreased time to ambulation (p <0.001), time to resumption of enteral feeding (p=0.022 and 0.002), passage of flatus (p=0.002 and 0.028), stool (p< 0.001 and p=0.003) and lower pain scores (p-value <0.001) were seen in benign and malignant cases on ERAS protocol. Complications were comparable in ERAS vs. conventional protocols for Grade 1 (p-value=0.359), Grade 2 (p-value=1.000) and Grade 3 (p-value=0.125). Patient satisfaction scores and readmissions between the two groups were comparable.

Conclusions This trial showed a significant decrease in hospital stay, early ambulation, resumption of oral feeds, bowel motility and lower pain scores with ERAS protocol. Patient satisfaction scores did not differ between ERAS and conventional protocols and adoption of ERAS did not increase postoperative complications and readmissions.