bleeding. 25 cases (13.6%) developed a post-operative complication, most commonly sepsis, thigh numbness and hyponatremia.

Conclusion Robot-assisted surgery is a safe minimally invasive technique for the treatment of gynaecological cancer. It has several advantages, including very low laparotomy conversion rate, reduced hospital stay even for complex procedures, low post-operative complication rate and improved ergonomics for the surgeon. Further research is needed in order to assess the cost-effectiveness of robot-assisted surgery against conventional laparoscopic techniques.

Disclosures N/A

#589 THE IMPLEMENTATION OF A PREHABILITATION AND ENHANCED RECOVERY AFTER SURGERY (ERAS) PROGRAM FOR PATIENTS UNDERGOING SURGERY FOR GYNECOLOGIC CANCER: COMPLIANCE AND IMPACT ON RECOVERY OUTCOMES

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Introduction/Background Enhanced recovery after surgery (ERAS) and prehabilitation programs are multidisciplinary interventions that aim to optimize the physical condition of patients prior to surgery. These programs improve postoperative recovery and reduce the impact of surgical interventions. In this study, we aimed to assess the compliance of patients and healthcare professionals to an ERAS-prehabilitation program at our gynecologic-oncology and investigate whether higher compliance rates were associated with improved postoperative outcomes.

Methodology From February 2018 to June 2020, patients undergoing surgery for gynecologic cancer were invited to participate in an ERAS-prehabilitation program, which included an initial assessment of patients' nutritional, cognitive, emotional, and functional status. Different interventions were proposed based on the patients' main needs to improve their fitness. Patients were followed up with weekly calls and a post-intervention assessment 28 days after starting the program. Intra and postoperative interventions were also proposed to mitigate surgical stress and speed recovery. Compliance with both preoperative and intra/postoperative interventions was described. The impact of a compliance rate >80% on postoperative outcomes was assessed.

Results 81 patients with a mean age of 70.2 years were prospectively included. Compliance was >80% in all preoperative interventions, in 8 out of 15 intraoperative interventions, and in 3 out of 7 postoperative interventions. Patients with a compliance rate >80% had a non-significant trend towards a shorter hospital stay compared to patients with a lower compliance rate (3 vs.5 days, p=0.356). A compliance rate >80% had no impact on complication or reintervention rates.

Conclusion an ERAS-prehabilitation program for patients undergoing surgery for gynecologic cancer is highly accepted by patients, with high compliance rates for preoperative interventions. However, compliance rates for intra and postoperative interventions still need improvement. While a compliance rate >80% did not have a significant impact on complication rates, it could lead to earlier discharge of patients.

Abstract #589 Table 1 Compliance rate to proposed pre-, intra- and postoperative interventions in the ERAS- program for patients undergoing surgery for gynecologic cancer

Preoperative interventions	
Informative visit	81 (100%)
Functional assessment	72 (88.9%)
Nutritional assessment	80 (98.8%)
Cognitive assessment	78 (96.3%)
Pre Albumina	77 (95.1%)
Anemia assessment	81 (100%)
Anemia (Hb<120)	20 (24.7%)
Treatment of anemia	17/20 (85%)
Funcional prehabilitation	73 (90.1%)
Nutritional prehabilitation	74 (91.4%)
Mindfulness	66 (81.5%)
Walking test	71 (87.7%)
Resistence test	73 (90.1%)
Timed Up and Go (TUG) test	73 (90.1%)
Numeric Rating Scale	78 (96.3%)
Mindful Attention Awareness Scale	73 (90.1%)
Hospital Anxiety and Depression Scale	67 (82.7%)
Compliance to all preoperative variables	
100%	43 (53.1%)
80%	72 (88.8%)
Intraoperative interventions	
Laparoscopy when indicated	50/56 (89,2%)
Epidural in laparotomies	26 (83.9%)
Local anesthesia in trocars	47 (94.0%)
Anesthetic adjuvant	5 (6.2%)
BIS (bispectral index)	64 (79.0%)
Glucemia monitoring	51 (63.0%)
Temperature monitoring	60 (74.1%)
Neuromuscular monitoring	2 (1.9%)
O2 60-80%	78 (96.3%)
Thermic blanket	81 (100%)
Prophylactic antiemetic medication	73 (90.1%)
No nasogastric tube	76 (93.8%)
No drainages	45 (55.5%)
Goal-Directed Fluid Therapy	16 (19.7%)
Reversion	73 (90.1%)
Postoperative interventions	
Temperature monitoring	80 (98.8%)
Glucemia monitoring	80 (98.8%)
Minimize use of opioids	80 (98.8%)
Oral intake < 24h after surgery	55 (67,9%)
Sitting < 24h after surgery	52 (64,2%)
Removal of urinary catheter < 24h after surgery	47 (58%)
Removal of drainages < 24h after surgery	10/36 (27,7%)

Disclosures Conflicts of interest: none.

#590 VARIATIONS IN THE RETROPERITONEAL VASCULAR ANATOMY – A SURGICAL CHALLENGE

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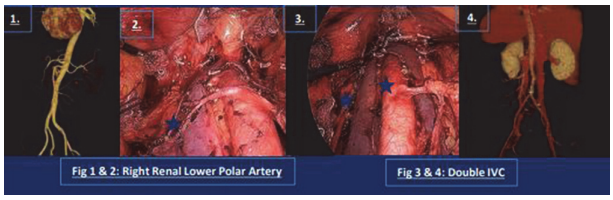
Introduction/Background Retroperitoneal nodal clearance forms part of the surgical procedure in treatment of various gynecologic malignancies. Variations in anatomy are not uncommon. Triphasic contrast enhanced computed tomography with vascular reconstruction helps delineate the anatomy pre-operatively. It thus serves as a roadmap for the surgery.

Methodology Retrospective data collection of patients with diagnosed endometrial/early stage ovarian cancers who had undergone retroperitoneal lymphadenectomy.

Results 55 patients underwent retroperitoneal lymphadenectomy, of which 2 were converted to laparotomy. We found 11 patients i.e. 20% had a vascular anomaly. 5 had an aberrant left lower polar renal artery, 4 had an accessory left lower polar renal vein and 1 each had infra-renal duplication of inferior vena cava and the last patient had left gonadal artery arising form polar renal artery.

Conclusion Imaging the retroperitoneum preoperatively helps identify any anatomical variations. It enhances the safety of the procedure. The reported incidence of variations in renal vein anatomy is between 1- 10% and for inferior vena cava

around 3%. In our small series, the overall incidence of aberrant anatomy was 20%.



Abstract #590 Figure 1 Operative photographs and reconstucted CT images of aberrant anatomy

Disclosures NONE

#593 PLEOMORPHIC LOBULAR CARCINOMA OF THE BREAST : CLINICAL PRESENTATION AND THERAPEUTIC CHALLENGES

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Introduction/Background Invasive pleomorphic lobular carcinoma(PLC) represents 15% of invasive lobular carcinoma(ILC) and is thought to be more agressive with a worse prognosis.
Methodology We retrospectively reviewed the clinical records of 18 patients diagnosed with PLC in Salah Azaiez Institute (2006–2021)
Results All reported cases were females, with a median age of 59.5.

Median tumor size was 30mm. Four patients had multifocal lesions while only two presented with bilateral tumors.

Only 5 cases were classified as stage T3/4 tumors and two patients were metastatic at the time of diagnosis

65% of the patients had preoperative core needle biopsy yielding a diagnosis of PLC in only 6 cases(46.15%). Two patients did not undergo surgery owing to the advanced stage at presentation and chemotherapy was conducted instead.

Among patients for whom surgery was stated, 11 patients underwent total mastectomy(64.7%). Sentinel lymph node dissection was performed on exactly 4 patients .Lymph nodes were free of tumor in the majority of cases.

On pathological examination, LPC was associated with invasive ductal carcinoma in 9 cases.

Almost 90% of the cases were high-grade carcinomas with a lympho-vascular invasion present in 8 cases. The tumor cells were positive for hormone receptors in 90% of cases while HER2neu was negative in 94.44% of cases.

Data on adjuvant treatment was available on merely 12 patients. Concomitant radio-chemotherapy with endocrine therapy was indicated for 10 patients, while others received either exclusive radiotherapy or chemotherapy.

The median follow-up was 27 months .At that time, most of the patients were free of disease, while one patient developed ipsilateral relapse for which she underwent total mastectomy . Two patients died 04 months after the onset of the treatment.

Conclusion The PLC's treatment approach is not well established however surgical resection remains the standard-of-care. More studies are required for further understanding of its clinical behavior and optimal treatment guidelines.
Disclosures the authors have nothing to disclose.

#600 LAPAROSCOPIC RETROPERITONEAL PARA-AORTIC LYMPHADENECTOMY: POSTOPERATIVE AND SURVIVAL OUTCOMES OF THE FIRST GREEK CASE-SERIES STUDY

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Introduction/Background Laparoscopic para-aortic lymphadenectomy is a procedure performed for staging purposes. Retroperitoneal approach is an alternative approach, potentially superior to intraperitoneal regarding bowel dysfunction and hemorrhage. Main purpose of the present study was to present the main intraoperative, postoperative and short-term survival outcomes of first relative cases treated with this approach in an ESGO-certified Gynecologic Oncology Center.
Methodology A prospective observational cohort was performed during 2020–2022. Epidemiological, histopathological characteristics and indications of the procedure were reviewed. Primary outcomes were intraoperative and postoperative complications, namely hemorrhage, vessel injury, need for transfusion, bowel injury, postoperative bowel dysfunction, perinephral hematoma, total hemoglobin drop, hospitalization duration. Short-term survival outcomes were also reviewed.
Results There were overall 8 cases in which laparoscopic retroperitoneal para-aortic lymphadenectomy was attempted. Median age was 52 years, median BMI 26.4. Indications were restaging for apparent early-stage ovarian cancer (n=3), surgical staging of high-risk apparent early-stage endometrial cancer (n=2), restaging for concomitant early-stage endometrial and ovarian cancer (n=1), staging for apparent advanced-stage cervical (n=1) and staging for potential lymph-node recurrence of previously treated vulvar cancer (n=1). All operations were performed by ESGO-certified physicians (S.P, N=6 and F.G, N=2). Method was abandoned in one case in which diagnostic laparoscopy for apparent early-stage serous endometrial cancer revealed diffuse omental metastasis and conversion was decided. Median surgical time was 135 minutes. Median number of resected nodes was 15. No major intraoperative and postoperative complication was observed. There was only 1 case of subcutaneous hematoma observed on 1st postoperative day, treated conservatively with compression. Median haemoglobin reduction was 2.3 gr/dl. Median hospitalization duration was 2 days. The total of patients remains free of recurrence and alive during follow-up period (5–29 months).