Disclosures The authors have no conflict of interest.

#914 PATIENTS’ SAFETY DURING THE EARLY DEVELOPMENT OF ROBOTIC SERVICE IN A TERTIARY GYNAECOLOGIC ONCOLOGY CENTRE
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Introduction/Background The transition from an established laparoscopic practice to the new robotic era is challenging for the surgeons and the service. Our aim is to evaluate the learning curve of a pioneer laparoscopic surgeon through the development of a new robotic service using Da Vinci-XI-system (DaVinci-XI; Intuitive Surgical Ltd) in Gynaecological Oncology, focused on patients’ safety outcomes.

Methodology All robotic cases (n=27) performed in the Northern Gynaecological Oncology Centre (NGOC), QE Hospital, Gateshead have been identified from departmental database. Clinico-pathological data, learning curve time-based metrics but also clinical metrics including peri-operative morbidity, surgical outcomes and length of stay were extrapolated from patients’ electronic database. Patients were divided into two groups: the early experience (n = 13) and a late experience group (n = 14) and the outcomes were compared. All procedures were performed by a single Gynaecological Oncologist, pioneer in laparoscopic surgery.

Results 27 robotic surgeries have been performed in the NGOC from the beginning of the robotic program in Gynaecological Oncology, 63% of these for malignancy. 10 (37%) had a robotic nodal excision and the detection rate for sentinel nodes was 89%. There was no return to theatre or conversion to laparotomy/laparoscopy in this cohort of patients. 1 (3.7%) intra-op complication identified (bowel serosa injury) and repaired. 6 (22%) patient had Clavien-Dindo grade 2 post-op complications needing pharmacological intervention and 1 patient re-admitted for IV antibiotics for wound infection. Blood loss was minimal in both early and late experience group [37.5 (10–250) vs 50mls (20–250), p 0.414] and there was no statistical difference regarding the length of stay [median 1day (1–3)] and the peri-operative complications.

Conclusion Robotic surgery, even in the early experience period has excellent results regarding patients’ safety. Oncologic outcomes, including overall survival and progression free survival cannot be evaluated in such a short period of time.

Disclosures Nothing to disclose.

#985 HOW LONG SHOULD PATIENTS STAY IN HOSPITAL AFTER MINIMALLY INVASIVE HYSTERECTOMY?

Introduction/Background Length of hospital stay (LOS) is an index related to patient safety and costs to hospital and society. Patients who have shorter LOS tend to heal better with less costs. There is an increased need for improving efficiency in the post-operative care. Pressure for ward beds is increasing. Long inpatient stay contributes to lack of bed availability, theatre case cancellation and overworked staff.

Methodology We conducted a literature search of PubMed, Medline, Embase, and Cochrane library website and reviewed the most recent articles, meta-analysis and randomised trials on the subject to identify the standards. Aim for 75% LOS for 24 hours and overall average for less than 2 days. We conducted a retrospective audit to identify the factors that affect LOS at University Hospitals of Leicester (UHL) by reviewing the electronic records for patients who had minimally invasive hysterectomy surgery between June 2021 to June 2022.

Results It was noted that age, BMI, and Charlson Comorbidity Index were significantly higher in patients who had been diagnosed with cancer compared to the benign group (P=0.005, 0.039,0.003 respectively).

There was no statistically significant difference between the mean of LOS in cancer (2.78 days) and benign cases (2.43 days) who underwent MIS(P=0.4165). Around 26% of patients who underwent MIS for treatment of cancer were part of the procedure is extracting of an large uterus or an unruptured adnexal mass. Without conversion to a laparotomy for specimen retrieval, urine bag could be used to easily retrieve large specimens through the vaginal route.

Methodology After completion of the hysterectomy, difficulty of extraction of hysterectomy specimen, as the uterus, fallopian tubes, and ovaries were too large to be retrieved intact despite multiple attempts of delivery through the vaginal route. Before conversion of laparotomy or morcellation of the uterus, a urine bag is prepared as a containment endoscopic bag by cutting the upper edge and folding the bag was placed through the vagina and the intact specimen was easily placed inside the bag under direct visualization and removed through the colpotomy incision.

Results There was no postoperative hemogram reduction was observed in the presented technique. No intraoperative and postoperative complications were occurred. The patients were discharged on the first day of the operation. In addition, since uterus was removed in a specimen bag, the technic reduces the possibility of spreading into the abdomen.

Conclusion We suggest this technique to retrieve large hysterectomy specimens that are not readily delivered through the vaginal route and find this technique to be safe, highly efficient, and cost effective when there is a need to remove large intact specimens during minimally invasive surgery.

Disclosures Nothing to disclose.

#954 TRANSVAGINAL RETRIEVAL OF ENLARGED UTERUS DURING MINIMALLY INVASIVE SURGERY USING URINE BAG

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Introduction/Background Minimally invasive surgery is more frequently getting used in gynecologic operations. The difficult