PATIENTS' SAFETY DURING THE EARLY DEVELOPMENT OF ROBOTIC SERVICE IN A TERTIARY GYNAECOLOGIC ONCOLOGY CENTRE

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10.1136/ijgc-2023-ESGO.480

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 pharmaceutical 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 The authors have no conflict of interest.

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

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10.1136/ijgc-2023-ESGO.482

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 statistical 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
discharged within 24 hours, compared to 41% of patients who had MIS for benign indication.

Conclusion 34% of patients who had MIS for hysterectomy met the target for discharge within 24 hours and around two-thirds of them were for benign indication. Age, BMI and comorbidities were the most pertinent factors in cancer group. A lot of factors affect the LOS in patients undergoing Laparoscopic or robotic hysterectomy. Further research is recommended to look into these factors in larger studies.

Disclosures No conflict of interest to disclose.

Abstract #1040

INDOCYANINE GREEN TO ASSESS ANASTOMOSES PERFUSION IN PATIENTS WITH GYNECOLOGICAL CANCERS UNDERGOING PELVIC EXENTERATION

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Introduction/Background Different studies have previously demonstrated the efficacy of intravenous indocyanine green (ICG) to assess the perfusion of bowel and urinary anastomoses. Nevertheless, the evidence of the use of ICG to assess anastomoses perfusion in patients with gynecological cancer undergoing pelvic exenteration (after radiotherapy) is scanty. The aim of the present study was to assess whether the level of ICG perfusion of ileal conduit urinary diversion (UD) could predict anastomosis leak and/or benign ureteric stenosis.

Methodology Prospective, observational, single-center study including consecutive patients undergoing anterior/total pelvic exenteration due to persistent/recurrent gynecologic cancers between 08/2020 and 02/2023. All patients underwent intravenous injection of 3–5ml of ICG (5mg/ml) once the UD was completed. A near-infrared camera was used to evaluate ICG perfusion of anastomoses (ileum–ileum, right and left ureter with small bowel, and colostomy or colorectal sides of anastomosis) a few seconds after ICG injection. Degree of perfusion was intraoperatively assessed independently by one urologist and one gynecologic oncologist and was divided according to a four-tier classification (−/−/+−/+/++).