During the analysis the percentage of procedures performed, complications, length of hospitalization, tolerance of the treatment were assessed.

Results

1. Ghost-stoma technique was used more frequently - in 29% of cases vs. 9% of protective ileostomies.
2. The percentage of emergency stomas was: group A: 0% vs. 3% in group B.
3. Length of hospitalization measured in postoperative days: on average, 5.5 days in group A vs. 4.5 days in group B.
4. No complications resulting from the creation of a protective ileostomy were found compared to 1 case of a peritoneo-cutaneous fistula after removal of the ghost-stoma.

Conclusion

1. The use of ghost-stoma results in a longer hospitalization time but does not require invasive intervention - stoma removal.
2. In group A (ghost-stoma), not a single patient required emergency stoma was found - this requires further observation.
3. Potential complications resulting from the use of ghost-stoma (according to our experience, enterocutaneous fistula) do not pose a significant clinical problem.

Disclosures None

#720 ONCOSEXUAL CONSULTATION IN GYNECOLOGICAL CANCER PATIENTS: WHEN, WHO AND HOW – PATIENTS' PERSPECTIVE

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Introduction/Background Lack of knowledge on human sexuality among medical specialists may results in unequal access to sexual counselling especially in cancers survivors. The aim of the study was to assess the quality of sexual counselling and expectations in context of time, scope and performing staff in gynecological cancer women in Poland.

Methodology 322 patients with gynecological cancers were eligible for this cross-sectional questionary-based on-line study performed between November 2022 and May 2023 in Poland. The final sample consisted of 155 patients with mean age of 43.2±9.31 years (range 24–67). The study group was divided into two subgroups: 113 patients who were sexually active (64.6% after chemotherapy, 41.6% - radiotherapy) and 42 sexually inactive after the cancer diagnosis (64.28% after chemotherapy, 50% - radiotherapy).

Results Sexual issues were not raised by medical staff in case of 65.4% of sexually active and 71.4% of inactive survivors ($p>0.005$). 28.3% of sexually active and 38.1% inactive decided to begin talking about sexual life with no response. Only 8,8% and 0%, respectively, had a possibility for sexual counselling. Gynecological oncologists, oncologists, radiotherapeutics, and sexologists have informed patients about sexual health in case of 25.6%; 25.6%; 8.8%; 0% sexually active and 7.1%; 11.9%; 11.9%; 4.8% sexually inactive women, respectively. According to the opinion of 54.8% and 66.4% survivors, respectively, gynecological oncologist should be the first to introduces sexual issues, followed by oncologists, sexologists, and radiotherapeutics. Finally, 73.5% and 83.3% survivors, respectively, would like to participate in workshops about sexual life in future.

Conclusion Patients with gynecological cancer need more attention in context of their sexual life irrespectively if they currently are or are nor sexually active. Gynecological oncologist should be the first to inform about negative influence of anti-cancer treatment on sexual health. More effort should be made to organize workshops concerning sexual issues for gynecological cancer survivors.

Disclosures none

#838 SEXUAL HEALTHCARE EDUCATION AS PART OF GYNECOLOGICAL MALIGNANCIES CARE IN JORDAN

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Introduction/Background Reports on sexual education (SE) for gynecological cancer patients especially in the Middle East and North Africa (MENA) are scarce. We aim to highlight the needs and provided education for sexual health of gynecological cancer patients, during cancer treatment and on follow up.

Methodology This is a cross-sectional survey of survivors of gynecologic cancer at King Hussein Cancer Center, validated by a multidisciplinary panel of experts. It explored patient-provider discussions regarding sexual health, and factors related to primary disease and long-term effects of treatment including surgery, radiotherapy and chemotherapy. Chi-square and ANOVA tests were used to measure association between these factors with sexual health education and patient satisfaction.

Results This pilot phase consisted of thirty patients, most of whom 14 (46%) had cervical cancer. The mean age was 49 years, and for their sexual partners was 55 years. All were married, of which 3 (11%) were sexually inactive, and 17 (57%) reported that their partners noted a negative impact on their sexuality. However, none considered stopping treatment to preserve sexual functions. 22 (73%) reported sexuality as somewhat or very important, of whom 18(61%) thought it was important to discuss in clinic. The most common barrier to SE discussion was having a male physician. In our primary analysis, we found that patients who were diagnosed with cervical cancer (compared to other gynecological cancers) were more likely to be educated about sexual side effects (p-value 0.023).

Conclusion To the authors knowledge; this is the first study in the MENA region tackling the topic of SE in this patient population. SE was found to be important in 2/3 of our patients. However, larger numbers are needed to validate our results and determine character of patients interested in discussing SE.

Disclosures None.

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