Results This presentation highlights the frustration associated with cancer management in rural settings in developing countries and emphasizes the need for expansion of cancer care facilities in these regions. Chorioncarcinoma is a curable disease; therefore it is unacceptable that a young woman could die today because she is not guaranteed access to cancer treatment.

Conclusion/Implications Universal health coverage is advocated to reduce out-of-pocket costs for essential cancer therapy and promote equitable access to screening, diagnosis, and management, ultimately reducing deaths from gynecological cancers in SSA. Paradigmatic shifts in governmental policies and engagement with traditional, complementary, and alternative medical practices are necessary to reduce missed diagnoses and late referrals. Tailored context-based guidelines for cost-effective cancer management algorithms are encouraged to be developed by interdepartmental working groups.

## FRAILTY AS A FACTOR IN SURGICAL DISPARITIES


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### Introduction

The objective of this study was to identify socio-demographic factors associated with frailty and impact on postoperative outcomes.

### Methods

Women undergoing ovarian cancer debulking from 2016–2020 in the National Inpatient Sample were identified. Frailty was defined by a Hospital Frailty Risk Score (HFRS) >5, a weighted index surveying >50 social and medical comorbidities. Mortality and postoperative complications were identified using ICD-10 codes from same admission and classified as medical, surgical or infectious. Social and clinical demographic data were collected. Pearson’s chi-squared test and logistic regression analysis were performed. Odds ratios with 95% confidence intervals were calculated.

### Results

Of 12,926 women undergoing debulking, 1,829 (14%) were frail. Frailty was associated with prolonged hospitalization (p<0.001) and >1 postoperative complication (p<0.001). In univariate analysis, frailty was associated with race/ethnicity, age, income and insurance status (p<0.01). In multivariate analysis, race/ethnicity were no longer associated with frailty (Black: 1.12; 95%CI 0.92–1.36; Hispanic: 0.99; 0.80–1.22) but low income (highest quartile income 0.76; 95%CI 0.7–0.9) and Medicaid as payor (1.3; 1.1–1.6) remained associated. Frail women were more likely to be treated in low ovarian cancer volume centers (high volume center 0.74; 0.64–0.85) and after controlling for frailty, treatment at a low ovarian cancer volume center was independently associated with postoperative complications (high volume treatment center 0.47; 0.41–0.53).

### Conclusion/Implications

Frailty was associated with adverse financial factors but not race/ethnicity. Frail women are more likely to be treated in low volume centers with independently higher rates of postoperative complications, indicating a disparity in access to care for this at-risk population.