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 is unaccettable 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.

EP389/#731 FRAILTY AS A FACTOR IN SURGICAL DISPARITIES

[1]David Samuel*, [2]Wei Zhao, [2]Tulay Koru-Sengul, [1]Molly Roy, [1]Alyssa Mercadel, [1]Angel Tabuyo-Martin, [3]Matthew Schlumbrecht, [3]Matt Pearson, [3]Abdulrahman Sinno. *[1]University of Miami, Miller School of Medicine, Gynecologic Oncology, Miami, USA; [2]University of Miami, Biostatistics and Bioinformatics, Miami, USA; [3]Sylvester Comprehensive Cancer Center, University of Miami, Miller School of Medicine, Gynecologic Oncology, Miami, USA*

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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.

AS18. Surgical techniques and perioperative management

EP390/#403 BASELINE COMPLIANCE WITH ENHANCED RECOVERY AFTER SURGERY (ERAS) IN GYNAECOLOGIC ONCOLOGY IN LOW MIDDLE INCOME COUNTRIES (LMIC), THE SOUTH AFRICAN EXPERIENCE

[1]Tracey Adams*, [2]Nomonde Mbatani, [3]Linda Rogers, [4]Steven Bisch, [4]Gregg Nelson, [1]Ravi Oodit. *[1]University of Cape Town Global Surgery (UCT GS), University of Cape Town, Cape Town, South Africa; [2]Groote Schuur Hospital, Obstetrics and Gynaecology, Cape Town, South Africa; [3]SA MRC UCT GCRC (South African Medical Research Council University of Cape Town Gynaecological Cancer Research Centre, University of Cape Town, Cape Town, South Africa; [4]University of Calgary, Obstetrics and Gynecology, Calgary, Canada*

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Introduction Enhanced Recovery After Surgery (ERAS) has significantly reduced complication rates and hospital stay in high income countries.There is a lack of perioperative multi-disciplinary teams, adherence to care guidelines and robust outcomes data in low-and middle- income countries (LMIC). The aim of this prospective cross sectional study was to determine baseline outcomes data, and compliance with guidelines prior to implementation of ERAS in Gynaecologic Oncology at a tertiary hospital in South Africa.
Methods Verbal consent to collect data was obtained from 50 patients, 18 years, and older undergoing elective gynaecological oncology surgery. Anonymised data was entered into the EIAS database by the ERAS Care coordinator. Data was collected on socio-demographic and patient characteristics as well as compliance to the ERAS guidelines in the preoperative, intraoperative, and postoperative period. Outcomes data on length of stay, readmission rates and 30-day follow-up were measured. Ethical approval for this study was obtained from the University of Cape Town Health Research Ethics Committee (HREC ref 068/2022).
Results Among the 50 patients, the overall compliance with ERAS guidelines was 43.9%. ERAS compliance was16.9% pre-admission; 78.1% pre-operative , 94.2% intra-operatively and 16.9% post-operatively. The average length of stay was 5 days, readmission rate was 4.3% and 30-day complication rate was 21.3%.
Conclusion/Implications Compliance with ERAS guidelines in gynaecologic oncology at our LMIC hospital remains low despite proven benefit of these interventions. This deficit is most pronounced in our pre-admission and post-operative periods. Formal implementation of ERAS will lead to improvement in patient outcomes in LMIC.

EP391/#83 EXPLORING NIPPLE SKIN SPARING MASTECTOMY WITH IMMEDIATE RECONSTRUCTION BY IMPLANTS FEASIBILITY WITH ASSISTANCE OF LAPAROSCOPIC SINGLE PORT-25 FIRST CASES REPORTS

Julien Bakenga*. *Clinic, Surgical Oncology, Poitiers, France*

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Introduction Movin forward from VNOTES technics in hysterectomy to a concept of No Scar in Breast Surgery and

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