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

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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

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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

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

exploring the optimisation of vision in Nipple Skin sparing Mastectomy during prophylactic Mastectomy

Methods this is a continuous series of a single institution and a single surgeons study. 25 patients with fully validate indications of prophylactic mastectomy underwent for assisted total laparoscopic skin sparing mastectomy and immediate reconstruction by a fully train single surgeon in reconstructive surgery and also fully train surgeon with more than 400 proceduresof laparoscopic abdominal single port ' myomectomy, borderline ovarian staging, laparoscopic assisted vaginal hysterectomy) We are describing our step by step technics the procedure is first described Dissection of the outter quadrant of the breast with scissors, then we put the single port and then we follow the procedure with endoscopic assistance and bipolar The first 7 patients was done by single port with assistance of an additionnal 3 mm port the second serie of 7 patients underwent laparoscopic assistance for the dissection of the NAC and inner part of the breast The last and recent serie of 11 patients underwent fully assisted procedure The removal of speciment is done in endobag without morcellation the insertion of the implant is challenging

Results All the patients underwents a complete procedure without a major oprétaive time-No immediate or Late complication occurs due to the technics patiente satisfaction is good

Conclusion/Implications The operation is safely feasible more cases are needed to validate that very interesting new technics

Abstract EP392/#415 Table 1 Type of surgery

Measure		Value
Indication for surgery		
	Endometrial hyperplasia	6/30 (20%)
	Endometrial cancer	18/30 (60%)
	Adnexal mass	6/30 (20%)
TLH*-BSO†		4/30 (13.3%)
TLH*-BSO†-SNL‡ biopsy		22/30 (73.3%)
MSO§		1/30 (3.3%)
BSO† and omentectomy		1/30 (3.3%)
TLH*-BSO†-SNL‡ biopsy and complete peritoneal staging		2/30 (6.6%)
Histology		
Endometrial cancer		20/30 (66,6%)
Hiperplasia		4/30 (13.3%)
BOT		2/30 (6.6%)
Other		4/30 (13.3%)

data are expressed as number (percentage).
**Total Laparoscopic Hysterectomy; †Bilateral Salpingo-Oophorectomy; ‡Sentinel Lymph Nnode; § Monolateral Salpingo-Oophorectomy*

EP392/#415 LOW PRESSURE LAPAROSCOPIC PROCEDURES IN OBESE GYNECOLOGICAL PATIENTS USING A NEW SUBCUTANEOUS ABDOMINAL WALL-RETRACTION DEVICE

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Introduction Treatment of obese female patients represents a challenge, due to cardiac function and hemodynamic changes during minimally invasive surgery with pneumoperitoneum and steep Trendelenburg position. Main reasons for LPT conversion in obese patients were inadequate exposure due visceral adiposity and an intolerance of Trendelenburg. The aim of this prospective study was to assess conversion to laparotomy and perioperative complications after of low pressure laparoscopy (LPL) surgery using a new subcutaneous abdominal wall-retraction device in morbidly obese patients.

Methods 30 consecutive obese patients (BMI > 35 kg/m^2) were eligible for the study. 20 patients had endometrial cancer, 4 atypical endometrial hyperplasia and 6 BOT/adnexal mass.

Results The mean age was 69, with a mean BMI of 39 kg/m2. The exposure of the operating field was optimal in 28 out 30 cases (93.3%). Laparotomy conversion rate was 6,6% (2/30). One intraoperative complication occurred. An hematoma related to insertion of the subcutaneous needle of the wall lifter occurred. According to the Dindo Classification ≥ a 2, early complications rate was 16%.

Abstract EP392/#415 Table 2 Type of surgery

Measure		Value
Operative time (min)		170 (111 – 249)
Conversion to laparotomy		7/30 (23.3%)
	Specimen extraction	3/30 (10%)
	Advanced disease	2/30 (6.6%)
	Difficult visualization	2/30 (6.6%)
Complete surgical staging		29/30 (96.6%)
Intra-operative complications		1/30 (3.3%)
Hospital stay (days)		4 (3 – 13)
30-days complications		7/30 (23.3%)
Clavien Dindo classification	grade 1	2/30 (6.6%)
	grade 2	5/30 (16.6%)
	No complications	23/30 (76.6%)

data are expressed as median (range) or number (percentage)

Conclusion/Implications LPL technique using the LaparoTenser device is safe and feasible in obese patients. The subcutaneous retractor is a way to create a large intra-abdominal operative space without the need of intraperitoneal high pressure and offers greater benefit to obese patients with no effect on the hemodynamic and respiratory functions. LPL technique may assist both surgeon and anesthesiologist to reduce conversions rate. Prospective studies could confirm our results.