PR092/#646 AVOIDING THE NEEDLE: APIXABAN FOR EXTENDED VENOUS THROMBOEMBOLISM PROPHYLAXIS AFTER MAJOR GYNECOLOGIC CANCER SURGERY

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Introduction Patients undergoing gynecologic cancer surgery at Vancouver General Hospital are recommended 28-days of low molecular weight heparin (LMWH) for post-operative thromboprophylaxis. Baseline survey (October 2021) revealed LMWH was associated with 91% adherence, but negatively impacted patient experience due to self-injection and cost. Our aim was to improve patient experience by reducing symptoms of pain and bruising by 50%, increasing adherence by 5%, and reducing financial toxicity over a 3-month period.

Methods Patients were offered a choice between apixaban (2.5 mg PO BID) or LMWH (enoxaparin 40 mg SQ daily) at discharge. A multidisciplinary team informed project design, implementation, and evaluation. Process interventions included pre-printed orders and a multimodal patient and care team education program. Telephone survey and chart audit informed outcome, process and balancing measures. Data were analyzed using statistical process control charts, descriptive statistics, and Mann-Whitney (two-sided, significance <0.05).

Results We included 127 consecutive patients from August to October 2022. Apixaban was chosen by 83.4% (n=106/127). Survey response rate was 73.2% (n=93/127). Patients who chose apixaban reported 72.8% reduction in pain, 52.9% reduction in bruising, 52.4% increase in comfort of administration, and 34.3% reduction in negative impact of the medication ($p<0.00001$ for all). Adherence was unchanged (92%). The proportion of patients paying less than $125 increased from 45% to 91%. There were no differences in balancing measures (bleeding, re-operation) and no VTE events.

Conclusion/Implications Introduction of apixaban for extended post-operative thromboprophylaxis was associated with significant improvements in patient-reported quality measures and reduced financial toxicity. Apixaban has become standard of care at our centre.

PR093/#279 OUTCOMES ASSOCIATED WITH POSTOPERATIVE CHEMOTHERAPY FOLLOWING PELVIC EXENTERATION FOR RECURRENT OR PERSISTENT GYNECOLOGIC MALIGNANCIES

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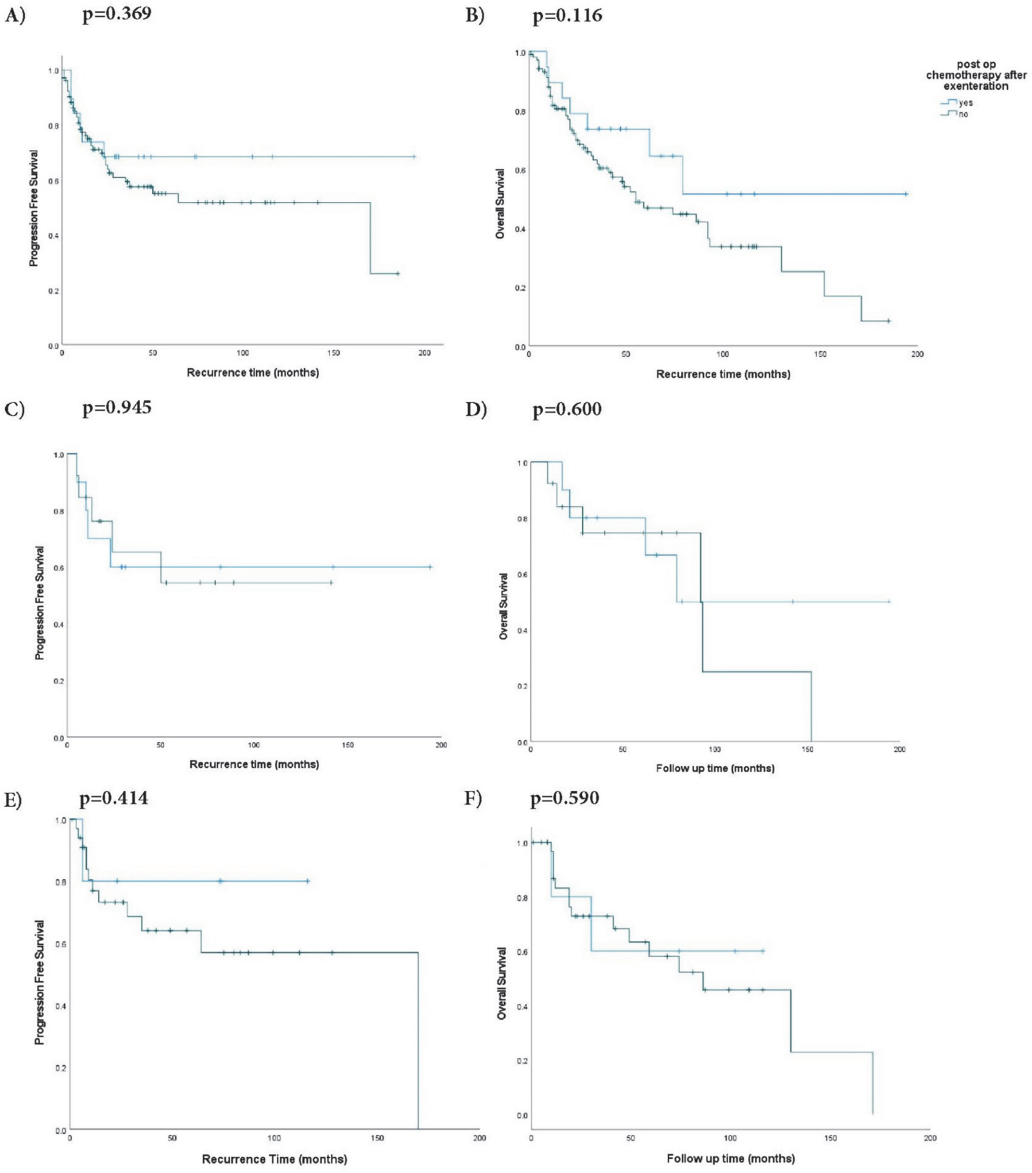
Introduction Pelvic exenteration can be performed with curative or palliative intent for treatment of recurrent gynecologic malignancies. We evaluated progression-free survival (PFS) and overall survival (OS) in association with postoperative chemotherapy following pelvic exenteration for recurrent gynecologic malignancies.

Methods We retrospectively reviewed patients with recurrent uterine, cervical, vulvar, or vaginal carcinoma who underwent pelvic exenteration from 5/01/2005–12/31/2019. Patients were excluded if surgery was performed for palliation without recurrence. Survival was assessed for allcomers and by uterine and cervical primary sites.

Abstract PR093/#279 Table 1 Clinicopathological demographics of patients who underwent pelvic exenteration compared with those who received postoperative chemotherapy and those who did not receive postoperative chemotherapy

	Overall (N = 123)	Exenteration followed with postoperative chemotherapy (n = 19)	Exenteration followed with no postoperative chemotherapy (n = 104)	*P-value*
Median age at exenteration, years (range)	61 (28-86)	56 (28-79)	62 (30-86)	*0.319*
Median body mass index, kg/m² (range)	25.8 (17-60)	29.6 (24-37)	25.7 (17-60)	*0.968*
Race/Ethnicity, number (%)				*0.780*
Non-Hispanic White	97 (79%)	16 (84%)	81 (78%)	
Black	7 (6%)	1 (5%)	6 (6%)	
Asian	4 (3%)	0	4 (4%)	
Latino/Hispanic	10 (8%)	1 (5%)	9 (9%)	
Other/not defined	27 (22%)	1 (5%)	4 (4%)	
Type of exenteration, number (%)				*0.638*
Anterior	36 (29%)	6 (32%)	30 (29%)	
Posterior	8 (7%)	1 (5%)	7 (7%)	
Total	79 (64%)	12 (63%)	67 (64%)	
Median operative time, minutes (range)	538 (136-973)	541 (262-666)	537 (136-973)	*0.957*
Median estimated blood loss, mL (range)	718 (100-12000)	950 (300-12000)	700 (100-4150)	*0.305*
Margin status				***0.025***
Positive	11 (9%)	4 (21%)	7 (7%)	
Negative	112 (91%)	15 (79%)	97 (93%)	
Primary Site, number (%)				***0.003***
Cervical	41 (33%)	5 (26%)	36 (35%)	
Vulvar	30 (24%)	1 (5%)	28 (27%)	
Uterine	29 (24%)	11 (58%)	19 (18%)	
Vaginal	23 (19%)	2 (11%)	21 (20%)	
Primary Histology, number (%)				***0.010***
Squamous cell	68 (55%)	5 (26%)	63 (61%)	
Endometrioid	23 (19%)	10 (53%)	13 (13%)	
Adenocarcinoma	20 (16%)	3 (16%)	17 (16%)	
Other	12 (10%)	1 (5%)	11 (11%)	



Abstract PR093/#279 Figure 1 A) Progression-free survival for all patients compared by receipt of postoperative chemotherapy or not (n=123). B) Overall survival for all patients compared by receipt of postoperative chemotherapy or not (n=123). C) Progression-free survival for patients with uterine histology by receipt of postoperative chemotherapy or not (n=29). D) Overall survival for patients with uterine histology by receipt of postoperative chemotherapy or not (n=29). E) Progression-free survival for patients with cervical histology by receipt of postoperative chemotherapy or not (n=41). F) Overall survival for patients with cervical histology by receipt of postoperative chemotherapy or not (n=41)

Results Of 123 patients identified, 32% (39/123) were referred to medical oncology; 25 (64%) of 39 were offered and 19 (76%) of 25 received postoperative chemotherapy. Regimens included carboplatin/cisplatin and paclitaxel (n=12), another platinum doublet (n=4), or single-agent platinum (n=3). Patients who received postoperative chemotherapy, compared with those who did not, more often had positive surgical margins (21% vs. 7%, p=0.025), a uterine primary (58% vs. 18% p=0.003), and endometrioid histology (53% vs. 13% p=0.010). One patient in the no-chemotherapy group received postoperative pelvic radiation. Of the 19 patients who received postoperative chemotherapy, 7 (37%) recurred— 5 (26%) locally and 2 (11%) distantly (brain, bowel). There was no difference in 2-year PFS rate (68.4% SE ±1.1 vs. 68.9% SE ±0.05) or 2-year OS rate (78.9% SE ±1.0 vs. 74.5% SE ±0.05) between patients who did and did not undergo postoperative chemotherapy, respectively.

Conclusion/Implications In this early assessment of postoperative chemotherapy following pelvic exenteration there was no association with outcome. Postoperative treatment decisions, especially in higher risk cases, require larger series and must be individualized.