Conclusions: PNI is associated with differences in both short and long-term outcomes in patients with epithelial ovarian carcinoma. This information may be useful in predicting survival, and may facilitate improved patient stratification, risk assessment, and medical optimization. Future studies with larger populations are needed to confirm these findings.

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Poster #32

The effect of New Hampshire State legislation changes on opioid prescribing practices for gynecologic oncology surgery in a tertiary care setting

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Objectives: The objective of this study is to determine the impact of HB 1423, legislation requiring participation in the state prescription drug monitoring program (PDMP), on opioid prescribing practices for acute postoperative pain control following gynecologic oncology surgery.

Methods: Patients who underwent gynecologic surgery for a cancer diagnosis between January 2016 to June 2016 (pre-HB 1423) and April 2017 to September 2017 (post-HB 1423) were included in this retrospective study. As new legislation was passed on January 1, 2017, a 6-month washout period prior to adaptation and 3-month period afterwards was included. The mandatory changes included completion of a risk stratification tool and querying the PDMP for each patient, as well as completing a narcotic-specific consent form prior to prescribing narcotics. The primary outcome is the amount of opioids prescribed in morphine milligram equivalents (MME) upon hospital discharge following surgery. Each opioid prescription at time of discharge was converted into MME; the mean MME was calculated and compared between the pre-legislation group and post-legislation group. Student's t-test and Chi-square analysis were used to compare demographic variables between groups.

Results: Of the 288 patients who underwent gynecologic surgery for a cancer diagnosis, 141 patients were pre-legislation change and 145 patients were post-legislation change. There was no significant difference in age, BMI, procedure type, estimated blood loss (EBL), use of regional pain control, or length of hospital stay between the two groups. There was also no significant difference in patients with chronic pain, history of illicit drug use or chronic narcotic use. A significant difference was observed between the amount of opioids prescribed pre-legislation and post-legislation, 180.9 +/- 14.5 MME compared to 66.6 +/- 5.8 MME respectively ($p < 0.0001$). Moreover, a significant difference was seen in the amount of opioids prescribed for both open and laparoscopic procedures. Among patients undergoing open procedures, there was a 55% reduction in MME prescribed post-legislation. Similarly, there was a 67% decrease in opioids prescribed for patients' status post laparoscopic surgery ($p < 0.0001$). The number of patients that were discharged without a prescription increased post-HB 1423 adaptation from 5.4% to 11.7% of patients following an open procedure, and 8.6% to 18% of patients following laparoscopic surgery.

Conclusions: Opioid prescribing practices for acute postoperative pain control in gynecology oncology patients changed significantly following adaption of the New Hampshire State Legislation. Further studies are needed to determine the impact of these legislative changes on patient satisfaction, rates of continued opioid use after surgery, and rates of opioid addiction state-wide.

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Poster #33

Factors associated with operating room times in robotic gynecologic oncologic surgery

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Objectives: Operating room time is an expensive and limited resource in the hospital. Robotic surgery has become a mainstay of gynecologic oncologic surgery; however, prolonged operative times are a known limitation. This study assesses factors associated with "position-and-prep" time and operative time in gynecologic oncologic surgery.

Methods: A retrospective cohort study was performed including all gynecologic oncologic patients undergoing robotic surgery between June 2016 and May 2018 at a single, academic health center across three hospitals. Patient, provider and facility factors were extracted from a central electronic medical record system. The primary outcomes were "position-and-prep time" (the interval between completion of anesthesia induction and skin incision) and operative time (skin incision to skin closure). X^2 tests and ANOVA tests were used for selected comparisons. Univariate and multivariate linear regression was used to assess for factors associated with longer times. All analyses were performed using STATA, Version 15.1

Results: A total of 796 robotic surgeries were performed in the study period by eight gynecologic oncologists. Patients had a mean age of 56.6 years (± 12.7 years) and a mean BMI of 31.9 kg/m^2 (± 8.6kg/m^2). 7.8% of the population was morbidly obese (BMI ≥ 40kg/m^2). 88.9% of the cases were total or radical hysterectomies. The mean position-and-prep time was 23.8 minutes (± 27.9 min) and the mean operative time was 168.2 min (± 65.7 min). The mean prep times differed significantly across the 3 locations: 18.7 min, 22.3 min and 41.3min ($P< 0.001$). Operative times were also significantly different across locations: 151.7 min, 168.0 min, 203.0 min ($P< 0.001$). Compared to patients with a BMI < 40 kg/m^2, morbid obesity was not associated with prep time ($P = 0.40$); however, it was significantly associated with longer operative times ($P<0.001$). In multivariate regression accounting for location, morbid obesity and number of surgeons/trainees in the case, hospital location was the only predictor of prep time ($P<0.001$). Factors associated with increased operative time in multivariate regression included performance of hysterectomy ($P<0.001$), performance of lymphadenectomy ($P<0.001$), location ($P <0.001$), morbid obesity ($P=0.006$) and increased number of surgeons ($P<0.001$).

Conclusions: There was significant variation in prep time and operative time for gynecologic oncology robotic surgery across hospitals in a single academic institution. Position-and-prep time seems to be driven by immeasurable processes by the individual facility or surgeons. In addition to surgery type and morbid obesity, the surgical personnel, including attending surgeon and trainees, were associated with increased operative time. Operating room efficiency may be increased by collaboratively improving processes and techniques across facilities and surgeons.

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Poster #34

Flatus: Flatus after undergoing surgery: Creation of a nomogram to predict postoperative ileus after gynecologic oncologic exploratory laparotomy

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