Objectives: Postoperative ileus is a common complication after gynecologic oncology laparotomies. It impacts patient satisfaction and comfort and increases costs to our healthcare system by prolonging length of stay and readmissions. Patient reported flatus has been used as a criterion to avoid premature discharge but may prolong hospital stay unnecessarily in a subset of patients. The aims of our study were to: 1) identify predictive factors that lead to the development of a postoperative ileus and 2) create a nomogram to predict the risk of developing an ileus so postoperative care can be modified appropriately.

Methods: From October 2016 to August 2017, 234 patients were identified who had an exploratory laparotomy by a gynecologic oncologist after implementation of an Enhanced Recovery After Surgery (ERAS) protocol at a single institution. Data was collected through the ERAS monitoring program and supplemented with individual chart review. Any patients undergoing surgery for a bowel obstruction were excluded. An ileus was diagnosed either by the surgeon as documented in the chart or if the patient met 2 of the 3 following postoperative criteria: 1) nausea or vomiting 2) abdominal distention and 3) radiologic confirmation of an ileus. Univariable logistic regression analysis was conducted to identify any variables associated with a postoperative ileus. Those variables with a p-value < 0.10 or those deemed clinically significant regardless of p-value were included in the multivariable analysis. A backward stepwise model was then performed to reach the final model that was the basis of the nomogram created to predict the risk of developing a postoperative ileus.

Results: Of the cases reviewed, 219 met inclusion, including 142 (64.8%) cases with malignancy on final pathology. Thirty-six (16.4%) patients developed a postoperative ileus. Those with and without ileus were compared. Sociodemographics were similar between the two groups except those who developed am ileus had a higher rate of smoking, 61.1% (22/36) vs. 42.1% (77/183) and a higher ASA Score, 2.8 vs. 2.6 (p=0.03 and p=0.01 respectively). Significant intraoperative and postoperative factors on univariable analysis included age, estimated blood loss and development of a postoperative venous thromboembolism or urinary tract infection (p <0.10). Smoking history (p=0.02) was the only independent predictive factor for postoperative ileus on multivariable analysis.

Conclusions: The rate of postoperative ileus development in patients undergoing gynecologic oncologic laparotomies was 16%, which is in line with previous literature. Smoking history was the only significant independent predictive factor. A nomogram was devised with the intent to predict postoperative ileus. We intend for this nomogram to be tested and validated in future studies with the goal of identifying patients appropriate for discharge prior to flatus.

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Poster #35

Counseling and documentation for modifiable cervical cancer risk factors: Quality improvement leading to increased reimbursement

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Objectives: This quality improvement (QI) study aimed to correct shortcomings in documentation of cervical dysplasia risk factors at clinic visits and implement new note templates to improve counseling for modifiable risk factors, as well as reimbursement rates.

Methods: Data was collected at all cervical dysplasia procedure visits from 4/13- 8/10/18 (n=187), and after 6/28/2018, a new note template was introduced with documentation of various risk factors including smoking and HPV vaccination status, and counseling on their contribution to the development of cervical cancer. Data was analyzed using a two-tailed students t-test. Reimbursement of tobacco cessation counseling was defined as $9.43 by current procedural terminology (CPT) code 99406 with modifier 25. Reimbursement of HPV vaccination was defined as $10.00 by CPT code 90649.

Results: Study populations before and after the intervention were not significantly different in median age, procedure type, and dysplasia pathology. Instituting a new note template significantly increased the rate of documentation of all targeted risk factors. Prior to implementation of the QI study, 89% of opportunities to counsel on smoking cessation were missed, compared to 6% after implementation (Table 1). This correlates to missed revenue of over $3800 annually. Prior to implementation of the QI study, 12% of dysplasia encounters included documentation of HPV vaccination status, versus 98% after implementation. Of these, 37.5% received counseling pre-QI and 78.5% received counseling post-QI. Similar percentage of patients were eligible for vaccination, 12.7% pre-QI and 16.5% post-QI. This correlates to $76 annually in clinic revenue.

Table 1
Documentation of cervical dysplasia risk factors and counseling provided to patients at each visit before and after the implementation of the quality improvement (QI) note template.

		Pre-QI	Post-QI	p-value
Risk Factor Documentation	Contraception	70.6%	96.5%	<0.001
	History of STI	52.9%	97.65%	<0.001
	Smoking status	67.7%	97.65%	<0.001
	Vaccination status	11.8%	97.65%	<0.001
	HIV status	1.3%	89.41%	<0.001
Counseling provided	Smoking cessation	11.11%	93.55%	<0.001
	HPV vaccination for patients ≤ age 26	37.50%	78.57%	0.058

Conclusions: The intervention significantly improved documentation of risk factors and rate of smoking cessation counseling. This also increased an area for reimbursement through smoking cessation counseling. While HPV vaccination is not a large source of income, the template prompts providers to offer vaccination and to counsel on the importance of vaccination for the young people in our patients' lives.

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Poster #36

Minimally invasive surgery rate as a quality metric: Feasibility and validity

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Objectives: Minimally invasive surgery (MIS) is a quality metric for endometrial cancer (EC) established by the Society of Gynecologic Oncology. A hospital-level rate of 80% MIS hysterectomy for EC has been proposed. Our study objectives were (1) to determine the frequency with which Commission on Cancer accredited hospitals met this metric and (2) to compare patient characteristics, patterns of care, and outcomes by hospitals meeting or not meeting this metric.

Methods: A retrospective study of women who underwent hysterectomy for EC in 2015 was conducted using the National Cancer Database (NCDB). Inclusion criteria were epithelial histology, Charleston comorbidity score of 0, stage I-III disease, and surgery at a hospital caring for ≥20 EC patients per year. Patient characteristics,