

chemotherapy and had catheter maintenance for >3 months were included for analysis. Groups were divided based on their maintenance interval: short interval (SI) at 4–6 weeks which is according to manufacturer's specifications, or long interval (LI) at 10–12 weeks which was historically performed with patient's 3-month surveillance visits. Complications were defined as events during the flush maintenance period that required removal of the port. Patient demographics and risk factors for inflammation, clotting, and infection were also collected for analysis. As a secondary outcome cost analysis was performed. SPSS was used to analyze data via Fisher's exact test and Chi-Square analysis. Significance was defined as $p < 0.05$.

Results: Data was collected on 259 patient charts from 2010 to 2017 of which 185 met inclusion criteria. Three complications requiring removal were seen during the study period: infection (1) and port malfunction (2). Complication rates were not statistically different between the SI group ($n=90$) 1.11% and the LI group ($n=95$) 2.10%, $p=0.525$. The groups were also noted to be evenly matched with no significant patient characteristics or demographic differences.

Currently, \$168 is billed for each implanted catheter flush encounter at the study facility. Patients traveled an average of 78.64 miles round trip to reach the facility. Considering only travel costs (gas, vehicle wear and tear) and billing, the LI scheduling could reduce a patient's expense by 50 to 66% and save as much as \$59–\$119 each month in addition to the individual's copay.

Conclusions: Our findings support the hypothesis that complication rates are not increased when using a long interval flush maintenance schedule. Additionally, the potential savings for the patient is not insignificant and warrants consideration

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Poster #42

Workplace harassment and discrimination in gynecology: Results of an International Society Survey

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Objectives: Sexual and non-sexual workplace harassment and discrimination have not been studied in gynecology despite reported concerns. Our objective was to characterize harassment and discrimination among physicians in gynecology.

Methods: An IRB-approved survey was constructed and beta-tested to inform policy changes within a professional gynecologic society. It was distributed by email to all members ($n=7026$) using the REDCap survey tool with questions regarding demographics, attitudes regarding harassment and discrimination, and experiences of workplace harassment and discrimination and perceived sequelae. All responses were anonymous and non-traceable and subjects provided consent at the time of survey submission. Frequency distributions were determined and non-parametric tests were performed.

Results: A total of 907 physicians responded; 603 were US and 304 were non-US. Sixty percent were female (F) and 40% were male (M). F were younger than M ($p < 0.05$); 20% were trainees. F were more likely than M to think that the #MeToo movement was justified and overdue ($p < 0.001$), independent of age or trainee status. More F than M experienced workplace discrimination (67% vs. 39%, $p < 0.001$), and gender was the most common factor for both. The most common

sequela was loss of self-confidence (46%); F reported this and lower salary, while M reported lower patient volume and fewer employment opportunities. Women felt harassment was more prevalent in the medical field than did men, independent of age or trainee status. Overall, 39% of physicians experienced workplace harassment, including 23% non-sexual, 37% sexual, and 40% both. Harassment was indicated by more F than M (81% vs. 18%, $p < 0.001$) and by more US than non-US respondents (43% vs. 30%, $p < 0.001$), and gender was the most common basis for harassment. The harasser was senior in 84% of cases, in a position of power in 72% of cases, and was more often a physician in cases involving F (91%). Sequelae occurred in 53% of victims but only 31% reported an incident, often due to fear of reprisal. Overall, 28% of respondents experienced sexual harassment; 84% were F ($p < 0.001$), 87% were US, and 44% were <40 years old. The nature of the events varied; 16 women and 2 men experienced workplace-related sexual assault. The sexual harasser was senior in 80% of cases and in a position of power in 59% of cases. Sequelae (work and personal issues) occurred in 36% of victims and 22% sought counseling. Only 8% of victims reported an incident; 62% did not think it was taken seriously and 10% felt subject to reprisal.

Conclusions: Workplace harassment, including sexual harassment, is commonly experienced by female and male gynecologists, usually related to a power differential. Gender based discrimination is commonly identified. Substantial improvements should be made in the workplace environment to achieve equity and a workplace free of harassment and discrimination.

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Poster #43

Prevalence of anemia and compliance to the National Comprehensive Cancer Network guidelines for workup and treatment of anemia among patients diagnosed with gynecologic cancer

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Objectives: The National Comprehensive Cancer Network (NCCN) recommends prompt evaluation of anemic patients with hemoglobin (Hb) ≤ 11 g/dL. There are a paucity of studies evaluating compliance with the NCCN guidelines. Our objective was to investigate the prevalence of anemia among patients diagnosed with ovarian and uterine cancer and assess compliance with NCCN guidelines.

Methods: We performed a retrospective cohort study of patients diagnosed and treated with ovarian and endometrial cancer at our institution from 2008–2018. Tumor-registry-confirmed cancer cases were identified using ICD-0 codes from the Synthetic Derivative (SD) database which is a de-identified copy our institution's electronic medical record. Patients were included if they were between the ages of 18 and 89, had their initial care at our institution, and had a hemoglobin (Hg) within the first 6 months of diagnosis. Anemia was defined as Hg ≤ 11 g/dL. Anemia was graded using the CTCAE v.4.0. Absolute and possible iron deficiency were defined by NCCN Guidelines.

Results: We identified 1190 patients who met our inclusion criteria. The median age was 61 years (interquartile range [IQR] 54–69). The most common malignancy was uterine cancer 875 (74%) followed by ovarian 273 (23%). Twenty-one were noted to have dual primaries (2%). Of the 1027 patients with a Hb identified prior to initiation of oncologic treatment 248 (24%) patients were noted to be anemic at time of diagnosis. Of the 1190 patients in our study, 851 (72%) were noted to be anemic within six months of diagnosis. Of these patients 279 (23%) were noted to have grade 1, 349 (29%) grade 2, and 223