1.94-14.56) after adjusting for age at diagnosis, BMI, stage, and grade. Patients with DMII with A1c ≥8.0 appeared to be at higher risk of complications but this did not reach significance (OR: 2.47 95% CI: 0.81-7.54), though this pilot study is likely underpowered to estimate this effect.
Conclusions: Women with EC and DMII who undergo laparotomies are at significant risk of complications when compared to laparoscopic procedures. A1c levels alone do not correlate with increased risk of post-operative complications, as age and BMI are confounders.

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Poster #4
Experience of gynecologic oncologists regarding endometrial ablation patients who develop endometrial cancer
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Objectives: To understand the current experience of gynecologic oncologists in managing patients with endometrial cancer (EC) after endometrial ablation.
Methods: A 17-question survey was sent out to Society of Gynecologic Oncology (SGO) members from Full, Associate, Candidate and Fellow-in-Training membership categories. Responses were collected from November 2017 to January 2018. The questionnaire asked SGO members about their experience in caring for women who have a history of post-ablation EC.
Results: 138 of the 1299 gynecologic oncology SGO members responded, with a 10.6% response rate. 116 out of 138 respondents (84.1%) completed the entire survey. Most (70.4%) reported that endometrial ablations were performed "sometimes" or "frequently" in their communities. 93.8% of gynecologic oncologists had been referred symptomatic post-ablation patients for further evaluation. 18.5% reported managing over 20 post-ablation patients in their practice. Most respondents found that post-ablation intrauterine scarring made accurate evaluation of the endometrial cavity "moderately" (36%) or "extremely" (48%) difficult. 52.5% reported that a majority of symptomatic post-ablation patients require hysterectomy to make an accurate diagnosis. While 74.4% of respondents thought that at least some patients had a delay in diagnosis of EC due to post-ablation intrauterine scarring, 21.4% believed that the majority of patients had a delay in diagnosis. Finally, 79.5% reported that they do not believe that there is a role for prophylactic endometrial ablation to decrease the risk of endometrial cancer.
Conclusions: This study is the first to describe the current views of gynecologic oncologists in treating post-ablation EC. Most believe that post-ablation intrauterine scarring can make diagnosis of EC more difficult and delayed. Although further research is needed, this study provides a glimpse at some of the long term consequences of endometrial ablation.

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Poster #5
Outcomes after implementation of an enhanced recovery pathway with major gynecologic oncology surgery at a Tertiary Care Center
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Objectives: To examine the impact of an enhanced recovery after surgery (ERAS) pathway in patients undergoing exploratory laparotomy due to suspected or known gynecologic malignancy.
Methods: This was a case-control study. The ERAS protocol pathway included preoperative counseling, tight glucose control, goal directed fluid therapy, standardized analgesic and anesthetic regimens, early mobilization, and prophylactic prevention of nausea and vomiting. Consecutive patients undergoing exploratory laparotomy at the University of California Los Angeles (UCLA) between March 2017 and February 2018 with known or suspected gynecologic malignancy were included in this study. A patient match study design was used to compare clinical outcomes along the following parameters: age and type of surgery. Patients in the control arm underwent surgery at UCLA between July 2014 and June 2016. Patients with significant post-operative complications (anastomotic leak and hospital acquired pneumonia) or with a history of chronic pain were excluded from the study. Clinical outcomes measured included length of stay, American Society of Anesthesiology (ASA) physical status classification, emergency department (ED) visit within 30 days of surgery, estimated blood loss (EBL), intraoperative blood transfusion, Post-Anesthesia Care Unit (PACU) nausea/emesis, and postoperative day 1 (POD1) pain control.
Results: When comparing 32 ERAS patients to 96 historical controls, the average length of stay was significantly reduced (3.91 compared with 5.31 days; P = 0.0073). ASA scores between the two cohorts were similar (2.38 compared with 2.54; P= 0.1464). Although not statistically significant, ERAS patients had a lower percentage of patients who were seen in the ED within 30 days of surgery (6.2% compared to 11.4%; P= 0.5155). EBL was lower in ERAS group compared to historical controls although not significant (324 mL compared to 474 mL; P= 0.0559). The percentage of patients requiring blood transfusion during surgery was lower in ERAS patients but not significant (6.6% compared to 19.7%; P= 0.2784). The ERAS and control groups had similar rates of PACU nausea/emesis (12.5% vs. 19.7%; P= 0.4340) and POD1 pain scores (average 1.78 vs. 2.19; P= 0.3109).
Conclusions: The ERAS protocol in patients with suspected gynecologic malignancy reduced length of stay by almost 2 full days. Although not significant, the ERAS protocol shows a trend toward decreased EBL and 30-day readmission rate in this case-control study. Further evaluation of the ERAS pathway is warranted for patients with suspected gynecologic malignancy undergoing exploratory laparotomy at tertiary care centers.

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Poster #6
Comparing usage of a running, barbed, polydioxanone suture vs. interrupted, braided polyglactin 910 suture for the closure of vulvar incisions in Gynecologic Oncology
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Objectives: Vulvar cancer is a rare malignancy accounting for 5% of gynecologic cancers. Wound complications following surgery for vulvar dysplasia and cancer, including incisional breakdown, have been reported to occur in 9-58% of cases. There is sparse research on techniques to prevent incision breakdown. Barbed, polydioxanone suture has been shown to be effective in vaginal cuff closure. This technique has not been evaluated in the closure of vulvar incisions. This study evaluated the use of barbed, polydioxanone suture in vulvar surgeries as compared to braided polyglactin 910 suture.
Methods: A retrospective chart review of vulvar surgeries at one institution from August 2008 to August 2017 was performed, comparing incisional complications using a running, barbed, polydioxanone (Quill) suture versus an interrupted, braided, polyglactin 910 suture.
Results: There were 173 vulvar surgeries performed in the study period. Ages of patients ranged from 17 to 92. Dehiscence was demonstrated