

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

for 91 incisions, occurring in 38 of 68 incisions (56%) closed with barbed, polydioxanone suture, and 53 of 105 incisions (50%) closed with braided polyglactin 910 suture ($p=0.487$). Univariate analysis revealed no significant difference in dehiscence rates between closure techniques, when stratified by cancer diagnosis, radicality, or attending surgeon. Univariate analysis also revealed no significant difference in dehiscence rates between smokers and non-smokers, at 56% vs 46% respectively. There was no significant difference in postoperative pain or in rates of suture removal at follow up. Multivariate analysis, controlling for body mass index, operating time, estimated blood loss, age, smoking, cardiovascular disease, history of vaginal delivery, preoperative antibiotics and immunosuppression, demonstrated no statistical significance in dehiscence ($p=0.55$). In the multivariate analysis, only body mass index significantly affected dehiscence rates ($p=0.0053$).

Conclusions: The use of barbed, polydioxanone suture is a viable technique for the closure of both radical and nonradical vulvar excisions. Barbed, polydioxanone suture did not result in significantly increased rates of incision dehiscence in vulvar surgery. This initial study provides a basis for future randomized controlled studies to evaluate barbed, polydioxanone suture in vulvar incision closures.

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Poster #7

Prevalence of pelvic floor dysfunction among cervical cancer survivors

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Objectives: The prevalence and severity of pelvic floor dysfunction among cervical cancer survivors is unknown, but has been hypothesized to be higher than the general population. This may have a significant impact on quality of life in these women. This goal of this study is to evaluate the prevalence of pelvic floor dysfunction in cervical cancer survivors and ascertain the most common pelvic floor complaints in these patients.

Methods: An IRB-approved prospective survey was conducted among cervical cancer survivors who had completed their most recent treatment ≥ 3 months prior. Patients with active disease, those currently undergoing therapy of any kind, or those with history of pelvic exenteration were excluded. Participants completed a survey developed from the NCI's Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE) during their routine surveillance visit. Summary statistics were used to describe demographic and clinical factors. Fischer's exact test, two sample t-test, Wilcoxon rank sum test, and chi-square test were used where appropriate.

Results: In total, 23 patients met inclusion criteria. Of these, 65.2% were Caucasian, 65.2% were stage 1, and the median BMI was 30. For primary therapy, 73.9% received radiation with or without chemotherapy, 17.4% received chemotherapy alone, and 56.5% received surgery with or without adjuvant therapy. The majority of patients (86.9%) reported some element of pelvic floor dysfunction. Regarding GI symptoms, 47.8% reported constipation, 39.1% reported diarrhea, and 17.3% reported fecal incontinence. In regards to urinary symptoms, 82.6% reported urinary frequency, 60.8% reported urinary incontinence, and 60.8% reported urinary urgency. The prevalence of pelvic pain was 39%. Of the 13 patients who answered questions about sexual dysfunction, 27% reported dyspareunia.

Conclusions: Pelvic floor dysfunction is very common among cervical cancer survivors. The most frequently reported symptoms are urinary, with more than three-fourths of patients noting urinary

frequency. Patient accrual for this study is ongoing to obtain a larger sample size. The knowledge gained from this data will help to determine how interventions, such as pelvic floor physical therapy, could improve quality of life in this patient population.

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Poster #8

Postoperative incisional cryoanalgesia for robotic hysterectomy

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Objectives: Cryoanalgesia has the ability to reduce local inflammation by producing isolated vasoconstriction and decreasing nerve conduction velocity. This process could theoretically decrease nociception at incision sites for postoperative patients and reduce need for opioid pain medications. The objective of this study was to obtain and compare Visual Analog Pain Scores (VAS) for robotic hysterectomy patients in the first postoperative 24 hours with and without application of cryoanalgesia to abdominal incision sites.

Methods: Consecutive patients receiving postoperative care for robotic hysterectomy following intervention for application of ice packs to abdominal incisions in the first postoperative 24 hours from November 2016 to May 2017 were compared to consecutive historical controls in a similar time period (April 2016 to October 2016). Patient demographics, medical comorbidities, surgical procedure, history of chronic pain medicine use, Visual Analog Pain Scores (VAS), total narcotic use and compliance to cryoanalgesia were collected. Student's t test, Analysis of Variance, the Tukey-Kramer method and multiple regression analysis were used for statistical analysis.

Results: A total of 93 patients were evaluated following ice pack intervention, and 72 patients were evaluated prior to intervention. Prior to the intervention, no patients received ice packs for cryoanalgesia. Following the intervention, all patients received an order for ice packs, with only 30 patients receiving ice, a 32% rate of compliance. Visual Analog Pain Scores were recorded over the first 24 postoperative hours in three separate 8-hour time frames using the Tukey-Kramer method for adjustment for multiple comparisons. In the pre-intervention group, the average VAS for each time frame 0-8 hours, 9-16 hours and 17-24 hours was 4.1, 3.1 and 3.9 respectively. For the post-intervention group, the average VAS for each time frame was 3.9, 3.1 and 3.9 respectively. There was no difference in VAS between the pre- and post-intervention groups ($p=0.98$). Similarly, there was no significant difference between patients that did not receive ice packs to those who did ($p=0.62$). A statistically significant difference in VAS was noted in both the pre- and post-intervention groups from 0-8 hours and 9-16 hours ($p=0.04$ and $p=0.01$, respectively). Multiple Regression Analysis concluded that VAS was positively correlated with number of narcotic pills used ($p < 0.0001$), but no correlation with age, BMI, estimated blood loss or ASA physical status classification.

Conclusions: Incisional cryoanalgesia did not improve Visual Analog Pain Scores during the first postoperative 24 hours in patients undergoing robotic hysterectomy. Overall low pain scores are reported following robotic hysterectomy where minimal analgesia is required.

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Poster #9

Expression and function of ER-B in premenopausal endometrial cancers

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