

Nutritional Status (CONUT) score has been postulated as an indicator of PFS and OS in several cancers.

The objective of the present study is to investigate CONUT score in MIBC patients undergoing radical cystectomy (RC) and its correlation with tumor recurrence/progression.

Methods: We retrospectively reviewed 126 patients from our prospectively maintained MIBC database. CONUT score was calculated based on serum Albumin concentration, lymphocyte count and total cholesterol concentration preoperatively. The cut-off score for high and low-CONUT score was calculated with a ROC curve. RFS and OS were analyzed for both groups.

Results: For CONUT score, the AUC was 0.7 (0.61–0.78) and the optimal cutoff value was 2. 50 patients (37%) were classified as high-CONUT (≥ 2) and 76 patients (56.3%) as low-CONUT (< 2). The patients with high-CONUT presented with worse ASA score (72% ASA 3–4) and advanced disease at path report (88% pT3–4, 46% N1). Neoadjuvant chemotherapy was administered to 6 (12%) patients with high-CONUT, only 5 completed the 3 cycles. 38 (30%) patients were enrolled in the ERAS Prehabilitation protocol. Similar rates of major complications were observed (5-low; 5-high). The patients with high-CONUT score had shorter 2-y PFS than the ones with low-CONUT scores (PFS 46% vs 63%; $p < 0.05$). Multivariate analysis after adjustment for pT stage, pN stage, ASA score, age at surgery and Clavien-Dindo classification revealed that CONUT score is an independent predictor of bladder cancer specificity survival (HR 1.84; IC del 95% 1.01–3.39; $p = 0.048$).

Conclusion: Preoperative CONUT score in MIBC patients undergoing radical cystectomy should be taken into consideration to predict oncological outcomes. No differences were observed in terms of major complications in the ERAS subgroup. Further studies are required to validate the current findings.

Disclosure of interest: None declared.

P033

THE ROLE OF SELF-EFFICACY IN PREHABILITATION AND ITS IMPACT ON POST-OPERATIVE RECOVERY

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Objectives: Self-efficacy (SE) describes one's confidence in achieving a particular goal and is not only a predictor of exercise behaviour but also an outcome in its own right. The aim of this study is to establish how self-efficacy impacts on prehabilitation and post-operative recovery.

Methods: Our PREPARE programme collects functional, psychological and nutritional measures, at 4 time points; diagnosis (T1), completion of neoadjuvant treatment (T2), immediately pre-operatively (T3) and 6 weeks after discharge post-surgery (T4). Validated tests of functional capacity are converted into a metabolic equivalent of task score (METS). Lorig's six-item questionnaire is used to evaluate SE. Health Related Quality of life (HRQoL) is measured using the validated EORTC QLQ C30 questionnaire. Post-operative outcome data, such as length of stay, is collected for each quarter.

Results: 59 patients enrolled into the PREPARE programme from January 2015 to October 2016. The mean age of the patients was 66 years old. We found an increase in METS over the period from T1 to T3 (4.6 vs 4.2 vs 5.1; $p = 0.001$) and a parallel increase in SE (8.1 vs 7.7 vs 9.2, $p = 0.003$). METS and SE were higher at T4 as compared to T1.

Patients who had an increase in self-efficacy during prehabilitation were more likely to have a higher global HRQoL score at T4 than at T1 in comparison to patients with no change or a fall in self-efficacy during prehabilitation (45% vs 7.7%, $p = 0.023$).

Between the first quarter of 2015 and the third quarter of 2016 the median length of stay decreased from 12 to 8 days.

Conclusion: Our results show parallel improvements in self-efficacy and functional capacity during prehabilitation. Despite the impact of chemotherapy and surgery, self-efficacy and functional capacity were higher at T4 than T1. Achievement of exercise goals leads to improved self-efficacy, which in turn leads to improved self-management. This contributes to accelerated post-operative recovery. Improving self-efficacy during

prehabilitation is associated with a higher global QoL after surgery than at diagnosis. Strategies to improve self efficacy are likely to improve the impact of prehabilitation on post-operative outcomes.

Disclosure of interest: None declared.

P034

PATIENT-REPORTED PHYSICAL FUNCTIONING IMPAIRMENT PREDICTS DELAYED BOWEL MOVEMENT AND FLATUS AFTER ABDOMINAL SURGERY

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Objectives: Delayed bowel movement (BM) and flatus are both indicators for postoperative ileus (POI), a surgery-induced stress response that impairs intestinal motility after abdominal surgery. We investigated whether patient-reported impairment of daily functioning in the first 48 hours after surgery could predict delayed BM and flatus.

Methods: This prospective study enrolled patients with cancer scheduled for abdominal surgery. The MD Anderson Symptom Inventory (MDASI) was administered daily after surgery. The MDASI "interference with walking" item was used to represent impairment of postoperative physical functioning. Delayed BM or flatus was assumed if time to first post-operative BM or flatus was ≥ 72 hours. Logistic regression modeling determined the predictive effect of interference with walking on delayed BM or flatus. Potential confounders (age, sex, race, cancer stage, and surgery type (open surgery vs. laparoscopy)) were controlled in all models.

Results: Of the 80 patients with digestive cancer (53 colorectal cancer) included in this analysis, 56 underwent open surgery and 24 had laparoscopic surgery. Time to first BM was 66.1 ± 24.7 hours (35 patients had delayed BM). Time to first flatus was 64.0 ± 23.3 hours (31 patients had delayed flatus). Patients with delayed BM reported significantly greater walking interference than did those without delay (7.9 ± 3.0 vs. 5.0 ± 4.2 on day 1, 6.1 ± 2.9 vs. 3.1 ± 3.2 on day 2, all $p < .0001$). Similar results were found for delayed flatus (7.9 ± 3.2 vs. 5.3 ± 4.3 at day 1, 5.8 ± 2.9 vs. 3.6 ± 3.5 at day 2, all $p < .01$). Logistic regression revealed that, at day 1, every 1-unit increase (on a 0–10 scale) in walking interference related to a 23% higher risk of having delayed BM (odds ratio (OR) 1.23, 95% confidence interval (CI) 1.05–1.44, $p = .01$) and 19% higher risk for delayed flatus (OR 1.19, 95% CI 1.02–1.39, $p = .02$). At day 2, a 1-unit increase in walking interference related to a 46% higher risk for delayed BM (OR 1.47, 95% CI 1.17–1.84, $p = .001$) and a 29% higher risk for delayed flatus (OR 1.29, 95% CI 1.06–1.57, $p = .01$).

Conclusion: Patient-reported impairment of physical functioning in the first 48 hours after abdominal surgery may predict the incidence of delayed BM and flatus, indicators for POI. Frequent patient-reported outcome assessment after surgery will help identify possible POI and promote its management.

Disclosure of interest: None declared.

P035

COMPLIANCE THE ERAS RECOMMENDATIONS FOR PRE AND INTRAOPERATIVE CARE IN LAPAROSCOPIC SURGERY FOR ENDOMETRIAL CANCER

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Objectives: In 2017 we aim to implement the Enhanced Recovery After Surgery (ERAS) Guidelines for perioperative care in gynecologic/oncology surgery¹.