

OE-0098 (PP-0089) Translation and validation of EORTC QLQ - CR 29 quality of life questionnaire (Sinhala version)

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Background and Aim: The aim of this study was to validate the Sinhala version of the EORTC QLQ-CR29 quality of life questionnaire for colorectal cancer. **Methods:** We translated and pilot tested ($n = 10$) the original questionnaire in Sri Lanka. We assessed reliability, factor structure, and construct validity. The testing was done in two tertiary care hospitals in Sri Lanka. **Results:** Of 110 participants, 103 (93%) returned the questionnaire, and 15 out of 20 (75%) returned the repeat-test questionnaire within a period of 2 weeks. Out of the original four scales, two had better reliability than the original scales (urinary frequency: Cronbach $\alpha = 0.82$ vs original $\alpha = 0.71$, blood and mucus in stools: $\alpha = 0.85$ vs original $\alpha = 0.56$). The defecation problems scale had sufficient reliability ($\alpha = 0.76$ vs original $\alpha = 0.84$). The body image scale showed low reliability ($\alpha = 0.33$) compared to the original ($\alpha = 0.80$). However, when one of the three items in the scale was omitted, it showed sufficient reliability ($\alpha = 0.74$). Factor analysis showed good reliability for overall assessment of the two-item scale for stool frequency ($\alpha = 0.82$) and six-item scale for defecation problems ($\alpha = 0.76$). Correlations between all the subscales and the QLQ-C30 subscales were below 0.40, except for body image, which correlated moderately ($r = 0.44$) with emotional functioning. **Conclusion:** The scales for urinary frequency, blood and mucus in stools, and defecation problems which were reliable and had good validity. The six-item scale for defecation problems showed less reliability when assessing patients with stoma; however, the two item stool frequency scale showed very high reliability. Body image scale failed to show sufficient reliability with the three-item scale, and we suggest to omit one of the items to improve the overall reliability of the questionnaire. Construct validity was comparable to published data.

Keywords: Sinhala version, translation, validation

OE-0130 (PP-0090) Enhanced recovery after colorectal surgery (ERAS) protocol in Sri Lanka: An assessment of current practice of colorectal surgery among general surgical units in a developing country in South Asia

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Background and Aim: Practices on elective colorectal surgery are largely reformed after the introduction of ERAS which is evidence-based clinical practice aiming a better, speedy postoperative recovery. Assessment of current practice is important as barriers to introduction of naive evidence-based clinical practice do exist, and one factor is the surgeon. Study was conducted to assess perioperative trends in elective colorectal surgery among general surgical units in Sri Lanka. **Methods:** A modified version of anonymous, self-administered questionnaire developed based on ERAS and used in similar study was distributed to consultant or registrar of respective surgical units. **Results:** Seventy-two participated. Pre-surgery patient education is practiced in all units; 60% prefers open surgery; 73% and 69% utilize mechanical bowel preparation (MBP) routinely before elective colonic and rectal surgeries, respectively. Adherence to steps of ERAS are as follows: preoperative carbohydrate loading (21%), DVT prophylaxis preoperatively with subcutaneous enoxaparin (28%), restrictive intravenous fluids during surgery (41%), routine use of naso-gastric tube (49%), abdominal drains (61%). Opioid analgesics were used in 87%. Median postoperative day of drain removal is 3 (range 2–7 days) and catheter removal is 3 (range 1–7 days). Median postoperative days of starting oral clear fluids and solids are day 3 (range 1–5) and day 5 (range 1–7), respectively. Patient mobilization starts on postoperative day 2 (range 1–6). Median postoperative day of discharge is day 7 (range 4–14 days). No significant difference found between open and laparoscopy groups. **Conclusion:** Level of practice of crucial elements of ERAS protocol (highly selective bowel preparation, preoperative DVT prophylaxis, selective drain use, early removal of catheter, early enteral feeding, and avoidance of opioid) is still low among Sri Lankan surgical community according to our data. Disseminating knowledge on ERAS among surgical units in the form of National guidelines on ERAS protocol would be beneficial as ERAS protocol has a proven benefit in postoperative recovery.

Keywords: ERAS, practice, South Asia