Major upper gastrointestinal (GI) surgery always poses unique perioperative challenges and high post-surgical complications. Prehabilitation encompassed of exercise, nutrition and medical optimization prior to surgery. There is an emerging evidence to show prehabilitation plays a significant role in reducing morbidity and mortality associated with major upper GI surgery by improving patient’s functional status. Its role in improving postoperative outcomes such as length of stay (LOS) is less established.

An interventional study conducted among oesophageal and gastric cancer patients who undergone oesophagectomy and gastrectomy surgery. All the preoperative patients are assessed by dietician and nutrition therapy will be provided. Study characteristics, ECOG status, handgrip, peak flow meter and spirometry are obtained. Primary outcome is impact of prehabilitation on functional capacity. Secondary outcomes include post-operative length of stay and complications based on Clavien-Dindo classification.

Thirty one (31) patients who were recruited [gastrectomy (n = 21) and oesophagectomy (n = 10)]. Mean age was 59.2 ± 8.9 years. 21(67.7%) was male patients. Majority of the participants were SGA B (51.6%) with good ECOG status of 1(61.3%). Most of the diseases were in advanced stage [stage III (54.9%), stage IV (9.7%)]. After prehabilitation, handgrip strength, peak flow meter and spirometry were significantly higher before surgery (20.9 vs 24.6, p = 0.002; 322.2 vs 419.3, p = 0.002; 77.4% vs 90.3%, p = 0.007 respectively). No significant difference in LOS and post operative complications were observed.

Prehabilitation was associated with significant increase in functional capacity after intervention. Hence prehabilitation should be strongly recommended among patient undergoing major upper GI surgery to accelerate recovery from cancer surgery. However, there is insufficient data to demonstrate its role in improving clinical outcomes, including LOS and post operative complications.

**Table 1 Pre- and post-operative symptomatology in patients with giant paraoesophageal hernia (n = 154)**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Pre-operative (%)</th>
<th>Post-operative (%)</th>
<th>Significance (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyspnoea</td>
<td>154 (100%)</td>
<td>4 (2.6%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>71 (46.3%)</td>
<td>24 (15.6%)</td>
<td>0.002</td>
</tr>
<tr>
<td>Aspiration</td>
<td>14 (9.1%)</td>
<td>2 (1.3%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**194. THE IMPACT OF PREHABILITATION IN UPPER GASTROINTESTINAL (GI) CANCER UNDERWENT MAJOR SURGERY**

Ramizah Shariff1, Mohammad Shukri Jaht1, Tee Sze Chye1, Abdul Aziz Harith2,3, Nurul Hanan Shahabuddin1, Saiyidah Adila Mohd Adibi1

1. National Cancer Institute, Putrajaya, Malaysia and 2. Institute for Public Health, Ministry of Health, Malaysia, and 3. Medical Department, University of Otago, New Zealand

Major upper gastrointestinal (GI) surgery always poses unique perioperative challenges and high post-surgical complications. Prehabilitation encompassed of exercise, nutrition and medical optimization prior to surgery. There is an emerging evidence to show prehabilitation plays a significant role in reducing morbidity and mortality associated with major upper GI surgery by improving patient’s functional status. Its role in improving postoperative outcomes such as length of stay (LOS) is less established.

An interventional study conducted among oesophageal and gastric cancer patients who undergone oesophagectomy and gastrectomy surgery. All the preoperative patients are assessed by dietician and nutrition therapy will be provided. A standard set of physical and breathing exercise are adopted. Study characteristics, ECOG status, handgrip, peak flow meter and spirometry are obtained. Primary outcome is impact of prehabilitation on functional capacity. Secondary outcomes include post-operative length of stay and complications based on Clavien-Dindo classification.

Thirty one (31) patients who were recruited [gastrectomy (n = 21) and oesophagectomy (n = 10)]. Mean age was 59.2 ± 8.9 years. 21(67.7%) was male patients. Majority of the participants were SGA B (51.6%) with good ECOG status of 1 (61.3%). Most of the diseases were in advanced stage [stage III (54.9%), stage IV (9.7%)]. After prehabilitation, handgrip strength, peak flow meter and spirometry were significantly higher before surgery (20.9 vs 24.6, p = 0.002; 322.2 vs 419.3, p = 0.002; 77.4% vs 90.3%, p = 0.007 respectively). No significant difference in LOS and post operative complications were observed.

Prehabilitation was associated with significant increase in functional capacity after intervention. Hence prehabilitation should be strongly recommended among patient undergoing major upper GI surgery to accelerate recovery from cancer surgery. However, there is insufficient data to demonstrate its role in improving clinical outcomes, including LOS and post operative complications.

**196. RISK FACTORS OF CERVICAL LYMPH NODE METASTASIS IN ESCC AND ESTABLISHMENT OF PREDICTION MODEL**

Taqian Gong

Department of Thoracic Surgery, Sixth Medical Center, Chinese People’s Liberation Army General Hospital, Second Clinical College of Southern Medical University, Beijing, China.

Cervical lymph node metastasis of esophageal squamous cell carcinoma (ESCC) is an important basis for lymph node dissection of ESCC. Now, there are still disputes about whether to perform two field lymph node dissection or three field lymph node dissection. Establishing prediction model by analysis big data could promote the accuracy of prediction of cervical lymph node metastasis in patients with ESCC which can help clinicians to select individualized surgical scheme for patients. The clinical data of 102 consecutive patients with ESCC who underwent radical esophagectomy and three-field lymph node dissection between December 2015 to December 2021 were retrospectively analyzed. They were divided into positive group and negative group according to cervical lymph node