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A NOVEL ENDOSCOPIC SURGERY METHOD: TRANSURETHRAL SURGERY – NATURAL ORIFICE TRANSLUMENAL ENDOSCOPIC SURGERY (TUS-NOTES) USING PNEUMOCYSTOSCOPY FOR TREATMENT OF VESICOVAGINAL FISTULA

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Introduction/Background Vesicovaginal fistula (VVF) formation represents a condition with devastating consequences for the patient and continues to pose a significant challenge to the surgeon. To minimize the morbidity of classical fistula repair, we hereby present a new minimally invasive surgery technique to perform a fistulae repair in transurethral surgery- natural orifice transluminal endoscopic surgery (TUS-NOTES) by using a new small fine needle holder (MRSD-Ney) and knot pusher.

Methodology

Setting A rigid cystoscope with 30 degree optics is inserted into the bladder with CO(2) insufflation. After inspecting and finding the fistulae orifices the fistulae area is manipulated with an endoscopic hooklet. First the monocryl 4–0 fibre is put into the needle holder. To fit into the needle is bended. The needle is put loose next to the cystoscope put into the bladder and after touching the wall the fibre is fixed at the end of the needle holder with a clamp. Now by a rotation the whole is at both sides stiched. With a grasp -put through the working channel- the needle is grasped and by loosening the clamp everything can be pulled out. By tying an extracorporeal knot and putting a knot pusher over the fibre, the knot is fixed. This procedure is repeated till the whole is closed. The fibres are cutted.

Results The aim is to present the TUS-NOTES technique and teach the viewer how to apply this novel intervention to close the fistulae inside of bladder at 27 cases. The mean operative time was 55 min (35 min–110 min), whereas the blood loss was less 10 ml. The patients were discharged 3 days after surgery, and the catheter were removed 10 days after surgery.

Conclusion To reduce morbidity and prolonged recovery of excision of the VVF – TUS-NOTES technique is efficacious and the preferred method of intervention.

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MALIGNANT STRUMA OVARI: AN UP-DATE ON THE CURRENT LITERATURE

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Introduction/Background Malignant struma ovarii is a rare monodermal ovarian tumor, that may affect women in their reproductive years. Data regarding effective treatment are scarce and are primarily derived from small retrospective studies. Therefore, there is no consensus on optimal treatment for those patients.

Methodology This review serves to provide information on the latest literature available pertaining to the treatment modalities and prognostic factors of malignant struma ovarii.

Data were derived from the search in medical databases (Pubmed, Cochrane, Clinicaltrials.gov) up-to-date.

Results Due to the rarity of malignant struma ovarii, there is a paucity in the current literature for high quality randomized controlled trials regarding optimal surgical management and adjuvant therapy. The best available evidence is derived from limited retrospective cohort analysis. Five (5) large retrospective cohort studies that were published within the last two years were analyzed. The overall survival seems to be negatively affected by specific histologic subtypes, poor differentiation, ascites, recurrences and ovarian capsular involvement. Radioactive therapy has no proven benefit on overall survival. However, it is documented that thyroidectomy in combination with radioactive therapy increases disease free survival, in comparison to surgery alone.

Conclusion In the absence of high-quality data from randomized controlled trials, a conservative surgical approach with adjuvant thyroidectomy and radioactive therapy seems a reasonable approach and is supported by the relevant literature.

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HOW THE INTENSE THROMBOPROPHYLAXIS MEETS THE NEEDS OF HIGH THROMBOTIC BURDEN GYNECOLOGICAL CANCER PATIENTS UNDERGOING SURGICAL TREATMENT? INTERMEDIATE RESULTS FROM THE METHOS STUDY

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Introduction/Background Gynecologic cancer surgery has 6-fold higher risk for DVT and 14-fold for PE, compared to benign disease. Two meta-analyses (Rasmussen2009, Farag-sanu2016) show residual VTE rates 5.3% and 14.3% in patients following standard thromboprophylaxis approach. Despite increased awareness, improved surgical techniques and more extensive use of primary thromboprophylaxis, postoperative DVT remains high.

Methodology MeTHOS is a prospective observational, phase IV study, aiming to evaluate the role of intense thromboprophylaxis (tinzaparin 0.4 ml, 8.000 Anti-Xa IU, OD) for High Thrombotic Burden (HTB) gynecological cancer patients undergoing surgery. Enrolled women had signed informed consent.

Results 221 patients enrolled. Their characteristics in accordance to cancer, patient and treatment high thrombotic burden risk factors are depicted in table 1. Median tinzaparin administration was 29 days (Q1-Q3: 26–34). Eight thrombotic events (TEs) recorded (efficacy:96.4%, 95%CI:93.0–98.2%): 2 in endometrial cancer surgeries, 5 in ovarian, 1 in sarcoma. FIGO-III or IV was linked to higher TE risk, compared to FIGO-I or II (OR: 8.8, p=0.02). Extremely severe (>5 hours) surgeries were prone to TEs, 12% of them followed by TEs, while for major and severe surgeries (2–5 hours) it was 1% and 3% (p=0.04) respectively. 89% of TEs occurred in patients with BMI>29 (OR:76.6, p=0.04). Ovarian cancer surgeries had increased risk for TEs compared to other malignancies (OR:4.2, p=0.04). Three bleeding events reported (1.4%, 95%CI: 0.4–4%). Compared to prophylactic dose, in the two meta-analyses (reported TEs: 5.3% and 14.3%) there

Abstracts

were less TEs (3.6%) when intensive dose was applied ($p<0.001$), without increasing bleeding events (2.8% and 1.8% vs. 1.4% in the current study).

Abstract 2022-RA-918-ESGO Table 1

Cancer related		Treatment related		Patient related	
Primary site		Surgery type		Demographics	
Endometrium	43%	Major (2-3 hours)	38%	Age (years)	62 [52-71]
Ovarian	30%	Severe (3-5 hours)	36%	BMI (Kgr/m ²)	29 [25-33]
Cervical	11%	Extremely severe (5+ hours)	26%	Smoking	33%
Vulvar	7%	Central venous catheter	29%	Alcohol	4%
Sarcomas	4%	Chemotherapy		Medical history	
Mixed & other	5%	Preoperative	42%	Comorbidities	58%
FIGO stage		Postoperative	55%	Anticoagulation history	13%
I	58%	Pre and post operatively	3%	Thrombosis history	2%
II	9%				
III	23%				
IV	10%				

Conclusion Postoperative intense tinzaparin administration 8.000 Anti-Xa IU for 1 month, was both effective and safe. Reducing the occurrence of thrombotic events without increasing bleeding risk. Important risk factors for thromboembolism were BMI \geq 29, advanced stage disease and ovarian carcinoma. Further research is needed.

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ROBOTIC SURGERY OUTCOMES IN A GYNAECOLOGICAL ONCOLOGY CANCER CENTRE

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Introduction/Background Robotic surgery (RS) in gynaecological oncology has been shown to overcome the limitations of conventional laparoscopy, improve perioperative outcomes and reduce length of stay (LOS). RS has lower conversion rates and shorter learning curve than laparoscopic surgery (LS). The blood loss is significantly less. RS is preferred in morbidly obese women. We share our experience of introducing RS at our centre and study its impact on our clinical outcomes and service.

Methodology RS was introduced in December 2020 during COVID-19 pandemic. A second surgeon trained from September 2021. Data was collected prospectively recording indications, operating-time, blood loss, LOS and complications. Outcomes were compared with the Hospital Episode Statistics (HES) data and cost analysed.

Results Until May 2022, 143 cases underwent RS using *da Vinci- Si, X or Xi* robots. Most women (84) had endometrial cancer. Complexity of surgery increased in latter half with women with BMI $>$ 40kg/m²(23), large fibroid uterus(22), ovarian cancer staging(12) and radical hysterectomy(3). Median docking time was eight minutes, median operating-time was 150 minutes and median blood loss was 50 ml. Average LOS was 1.8 days and median LOS 1 day(range 0–6 days). Average LOS for LS was 3 days and open abdominal surgery 8.6 days. Minor complications(11) were treated conservatively. Two patients with adhesions had bladder injury. One surgery was converted to open abdominal surgery during the early learning phase. Introduction of robotic surgery increased the minimal-access surgery (MAS) rate by 15%. The operating-time showed

decreasing trend with experience while surgical productivity {average number of cases per theatre list} remained the same. **Conclusion** There is a significant reduction in hospital stay and a clear cost benefit of robotic surgery. There is a significant increase in the MAS rates even during the early phase of learning with no increase in overall morbidity.

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RISK OF VENOUS THROMBOEMBOLISM AND MAJOR BLEEDING IN GYNAECOLOGICAL CANCER SURGERY: SERIES OF SYSTEMATIC REVIEWS AND META-ANALYSES

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Introduction/Background Pharmacological thromboprophylaxis involves balancing lower risk of venous thromboembolism (VTE) against higher risk of bleeding, a trade-off that critically depends on VTE and bleeding risks in the absence of prophylaxis (baseline risk). Baseline risks likely vary between procedures, but their magnitude remains uncertain. At least in part due to uncertainty regarding baseline risks in gynaecological cancer surgery, thromboprophylaxis practices vary substantially within and between countries.

Methodology We conducted comprehensive searches on Embase, MEDLINE, Web of Science, and Google Scholar. We identified observational studies reporting symptomatic VTE or major bleeding (bleeding requiring reoperation, bleeding leading to transfusion, or Hb $<$ 70g/L) after gynaecological cancer surgery. Furthermore, we performed separate searches for randomised trials addressing effects of thromboprophylaxis