and conducted a web-based survey on thromboprophylaxis practice. We adjusted the reported risk estimates for thromboprophylaxis and follow-up length to determine baseline cumulative incidence at 4 weeks post-surgery for each procedure. We stratified VTE risk by patient risk factors as low (no patient risk factors), medium (age >75, BMI >35, or VTE in a 1st degree relative), or high (any combination or personal VTE history). We used the GRADE approach to rate evidence certainty.

Results We identified 7,556 titles and abstracts, of which 188 proved eligible, reporting on 37 gynaecological cancer surgery procedures. The quality of evidence was generally very low or low. 4-week risks of major bleeding and especially of VTE varied widely between procedures, and between approaches within the same procedure (tables 1–2).

Abstract 2022-RA-933-ESGO Table 1 4-week postoperative risk of symptomatic venous thromboembolism (VTE) and bleeding requiring reoperation (BRR) after certain gynaecological cancer procedures

Procedure	Outcome	Patients (studies)	Estimate (%) Median (Low-Medium–High)	Certainty in estimate
Cervical conization, vaginal	VTE	1359 (1)	0.1 (0.1 - 0.2 - 0.3)	Low
Trachelectomy, radical, vaginal	VTE	226 (2)	2.9 (2.6 - 5.2 - 10.4)	Very low
	BRR	267 (3)	1.2	Very low
Surgery for ovarian cancer, any, open	VTE	101238 (18)	7.4 (5.3 - 10.7 - 21.3)	Low
	BRR	2326 (12)	1.2	Very low
Surgery for ovarian cancer, any, minimally-invasive	VTE	4885 (2)	2.9 (2.2-4.4-8.8)	Very low
Pelvic exenteration, any, open	VTE	1327 (10)	11.1 (8.4 - 16.8 - 33.6)	Very low
	BRR	154 (2)	0.7	Very low
Vulvectomy, any	VTE	618 (2)	3.2 (2 - 3.9 - 7.9)	Low
Radical vulvectomy, with lymphadenectomy, open	VTE	250 (2)	12.3 (7.2 – 14,4 – 28,7)	Very low

Abstract 2022-RA-933-ESGO Table 2 4-week postoperative risk of symptomatic venous thromboembolism (VTE) and bleeding requiring reoperation (BRR) after hysterectomy for malignant disease

Procedure	Outcome	Patients (studies)	Estimate (%) Median (Low-Medium–High)	Certainty in estimate
Total hysterectomy, without lymphadenectomy, laparoscopic	VTE	2049 (1)	0.3 (0.3 - 0.5 - 1.1)	Moderate
	BRR	1793 (8)	0.2	Very low
Total hysterectomy, with lymphadenectomy, laparoscopic	VTE	5712 (15)	1.3 (0.9 - 1.8 - 3.6)	Low
	BRR	588 (3)	0.3	Low
Total hysterectomy, with lymphadenectomy, open	VTE	12569 (8)	3.2 (2.4 - 4.9 - 9.7)	Very low
Radical hysterectomy, with lymphadenectomy, minimally-invasive	VTE	6730 (21)	1.5 (1.2 - 2.5 – 5.0)	Very low
	BRR	747 (4)	0.7	Very low
Radical hysterectomy, with lymphadenectomy, open	VTE	10227 (18)	3.3 (2.7 - 5.4 - 10.8)	Very low
	BRR	2888 (6)	0.5	Very low

Conclusion Our results suggest that extended thromboprophylaxis is warranted in many gynaecological cancer procedures, such as ovarian cancer surgery, total hysterectomy with lymphadenectomy and radical hysterectomy. In some procedures, such as laparoscopic total hysterectomy without lymphadenectomy, the risks of VTE and bleeding are closely balanced. In these cases, decisions depend on individual risk prediction and patient values and preferences.

2022-RA-952-ESGO KNOWLEDGE AND AWARENESS ABOUT CERVICAL CANCER AND ITS PREVENTION AMONG PREMENOPAUSAL WOMEN: WHATSAPP MESSENGER AS A PLATFORM TO ENHANCE AWARENESS AND KNOWLEDGE

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Introduction/Background Activities directed towards optimizing women's health depend on their social and cultural standing. Considering the weaknesses of traditional health campaigns, medical professionals may use different initiatives to educate women. This study aimed to determine awareness and knowledge levels of menopausal transition and cervical cancer (CC), and CC prevention among premenopausal women, and investigate the feasibility of WhatsApp as a platform to raise awareness by engaging a GP.

Methodology In phase one, participants aged 40 to 51 were enrolled while visiting GP clinics. Self-administered questionnaires were distributed. Participants were invited to join WhatsApp. An educational pamphlet was sent through WhatsApp in sections, and discussions were encouraged.

Results Overall 273 participants were recruited in phase one. Only 48% had a normal BMI and the majority were aged 40 to 41 (23%), married (86%), and had 4 children (57%). About 42% had at least one illness, with urinary incontinence (18%) and hypertension (12%) having the highest prevalence. Musculoskeletal symptoms, depleted energy, sleep disturbances and mood swings were prevalent. Surprisingly, 40% of participants reported no gynaecological exam in their life. Although 75% said they heard about CC, only 39% knew at least one cause of it and 28% knew some available treatments. About 56% mentioned that infection is the most common cause of CC. Despite the majority hearing about or having done Pap tests, only 43% knew it helps to diagnose CC. For phase two, only 42 women joined WhatsApp but 33 remained until the end. Ultimately, 12 participants responded to the same questionnaire resent through WhatsApp.

Conclusion Knowledge regarding perimenopause symptoms, CC, and CC prevention has not been attained by the target group despite the role of technology; WhatsApp proved ineffective in educating middle-aged women. A concerted effort using both traditional and online mediums and active discussions with healthcare providers is invaluable.

2022-RA-964-ESGO RADIOGUIDED OCCULT LESION LOCALISATION (ROLL) FOR GYNECOLOGIC TUMOR RELAPSES: DEVELOPMENT OF A TECHNIQUE

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Introduction/Background Excision of peritoneal or nodal solitary lesions frequently involves performing a surgery on a

previously operated area, which is more difficult to achieve with minimally-invasive approaches. Our aim was to describe the technical aspects, feasibility and complications derived from the application of the radioguided occult lesions localization (ROLL) in gynecologic oncology recurrence excision.

Methodology All consecutive patients bearing localized relapses of a gynecologic tumor that were considered candidates for surgical excision were assessed to undergo a ROLL procedure. After multidisciplinary review of images and surgical indication, patients were considered as suitable for ROLL. Injection of the relapsed tumor was performed by ultrasonography or CT guidance. Relapses were localized using a gammaprobe by minimally-invasive surgery (laparoscopic or robotic surgery) when located in the abdomen, or pecutaneously when located in the groin. Intraoperative and early (up to postoperative day 30) complications were prospectively recorded, and complications were graded according to Common Terminology Criteria for Adverse Events (CTCAE) version 5.0

Results A total of 8 patients underwent the procedure. Median age was 59 years (range: 35–87). Four patients had abdominal relapses, while four patients presented groin relapses. Mean operative time was 120 minutes (range: 30–190), while median estimated blood loss was 5 cc (range: 0–150 cc). All of the targeted lesions were successfully removed. No intraoperative complications were reported. One postoperative complication (inguinal lymphocele) was reported after surgery, corresponding to CTCAE grade 2 severity.

Conclusion ROLL surgery is feasible for excision of recurrences of gynecological tumors.

2022-RA-993-ESGO

COMPARING THORACIC EPIDURAL ANALGESIA TO SURGEON-ADMINISTERED CONTINUOUS TRANSVERSUS ABDOMINUS PLANE BLOCKS IN GYNAECOLOGIC ONCOLOGY PATIENTS: A RETROSPECTIVE COHORT STUDY

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Introduction/Background Post-operative analgesia comprises of a thoracic epidural (TEA) with multimodal adjuncts. Literature has shown transversus abdominus plane blocks (TAP) offer equivalent analgesia with potential secondary benefits. Our study assessed whether surgeon-administered continuous TAP blocks (cTAP) provided equivalent post-operative analgesia in Gynecologic Oncology patients undergoing abdominal surgery.

Methodology A retrospective cohort study of patients undergoing abdominal surgery at McGill University Health Centre from January 2018–2022 was completed. During the CoVID-19 pandemic, an institutional practice change was made in January 2020 to offer a cTAP with IV rescue patient-controlled analgesia. Patients in the TEA group were treated per standardized Department of Anesthesia protocols. Patients in the cTAP group received a surgeon-administered TAP catheter insertion prior to fascial closure with infiltration of bupivicaine 2–2.5 mg/kg 0.5% diluted 1:1 NS + 10 mg dexamethasone divided bilaterally followed by an infusion of 5–10 cc/hour. Our primary outcome was self-reported pain (numerical rating scale (NRS 0–10)) at 24 h; secondary outcomes included NRS at 1 h, first flatus and bowel movement, vomiting, hospitalization length, and analgesia-related complications. Univariate and multivariate analyses were completed, adjusting for age, body mass index, estimated blood loss, and operative time.

Results Two-hundred forty-four patients met study inclusion criteria: 135 and 109 patients received a TEA and cTAP, respectively. There was no difference in pain scores at 24 h between groups unadjusted *($p=0.668$)* and adjusted *($p=0.795$)*. The cTAP group had significantly earlier flatus (-0.3 days, *$p<0.05$*), bowel movement (-0.7 days, *$p<0.05$*), hospital discharge (-1.4 days, $p\leq0.05$), less vomiting events (OR 0.5 *$p>0.05$*), and higher NRS at 1 h (1.3, *$p<0.05$*). The TEA group had more adverse events, hypotension, and inadequate pain control (*$p<0.05$*).

Abstract 2022-RA-993-ESGO Table 1 Baseline demographic and clinical characteristics by types of anesthesia

	Epidural Group (n=135)	Tap Block Group (n=109)
Age	58.0 (48.0, 67.0)	58.0 (49.5, 66.0)
BMI	27.0 (23.5, 32.5)	26.6 (22.8, 32.2)
OR time	190.0 (152.0, 228.0)	218.0 (170.0, 256.0)
Estimated blood lost	400.0 (250.0, 800.0)	400.0 (250.0, 775.0)
Pain on day 1	2.0 (0.0, 3.0)	2.0 (0.0, 4.0)
NRS 1 hour	1.0 (2.0, 4.0)	4.0 (2.0, 5.0)
Day of first void	2.0 (1.0, 2.3)	1.0 (1.0, 2.0)
Urinary retention event	10 (7.4)	8 (7.3)
Day of Flatus	2.0 (2.0, 3.0)	2.0 (1.0, 3.0)
First BM	3.0 (2.0, 5.0)	3.0 (2.0, 4.0)
Vomiting event	52 (38.5)	30 (27.5)
Ileus event	14 (10.4)	5 (4.6)
Day of ambulation	2.0 (1.0, 3.0)	2.0 (1.0, 3.0)
Duration of admission	6.0 (5.0, 8.0)	6.0 (5.0, 7.0)