2022-RA-1327-ESGO INTRATHECAL MORPHINE, A WAY TO ACHIEVE OPIOID-FREE PAIN MANAGEMENT WITHIN AN ERAS

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Introduction/Background The main aim of the study was to evaluate whether intrathecal morphine (ITM) can replace systemic opioids in postoperative pain control in patients undergoing radical surgery for gynaecological cancers.

Methodology This is a retrospective, single center study analyzing perioperative data of patients who underwent surgery for a gynaecologic malignancy from January 2019 to December 2021.We reviewed use of systemic opioids in 24 hours after surgery, visual analog scale (VAS, 0–10) assessing pain during the first 24 hours and time from ITM application to the first VAS 3 or more was measured. We analyzed the most frequent side effects of ITM – incidence of pruritus, nausea and vomiting, hypotension and respiratory depression during the first 24 hours after ITM administration.

Results Intrathecal morphine in dose 0.2 – 0.5 mg was used in 170 patients before the surgery for postoperative analgesia. Systemic opioids were administered during the first 24 hours after surgery in 3 cases.65 patients had one or more side effects. 3 patients had pruritus, 46 patients suffered from nausea or vomitus. Postoperative hypotension with vasopressors treatment was reported in 26 cases. There was no case of respiratory depression requiring mechanical ventilation.

Conclusion Our results show that intrathecal morphine is an effective method of postoperative analgesia in patients undergoing radical oncogynecologic surgery. We managed to minimize the use of systemic opioids with a very low frequency of side effects.

2022-RA-1328-ESGO COMPARISON OF PROGNOSTIC RISK SCORING SYSTEMS TO PREDICT OUTCOMES IN GYNECOLOGIC ONCOLOGY PATIENTS

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Introduction/Background Surgery remains the main therapeutic module in many gynecologic malignancies. During the last decades, the operations have shifted to more radical and extensive procedures with multivisceral resections. This trend has come with increased complication rates, hospitalization, and healthcare costs. Multiple risk score systems have been proposed in order to identify high risk patients for adverse outcomes and Charlson comorbidity index (CCI) is widely accepted as highly accurate. This study compares CCI against Memorial Sloan Kettering-Frailty index (MSK-FI).

Methodology Retrospective analysis of 975 patients that have been operated in the Gynecologic Oncology Unit of our Department. The records of the patients were reviewed for risk factors and the department's readmissions and ICU admissions and deaths were retrieved from the complications database of the unit.

Results 26.3% of the patients had complications. Univariate analysis showed that older patient and patients of stage 3 and 4 and those with greater CCI had greater probability of complication. CCI but not MSK-FI, remained significant in multiple analysis. Twenty-two patients (2.3%) died. Multiple logistic regression showed that Greater age, CCI and MSK-FI were significantly associated with greater probability of dying. 1.7% of the patients were admitted to ICU. Greater age, CCI or MSK-FI were significantly associated with greater probability of being admitted to ICU. From multiple logistic regression emerged that only greater CCI was significantly associated with greater probability of being admitted to ICU. Median duration of hospitalization was 7 days (IQR: 5–10 days). Greater age, stage, CCI or MSK-FI were significantly associated with greater duration of hospitalization. When multiple linear regression was conducted it was found that CCI was significantly associated with greater duration of hospitalization.

Conclusion From our analysis MSK-FI is less accurate in identifying high risk patients for complications, ICU admission, increased hospitalization or complications' related death.

2022-RA-1341-ESGO MINIMALLY INVASIVE VERSUS OPEN PELVIC EXENTERATIONIN GYNECOLOGICAL MALIGNANCIES: A PROPENSITY-MATCHED SURVIVAL ANALYSIS

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Introduction/Background The primary endpoint of the present study was to compare the disease-free survival (DFS) of patients undergoing open versus minimally invasive pelvic exenteration (PE). Secondary endpoints cancer-specific survival (CSS) and peri-operative morbidity.

Methodology Multi-center, retrospective, observational cohort study. Patients undergoing anterior or total PE for gynecological cancer by minimally invasive and open approach between 2010–2021 were included. Positive para-aortic/inguinal lymph nodes and with distant metastases were excluded. A 1:2 propensity match analysis between patients undergoing minimally invasive and open PE was performed to equalized baseline characteristics.

Results 117 patients were included, 78 (66.7%) and 39 (33.3%) in the open and minimally invasive group, respectively. No significant difference in intra- and post-operative complications was evident between the two study groups (trend toward higher incidence of complications in open