

addition to the ICG fluorescence lymphangiography, we also analyzed physical findings.

Results By the present, we have performed the test on 14 patients including 6 cervical cancer, 7 corpus cancer and 1 fallopian tube cancer. So far, we have obtained the following three new findings. (1) If a patient already has lymphedema preoperatively, there is no improvement after lymphadenectomy; (2) Lymphedema that was present at 1 month after surgery may improve over time; and (3) Though the lymphangiography pointed out the lymphedema without subjective symptoms, lymphedema may become apparent later.

Conclusion The results of the intermediate analysis to the present show significant findings that innate lymph duct function and morphology may be involved in the development of lymphedema. The final evaluation will be made at the time of 30 cases registered for this study.

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DOES THE USE OF LONG-TERM ASPIRIN REDUCE RISK OF POST OPERATIVE VTE IN GYNAECOLOGICAL CANCER PATIENTS

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Introduction/Background Gynaecological cancer patients are at elevated risk of VTE. Aspirin has shown to be effective in reducing arterial thrombosis risk. In a study looking at role of aspirin in reducing VTE risk in elderly cancer patients. Patients who received aspirin had a lower incidences of acute PE, DVT. In hospital mortality was lower in patients receiving long term aspirin who had lung, colon, pancreatic, prostate, kidney, breast cancer, lymphoma, and leukaemia. Aim of the study: To investigate the effect of long-term aspirin therapy on VTE rates post gynaecological cancer surgery.

Methodology A retrospective cohort study. 1085 gynaecological cancer patients who underwent surgery in St. James's Hospital between 2006 and 2019. The primary outcome variable was objectively confirmed VTE within 1 years of gynaecological cancer surgery. A secondary outcome was the effect of VTE on progression free and overall survival.

Results 1022 completed 1 year follow up. 498 (45.9%) ovarian cancer, 412 (38%) endometrial cancer and 107 (9.9%) cervical cancer. The mean age at time of surgery 57 (18–93). The mean BMI was 30 (14–73). 92 patients were on long term aspirin for medical comorbidities. 6 patients had missing data on aspirin use. A total of 74 patients had VTE during 1st year follow-up (7.24%). 5 patients who suffered a VTE were on long term aspirin therapy. There was no significant difference in VTE rates at 1 year in patients who were on long term aspirin compared with those who did not take aspirin (5.7% v 7.3%). Overall survival rate (P= 0.33) or on progression free survival (P=0.173) were similar in both groups.

Conclusion Our study showed that long term aspirin did not significantly affect VTE rates in gynaecological cancer patients. The number of patients in our study was small and these findings require confirmation with large scale studies.

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EFFECT OF ELAPSED TIME AFTER TREATMENT ON OVERALL QUALITY OF LIFE, NEUROTOXICITY, SEXUAL LIFE, LYMPHEDEMA, AND UTILITY IN OVARIAN CANCER SURVIVORS (OVQOL)

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Introduction/Background We examined the effect of elapsed time after treatment on overall quality of life, neurotoxicity, sexual life, lymphedema, and utility in ovarian cancer survivors.

Methodology This is a secondary analysis of a cross-sectional study which investigated overall quality of life, neurotoxicity, sexual life, lymphedema, and utility in ovarian cancer survivors. One hundred seventy six patients with epithelial ovarian cancer who received platinum-based chemotherapy as the first-line treatment and did not suffer a recurrence were included in this analysis. Associations of elapsed time after treatment with overall quality of life (NFOSI 18, NCCN/FACT Ovarian Symptom Index-18), neurotoxicity (NTX4), sexual life (FSFI-6K, Female Sexual Function Index Scoring), lymphedema (GCLQ, Gynecologic Cancer Lymphedema Questionnaire), and utility (EQ-5D, EuroQol-5 dimension) were visualized via line plot.

Results Overall quality of life (NFOSI 18) improved till 3 years (29 at 1 year -> 28 at 2 year -> 26 at 3 year) after treatment and plateaued. Neurotoxicity (NTX4) improved till 5 years after treatment (8 -> 7.5 -> 6->5), but it did not reach a normal level (score 0). Sexual life (FSFI-6K) improved till 3 years after treatment (4->7->10) and plateaued at score 10 indicating female sexual dysfunction (score<21). Lymphedema (GCLQ) not improved over time (15 -> 14 -> 16.5), and it did not return to a normal level over time (score>5). Utility (EQ-5D index) improved till 3 years after treatment (0.8250->0.875->0.925) and EQ-5D VAS improved gradually till 5 years after treatment (71.5->72->73->76->74) suggesting gradual recovery of utility over time.

Conclusion In ovarian cancer survivors, the quality of life, symptom burdens and utility slowly improved as elapsed time after treatment increases, but were not fully recovered.

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QUALITY OF LIFE IN PATIENTS WITH ADVANCED OVARIAN CANCER AFTER PRIMARY DEBULKING SURGERY VERSUS NEOADJUVANT CHEMOTHERAPY: RESULTS FROM THE RANDOMIZED SCORPION TRIAL

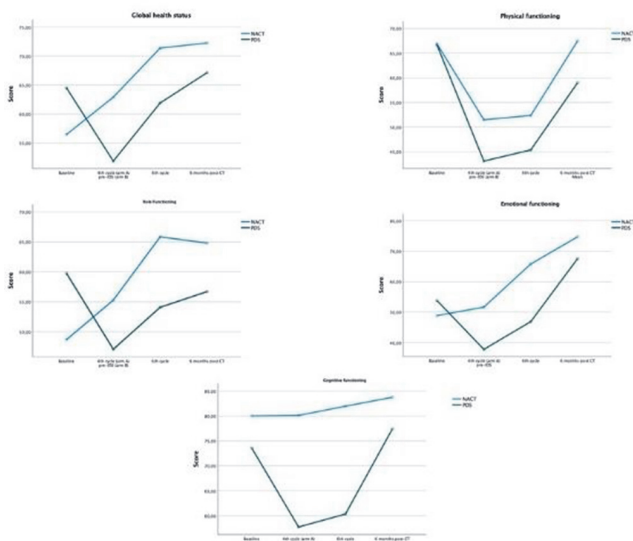
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Introduction/Background In the SCORPION trial, neo-adjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) was shown to achieve similar survival results with lower toxicities when compared with primary debulking surgery

(PDS), in patients with advanced ovarian cancer (AOC). Here, we analyze effects on quality of life (QoL).

Methodology the SCORPION trial is a single-Institution, superiority, randomized phase III trial enrolling AOC women with high tumor load assessed at staging laparoscopy. They were randomly assigned to undergo either PDS followed by systemic adjuvant chemotherapy (arm A, standard), or NACT followed by IDS (arm B, experimental). QoL was assessed as a secondary endpoint, using the EORTC quality of life questionnaire QLQC-30 and QLQ-Ov28. These were completed at study entry, at the 4th cycle or before IDS (in arm A and arm B, respectively), at the 6th cycle, and 6 months after the last cycle of chemotherapy (12 months after diagnosis).



Abstract 2022-RA-972-ESGO Figure 1

Results 171 patients were enrolled in the study period (PDS=84; NACT=87). QoL questionnaires were completed by 142 (83%) patients at baseline, and by 119 (69.6%) at 12-months. Using cross sectional analysis, we observed no significant difference between treatment arms in any of the QoL functioning scales at 12 months. A significant change in diarrhea was found at 12-months between study groups (group A vs group B, difference in mean score -8.6636, 95% CI -15.2805–2.0467; $p=0.009$). At longitudinal analysis, we found lower global health scores for those undergoing PDS than those receiving NACT (group A vs group B, difference in mean score 6.27, 95% CI 0.440–12.11; $p=0.035$). Similar results were found with regard of emotional and cognitive functioning.

Conclusion We found no difference in global QoL between treatment groups at 12 months; however, patients undergoing NACT followed by IDS reported higher mean quality of life in all scores of QOL functioning scales.

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MODIFIED MARTIUS FLAP TO REPAIR A COMPLEX PERINEAL FISTULA

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Introduction/Background The modified Martius flap is a vascularized adipose tissue flap from the labium majora between the bulbocavernosus and ischiocavernosus muscles. This pedicled flap receives arterial supply from the perineal branch of the internal and external pudendal artery and their collaterals. This procedure is a vaginal approach to repair a perineal fistula such as a vesicle-vaginal or vagino-rectal fistula.

Methodology The video presents a comprehensible 10 steps video of the surgical procedure to be reproducible easily.

Results 1. Intraoperative identification of the fistula by a mapping substance, cystoscopy and or rectoscopy if needed. 2. Anatomical direct repair of the fistulous tract: fistula tissue is circumcised with a scalpel through the vaginal wall with a margin of healthy tissue. 3. Design Martius flap: Incision over the labium major. 4. Design Martius flap: dissection of the fat-tissue flap with the vascular pedicle. 5. Tunnel creation: subcutaneous wide enough tunnel is made from the labium major to the fistula. 6. Transposition of the flap being careful with the vascularisation of the pedicle. 7. Cover and fix with the Marius flap over the fistula reparation in vagina. 8. Colocation a subcutaneous drainage (number 10). 9. Check the reparation with a mapping substance, cystoscopy and rectoscopy. 10. Suture the labial incision with an intradermal suture. The Martius flap procedure used to repair vaginal fistulas is a simple, safe, reproducible and effective technique with excellent functional aesthetic results.

Conclusion The Martius flap procedure used to repair vaginal fistulas is a simple, safe, reproducible and effective technique with excellent functional aesthetic results.