

Introduction/Background Perioperative morbidity is an undesirable but critical issue for gynecologic cancer patients. It may cause delay in subsequent treatment and escalate the cost of postoperative management. Various studies have identified potential risk factors for postoperative morbidity in non-gynecologic surgery. The aim of this study was to assess the pattern of perioperative complications for diagnosed or suspected gynecological malignancy and to identify risk factors for morbidity and mortality within 30 days

Methodology A prospective observational study of patients who underwent major surgery for diagnosed or suspected gynecological malignancy from November 2019 to December 2021. Details of age, BMI, comorbidities, ASA status, preoperative hemoglobin, serum albumin, surgery, and complications were collected. Clavien-Dindo grade II-V post-op complications were included in the analysis. Univariable and multivariable regression was used to identify predictors of complications

Results A total of 348 women were included in the analysis. The median age was 56 yrs, and 9.5% had an ASA grade ≥ 3 . One hundred and thirty-five patients had carcinoma endometrium, 173 patients had carcinoma ovary, 7 patients underwent radical hysterectomy for carcinoma cervix and 33 patients had other pathologies. Intraoperative complications were reported in 61 patients with the majority being intraoperative hemorrhage (78.6%). Clavien-Dindo grade 2 or more postoperative morbidity was reported in 95 patients (27.3%) among whom 79 patients had grade 2 complications. Nine patients had grade 3 complications and 7 had grade 4 complications. On analysis, the independent predictors for perioperative morbidity were the complexity of surgery (p-value 0.47) and ASA score ≥ 3 (p-value 0.037).

Conclusion The independent predictors for perioperative morbidity in gynecological malignancy were the extent of surgical resection and the ASA status of the patient irrespective of age, BMI, or other comorbidities.

2022-VA-1291-ESGO HOW TO GET OUT AND SOLVE A CHALLENGING SURGICAL CASE OF ENDOMETRIAL CANCER ENTRAPPED IN AN ENDOMETRIOSIS BLANKET. A SYSTEMATIC AND REPLICABLE SURGICAL APPROACH

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Introduction/Background Laparoscopic hysterectomy with bilateral salpingoophorectomy represents the gold standard technique in endometrial cancer. An unusual situation such as an associated deep endometriosis freezing the pelvis may occur making the procedure a challenge even for very expert surgeons.

Methodology A 48-year-old patient referred to our center with a histological diagnosis of endometrioid endometrial cancer G1, FIGO Ia, MMS (mismatch repair stability), p53 wild-type. The pre-clinical staging performed with transvaginal ultrasound and magnetic resonance, showed besides a picture of retro-cervical and rectum endometriosis and multiple pelvic adhesions. According to the guidelines the surgical planning is laparoscopic hysterectomy and bilateral salpingoophorectomy.

Results The operation situs showed an extremely complex situation, thus the so-called frozen pelvis. Neither the uterus

nor the adnexa were identifiable. The anterior compartment was overturned by the bladder that was cranially stretched totally covering the uterine fundus. The posterior compartment was even more subverted by strong adhesions and fibrosis that brought the sigma to cover the uterus until the fundus. The adnexa were inextricably embedded to the sigma, the pararectal tissue, the posterior broad ligaments and uterosacral ligaments. During the procedure a large endometriosis nodule was detected between the uterosacral ligaments and the broad posterior ligament infiltrating the retro cervical tissue, pararectal tissue e anterior rectal wall at two different levels creating a clepsidra rectal stenosis. The ureters appeared medialized from the fibrosis without sign of infiltrating endometriosis.

Conclusion Our surgical approach requires carefully evaluation and systematic and replicable steps that will help mostly in any situation. This video will show, with a step by step short description, how to perform a challenging mini-invasive surgery.

2022-RA-1317-ESGO ACUPUNCTURE DURING GYNECOLOGICAL ONCOLOGY SURGERY: A RANDOMIZED CONTROLLED TRIAL ASSESSING THE IMPACT OF INTEGRATIVE THERAPIES ON PERIOPERATIVE PAIN AND ANXIETY

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Introduction/Background In this study we explore the impact of a multimodal integrative oncology (IO) pre- and intraoperative intervention on pain and anxiety among patients undergoing gynecological oncology surgery

Methodology Study participants were randomized to three groups: Group A received preoperative touch/relaxation techniques, followed by intraoperative acupuncture; Group B preoperative touch/relaxation only; with a control group (Group C) receiving standard care. Pain and anxiety were scored before and after surgery using the Measure Yourself Concerns and Wellbeing (MYCAW) and Quality of Recovery (QOR-15) questionnaires, using Part B of the QOR to assess pain, anxiety and other quality-of-life (QoL) parameters.

Results A total of 99 patients participated in the study: 45 in Group A, 25 in Group B and 29 in Group C. The three groups had similar baseline demographic and surgery-related characteristics. Postoperative QOR-B scores were significantly higher in the treatment groups (A and B) when compared to controls (p=0.005), including for severe pain (p=0.011) and anxiety (p=0.007). Between-group improvement for severe pain was observed in Group A compared with controls (p=0.011). Within-group improvement for QOR depression subscales was observed in only the intervention groups (p<0.0001). Compared with group B, group A had better improvement of MYCAW-reported concerns (p=0.025).

Conclusion A preoperative touch/relaxation intervention may significantly reduce postoperative anxiety, possibly depression, in patients undergoing gynecological oncology surgery. The addition of intraoperative acupuncture significantly reduced severe pain when compared to controls. Further research is needed to confirm these findings and better understand the impact of intraoperative acupuncture on postoperative pain.