

aim of our study was to evaluate the features of the clinical course and to develop the surgical treatment tactic.

Materials The study involved 43 patients with intravenous leiomyomatosis, who underwent treatment in our clinic in 2010–2019.

Results Intravenous leiomyomatosis predominantly developed in reproductive and pre-menopause periods. Most patients (75,6%) had history of uterus leiomyoma. The group with non-intracardiac leiomyomatosis included 25 patients, with intracardiac – 18.

In the group of intracardiac intravenous leiomyomatosis the tip of the thrombus extended to the right atrium in 8 patients, to ventricle – in 8 patients, to pulmonary arteries – in 2 patients. In 6 patients the tumor thrombus extended from pelvis through internal iliac veins, in 6 – through ovarian veins, in 6 – through ovarian veins and internal iliac veins. The extent of surgery was hysterectomy with bilateral salpingo-oophorectomy, complete cytoreduction and thrombectomy. The surgery was performed in 10 patients by sternolaparotomic access, in 8 – by laparotomic. Two patients underwent surgery without cardiopulmonary bypass. Among 16 patients operated with cardiopulmonary bypass, the parallel extracorporeal circulation was used in 5 cases. All procedures were performed in one-stage approach. All patients are alive with no evidence of disease.

Conclusion This study is important step forward to the understanding of clinical course and developing the surgical management standards of disease.

IGCS20_1323

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MINIMALLY INVASIVE VERSUS OPEN RADICAL HYSTERECTOMY FOR STAGE IB2 CERVICAL CARCINOMA; AN UPDATED SURVIVAL ANALYSIS OF THE NATIONAL CANCER DATABASE

D Nasioudis*, E Ko, A Haggerty, L Cory, RL Giuntoli 2nd, SH Kim, MA Morgan, N Latif. *Division of Gynecologic Oncology, Penn Medicine, USA*

10.1136/ijgc-2020-IGCS.261

Introduction Evaluate outcomes of minimally invasive radical hysterectomy (MIRH) for patients with FIGO (2019) stage IB2 (tumor size ≥ 2 and < 4 cm) cervical carcinoma.

Methods Patients with pathological stage IB2 squamous, adenocarcinoma, adenosquamous carcinoma of the cervix, no history of another tumor, who underwent primary radical hysterectomy and lymphadenectomy with known mode of surgery, diagnosed between 2010–2015 with at least one month of follow-up were drawn from the National Cancer Database. Impact of MIRH (robotic-assisted or traditional laparoscopic) on overall survival (OS) was assessed with the log-rank test. A Cox model was constructed to control for confounders.

Results A total of 1304 patients were identified; 621(47.6%) had open, 134 (10.3%) laparoscopic and 549 (42.1%) robotic-assisted laparoscopic radical hysterectomy. Overall conversion rate was 3.5%. Open and MIRH groups were comparable in terms of age, presence of co-morbidities and

histology. Patients in both groups had a median of 18 lymph nodes removed ($p=0.83$). Patients who had MIRH had shorter hospital stay (median 1 vs 3 days, $p<0.001$). Unplanned re-admission rates were comparable between open and MIRH groups (3.6% vs 5.3%, $p=0.13$). Median follow-up was 39.1 months. Patients who underwent MIRH had worse OS compared to those who had an open approach, $p=0.006$; 4-year OS rates were 88.8% and 93.2% respectively. After controlling for patient age, race, insurance status, histology and presence of lymph-vascular invasion, MIRH was associated with worse survival (HR: 1.90, 95% CI: 1.24, 2.92).

Conclusions MIRH is associated with worse overall survival for patients with pathological stage IB2 cervical carcinoma.

IGCS20_1324

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SURGICAL COMPLEXITY AND INTRA-OPERATIVE FLUID MANAGEMENT INFLUENCE DURATION OF ICU CARE FOLLOWING CYTOREDUCTIVE SURGERY

A Collins*, S Spooner, J Horne, M Chainrai, E Moss, Q Davies, S Chattopadhyay, R Bharathan. *University Hospitals of Leicester NHS Trust, UK*

10.1136/ijgc-2020-IGCS.262

Introduction Increased routine radical cytoreductive surgery for advanced ovarian cancer has resulted in higher utilisation of intensive care settings for post-operative recovery. We aimed to identify peri-operative variables associated with extended ICU admission.

Methods A retrospective review of all patients admitted to the ICU following cytoreductive surgery for ovarian cancer in a tertiary referral centre from 2015–2019. Patients were categorised according to length of stay, < 48 hours and ≥ 48 hours. Peri-operative variables were compared using student's t-test or Fischer's exact test.

Results 56 patients were admitted to the ICU immediately post-operatively, 37 for < 48 h and 19 for ≥ 48 h (range 3–11 days). There were no differences between cohorts in terms of median age, BMI, Charleston co-morbidity index or whether the patient had received NACT. Intra-operative predictors of prolonged ITU stay included extended duration of surgery (313 v 242 mins, $p=0.020$), higher surgical complexity score (5.6 v 4.1, $p=0.016$), bowel resection (63.2% v 32.4%, $p=0.045$), extensive intra-operative fluid use (6071 v 3789 ml, $p=0.0002$), intra-operative blood transfusion (63.2 v 32.4%, $p=0.045$) and higher estimated blood loss (1594 v 835 ml, $p=0.013$). Post-operative variables associated with prolonged ITU admission included higher immediate post-operative lactate (2.31 v 1.56, $p=0.031$), lower post-operative albumin (23.5 v 28.5, $p=0.018$) or eGFR (74 v 83, $p=0.028$) and need for post-operative blood transfusion (89.5 v 40.54%, $p=0.005$).

Conclusions Utilising identified intra-operative risk factors to perform individualised risk assessments for prolonged ICU admission could be used to assist communication between surgeons and intensivists to improve planning of ICU resources.