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 sternalola-parotomic 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.

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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 Chairai, E Moss, Q Davies, S Chattopadhyay, R Bharathan. University Hospitals of Leicester NHS Trust, UK

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**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 <48h and 19 for >48h (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 (1394 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** Using 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.