Abstract 1089 Figure 2

cardiac surgeons, pathologists, oncologists and cardiovascular anesthesiologists were involved. A complete trans-thoracic echocardiogram was performed, showing an isoechoic, mobile, adherent to the tricuspid ring, 22 x 50 mm mass with non-smooth margins, resulting in obstruction of the right ventricular filling (gradient 7 mmHg). Cardiac magnetic resonance imaging (MRI) demonstrated a 41x35 mm, polylobed mass, adhered to the tricuspid ring on the inferior-posterior side, which incorporated the posterior and septal flaps of the tricuspid valve, extensively emerging in the ventricular cavity in the diastolic phase. The mass obstructed the right ventricular filling and its most caudal portion partially occupied, in the systolic phase, the outlet of the inferior vena cava in the atrium. Because of the life-threatening obstruction, the mass was removed by cardiac surgeons with sternotomy in extracorporeal circulation. During surgery, the mass was analyzed by pathologist, confirming the endometrial origin. Postoperatively, radiotherapy (RT) on the heart was performed, followed by second line CHT with Liposomal Doxorubicin till February 2021.

Result(s)* In February 2021 cardiac MRI was performed, showing no evidence of disease. Complete response of the oropharyngeal and abdominal recurrences was also detected. But the woman presented with neurological symptoms, as partial paralysis of the legs. Encephalic MRI was performed showing brain metastases. The woman underwent pan-encephalic RT with subsequent reduction of those lesions.

In June 2021, the woman is still alive without neurological nor other symptoms.

Conclusion* A multidisciplinary approach is essential to treat rare EC metastases. Reference centers for the treatment of EC must have specialists from other disciplines available, to ensure the best clinical practice.

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OPTIMISING OUTCOMES FOR LAPAROSCOPIC HYSTERECTOMY IN PATIENTS WITH MORBID OBESITY

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Introduction/Background* Operating on patients with a significantly raised body mass index (BMI) represents a significant challenge to the surgical and the anaesthetic team. Hysterectomy for early-stage uterine cancer is usually performed via laparoscopy.

We aimed to evaluate whether a two consultant 'buddy operating' approach improves on intra-operative and post-operative outcomes in patients undergoing total laparoscopic hysterectomy (TLH) for endometrial cancer who are morbidly obese.

Methodology A prospectively selected cohort of 25 patients with a BMI 47-70 undergoing TLH was divided into two groups according to whether the first assistant to the Gynaecology consultant was a registrar (ST3-7), or a consultant ('buddy operating'). Anaesthetic time, operating time, intraoperative estimated blood loss (EBL), requirement for high dependency unit (HDU) bed and length of stay (LOS) were compared in the two groups.

Result(s)* Average 'buddy' operating time was significantly shorter compared to the registrar-assistant group (01:31h vs 01:59h respectively; $p < 0.001$); a similar trend was seen with the average total anaesthetic time (02:48h vs 03:23h respectively; $p < 0.001$). EBL was less in the 'buddy operating' group (39 mls) vs registrar-assistant group (169 mls; $p < 0.001$). Post-operatively, LOS was shorter in the 'buddy operating' group as compared to the registrar-assistant, though not significantly so (1.13 vs 1.59 days; $p = 0.109$). 2 of the total patients (8%) required a one-night stay in HDU for observation due to their co-morbidities, both in the registrar-assistant group. Mean BMI, age, ASA and comorbidities were similar in the two groups.

Conclusion* In patients with a significantly raised BMI, TLHs by two consultants vs consultant and registrar are associated with better intra and post-operative outcomes, including reduced overall anaesthetic time, operating time, and EBL. There is an association with a reduced length of overall hospital stay, though this was not significant.

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IMPLICATIONS OF OBESITY IN ENDOMETRIAL CANCER

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Introduction/Background* Over half of the endometrial cancers (EC) are caused by obesity, known as an independent risk factor. In Romania, in the last years the obesity rate had an alarming growth, with many high grade cases that influence the clinical management of the disease, the surgical procedure, radiotherapy planning, and the survival rate.