factors for recurrence. 35 patients were treated with a recurrence of a BOT. FSS was repeated in 11 (36.7%) patients. After FSS, the recurrence rate was 1/11 (9%). After complete surgical staging, 3/24 (12.5%) patients experienced a recurrence.

**Conclusion** Patients with BOT who receive a quality assured treatment have a very low risk of a malignant transformation. After individual consideration, FSS is safe in BOT in early FIGO stages. Patients should be counseled about a higher risk of recurrence in cases of FSS, especially in higher FIGO stages. In selected cases, FSS can also be reconsidered in the recurrence situation.

### 2022-RA-1545-ESGO UTERINE TRANSPOSITION: IS IT AN OPTION FOR FERTILITY SPARING IN LOCALLY ADVANCED CERVICAL CANCER

Maria Ercilia Ibarra, Sebastián Altuna, Martín Mariano Ballarin, Maria Magdalena Betti, Carolina Maya, Tomás Demarco, Juan Carlos Balparda. *Ginecologia, Hospital universitario Austral, Provincia de Buenos Aires, Argentina*

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**Introduction/Background** In Argentina, cervical cancer is the second most frequent and 1,600 women die from this cause per year. Conventional fertility preservation surgical treatments are not viable treatment options in advanced stages. Uterine transposition was promoted by Dr. Reitán Ribeiro.

**Methodology** We present two cases reports of patients with cervical cancer FIGO 2018 stage IIIC1 despite this, they insisted on preserving fertility. Both nulliparous, 29 and 34 years old, the first case referred with Loop Electrosurgical Excision Procedure (LEEP): 0.7x0.5 cm with squamous no queratinizante carcinoma + HSIL in endocervix. The second case had LEEP: 1.3x1.2x0.3 cm with endocervical adenocarcinoma and compromised margins. Both had Magnetic Resonance (MR) without residual tumor; only finding: 44 mm and 8 mm obturator lymph node respectively. PET-CT: Distant hypermetabolic foci not seen. Oocyte cryopreservation in both. Subsequently, the first surgery: laparoscopic sentinel lymph nodes with intraoperative frozen-section confirming macrometastasis. The uterus and ovaries were transposed without the cervix to the upper abdomen. Ultrasound was used to guide the section on the uterus, leaving a uterine remnant of at least 1 cm suitable for cerclage. With the cervix in the pelvic position, primary treatment: concurrent chemoradiotherapy with cisplatin (6 cycles) and brachytherapy was started on postoperative day 20. Subsequently, in the second surgery, a simple trachelectomy was performed and repositioning of the uterus in the pelvis with negative margin frozen section

**Results** After 18 and 10 months of follow-up with physical examination, images and cytology-HPV cotesting, no signs of recurrence.

**Conclusion** We emphasize the importance of strict informed consent, explaining risks and benefits, especially in this controversial case that goes against scientific evidence. They were carefully selected cases with tumours less than 2 cm, without residual disease by MR post LEEP, and the best treatment tested by stage was respected without delay. Pending longer follow-up in time.

### 2022-RA-1599-ESGO PREGNANCY ASSOCIATED BREAST CANCER: ABOUT 10 CASES

Amal Chermiti, Hajer Bettaieb, Rahma Bouhmida, Nesrine Souayeh, Meriem Ouederni, Hadir Lamiri, Mohamed Frikha, Wael Mbarki, Hadhami Rouiss, Hedhili Oueslati, Chaouki Mbarki. *Gynecology and obstetrics, Regional hospital ben Arous Tunisia, Tunis, Tunisia*

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**Introduction/Background** Pregnancy-associated breast cancer (PABC) is defined as breast cancer diagnosed during pregnancy or in the first postpartum year. While it is relatively uncommon (occurring in 1 per 3000 pregnancies), it represents a challenge to both the patient and the multidisciplinary team. we ought in this study to describe, the clinical, paraclinical and management of pregnancy associated breast cancer.

Methodology we conducted a retrospective single-center cohort study of 10 patients diagnosed and treated for breast cancer during pregnancy between 2005 and 2022 in the obstetric and gynecology department of Ben Arous hospital.

**Results** Five patients were diagnosed during the second trimester, 3 during the first trimester and 2 in the postpartum period. A suspicious area was detected by ultrasound in 10 of 15 women. A recurrent abscess was present in 2 cases and the biopsy revealed the cancer. Five patients had positive hormone receptors and 7 sub expressed. One patient was in stage 0, 2 in stage 1, 2 in stage 3 and 5 in stage 4. Three patients decided voluntarily to legally terminate their pregnancies. Seven patients were treated with chemotherapy during pregnancy after the second trimester using anthracycline-based treatment. Three patients had gestation-related complications including preterm labor, intrauterine growth restriction dyspnea and chemotherapy related granulocytopenia.

Conclusion pregnancy associated breast cancer is a rare entity. It is associated with a high number of complications. A multidisciplinary approach is needed and patients should be an integral part of therapeutic decisions.

## Miscellaneous

### 2022-RA-128-ESGO ULTRASOUND ASSESSMENT OF PATHOLOGICAL LYMPH NODES IN GYNECOLOGIC CANCERS

Ahmed Elagwany. *Alex uni, Alexandria, Egypt*

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**Introduction/Background** Lymph nodes can be affected in gynecologic cancers and they are uplifting the stage of cancer. They are a poor prognostic factor for cancers. They usually need radiotherpay if they are affected by metastasis. Usually they are detected by CT scan and MRI during assessing any pelvic malignancy. Ultrasound can be used for detecting suspicious nodes. We are aiming here to spot the light over this and showing a pictorial essay for nodes detected on ultrasound

**Methodology** Nodes are pathological on stage 3 cancer vulva (of inguinal ones and stage 4 if pelvic ones), stage 3 endometrial cancer (in pelvic ones and stage 4 if inguinal ones or scalene ones), Stage 3 cancer cervix (if pelvic and stage 4 if

paraaortic ones), Stage 3 cancer ovary for pelvic and paraaortic ones. The approach for visualizing lymph nodes starts at the inguinal canal and proceeds towards the diaphragm. A transvaginal examination visualize lymph nodes related to external iliac vessels and the obturator fossa.

**Results** Pathological nodes involved by metastasis has a peripheral or mixed perfusion as an early sign. The shape of an infiltrated lymph node is round, with loss of the hilum sign and inhomogeneous and hypoechogenic. Necrosis, calcification or lymph-node deposits produce a heterogeneous pattern. Later, there is extracapsular growth and irregular margin. Lymph nodes can have a large size more than 2 cm but it is not correlated to malignancy. Nodes are assed based in shape, echogenicity, regularity, homogencity and vascularity. Usually if 2 abnormal signs are seen on ultrasound, this indicates a pathological node apart from size.

**Conclusion** Ultrasound can be used in assessing lymph nodes.

## 2022-RA-156-ESGO MINIMALLY INVASIVE VERSUS OPEN ABDOMINAL APPROACHES FOR EARLY-STAGE CERVICAL AND ENDOMETRIAL CANCER: A META-ANALYSIS OF PROSPECTIVE RANDOMISED CONTROLLED TRIALS (RCTS)

[1,2]Inès Ongenda, [3]Léa Leufflen. [1]*University of Exeter Medical School, Exeter, UK*; [2]*World Bank Group, Washington, DC, DC*; [3]*Private Practice, Lyon, France*

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**Introduction/Background** To investigate if minimally invasive surgical techniques lead to higher disease-specific mortality and all-cause mortality at 4.5 years for patients with early-stage cervical and endometrial cancer.

**Methodology** PubMed/Medline and EMBASE were searched for results from inception to 2021. Prospective randomised controlled trials reporting disease-specific mortality and all-cause mortality at 4.5 years for patients who had minimally invasive or open procedures for early-stage cervical cancer (< II) or endometrial cancer (< III) were selected. Stata 17 was used to conduct a random-effects meta-analysis generating relative risk estimates, odds ratios and 95% CIs. Heterogeneity was examined, small-study effects (Egger's test), publication bias and study quality (RoB2) assessments were performed.

**Results** Seven randomised clinical trials between 2001 and 2020 including 4320 patients from 7 countries were included. Two RCTs for cervical cancer and five RCTs for endometrial cancer were selected. Of these, 2584 (60%) patients had minimally invasive surgery, and 1736 (40%) patients had open abdominal surgery. The non-statistically significant risk of all-cause mortality was 18% higher (RR 1.18, 95% CI 0.80, 1.76, $I^2$50.5%) and of disease-specific mortality was 26% higher for patients who underwent minimally invasive surgery compared to open abdominal surgery (RR 1.26, 95% CI 0.83, 1.89, $I^2$21.4%). However, p = 0.403 (all-cause mortality) and p = 0.265 (disease-specific mortality) indicated little evidence against the null hypothesis. There were no small study effects, little evidence of publication bias and study quality was generally high.

**Conclusion** Based on a systematic review of the literature and meta-analysis of prospective randomised-controlled trials for patients with early-stage cervical and endometrial cancer, minimally invasive surgery could be associated with a non-significant higher risk of all-cause mortality (18%) and disease-specific mortality (26%) at 4.5 years compared to open abdominal surgery. However, as p > 0.05 and the CI included 1, this meta-analysis was inconclusive.

## 2022-RA-165-ESGO SURGEON-ADMINISTERED TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK VERSUS PLACEBO AFTER MIDLINE LAPAROTOMY IN GYNECOLOGIC ONCOLOGY: A DOUBLE-BLIND RANDOMIZED TRIAL

[1,2]Laurence Bernard, [2]Melissa Lavecchia, [2]Gabrielle Trepanier, [2]Sarah Mah, [2]Alida Pokoradi, [2]Justin M McGinnis, [2]Mohammad Mohammad Alyafi, [3]Bryan Glezerson, [2]Julie Nguyen, [2]Vanessa Carlson, [2]Limor Helpman, [2]Laurie Elit, [2]Waldo Jimenez, [2]Lua Eiriksson, [2]Clare Reade. [1]*The University of Texas MD Anderson Cancer Center, Houston, TX*; [2]*Juravinski Cancer Centre, Hamilton, ON, Canada*; [3]*McGill University, Montreal, QC, Canada*

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**Introduction/Background** Surgeon-administered Transversus Abdominis Plane (TAP) block is a contemporary approach to providing postoperative analgesia. We evaluated its efficacy in a double-blind, randomized, placebo-controlled trial, hypothesizing that TAP blocks would decrease total opioid use in the first 24 hours postoperatively. Secondary outcomes included pain scores, postoperative nausea and vomiting, incidence of clinical ileus, time to flatus, and hospital length-of-stay.

**Abstract 2022-RA-165-ESGO Table 1** Patient characteristics and outcomes

| | Bupivacaine (n=38) | Placebo (n=41) | p-value |
|---|---|---|---|
| **Patient factors/operative variables** | | | |
| Age, mean±SD | 60.8 ± 14.5 | 58.9± 13.4 | |
| BMI, mean±SD | 29.5±6.8 | 29.1±8.5 | |
| *Type of incision* | | | |
| Infra-umbilical, *n* (%) | 60.5 | 63.4 | |
| Supra-umbilical, *n* (%) | 39.5 | 36.6 | |
| *Type of surgery* | | | |
| Surgery involving upper abdomen, *n* (%) | 15.8 | 4.9 | |
| Surgery involving bowel resection, *n* (%) | 10.5 | 14.6 | |
| Surgery involving cytoreduction, *n* (%) | 29 | 24.4 | |
| **Outcomes** | | | |
| Dose of opioid (in morphine mg equivalents) received in first 24 hours of postoperative period, mean±SD | 98 ±59.2 | 100.8±44 | 0.85 |
| Dose of opioid (in morphine mg equivalents) received 24- 48 hours of postoperative period, mean±SD | 30.4±73.7 | 41.9±41.3 | 0.23 |
| Pain score 4 hours after surgery, mean±SD | 3.1 ±2.4 | 3.1 ±2 | 0.93 |
| Pain score, 8 hours after surgery, mean±SD | 2.9±1.8 | 3±2.1 | 0.76 |
| Clinically significant nausea or vomiting on postoperative day 1, *n* (%) | 2.6 | 2.4 | 0.95 |
| Time to flatus (in hours), mean±SD | 60.6±20.4 | 54.5±24.4 | 0.23 |
| Clinical ileus, *n* (%) | 10.8 | 14.6 | 0.62 |
| Time to discharge (in hours), mean±SD | 88 ± 44.5 | 89.7 ±45.6 | 0.86 |