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)

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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

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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