paraaortic ones), Stage 3 cancer ovary for pelvic and para-
aortic 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 per-
ipheral 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 assessed based in shape,
echogenicity, regularity, homogeneity 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.

Introduction/Background

To investigate if minimally invasive surgery could be associated with a non-signifi-
cantly 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.

METHODS

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 with early-stage
cervical and endometrial cancer.

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 mini-
mally 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, I²50.5%) 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, I²21.4%). 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 gener-
ally 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, mini-
mally invasive surgery could be associated with a non-signifi-
cantly 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.

Abstract 2022-RA-165-ESGO Table 1

<table>
<thead>
<tr>
<th>Patient factors/operative variables</th>
<th>Bupivacaine (n=38)</th>
<th>Placebo (n=41)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean±SD</td>
<td>60.8 ± 14.5</td>
<td>58.9 ± 13.4</td>
<td></td>
</tr>
<tr>
<td>BMI, mean±SD</td>
<td>29.5 ± 6.8</td>
<td>29.1 ± 8.5</td>
<td></td>
</tr>
<tr>
<td>Type of incision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infra-umbilical, n (%)</td>
<td>60.5</td>
<td>63.4</td>
<td></td>
</tr>
<tr>
<td>Supra-umbilical, n (%)</td>
<td>39.5</td>
<td>36.6</td>
<td></td>
</tr>
<tr>
<td>Type of surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery involving upper abdomen, n (%)</td>
<td>15.8</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Surgery involving bowel resection, n (%)</td>
<td>10.5</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>Surgery involving cytoreduction, n (%)</td>
<td>29</td>
<td>24.4</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose of opioid (in morphine mg equivalents) received in first 24 hours of postoperative period, mean±SD</td>
<td>98 ± 59.2</td>
<td>100.8 ± 44</td>
<td>0.85</td>
</tr>
<tr>
<td>Dose of opioid (in morphine mg equivalents) received 24–48 hours of postoperative period, mean±SD</td>
<td>30.4 ± 77.3</td>
<td>41.9 ± 41.3</td>
<td>0.23</td>
</tr>
<tr>
<td>Pain score 4 hours after surgery, mean±SD</td>
<td>3.1 ± 2.4</td>
<td>3.1 ± 2</td>
<td>0.93</td>
</tr>
<tr>
<td>Pain score, 8 hours after surgery, mean±SD</td>
<td>2.9 ± 1.8</td>
<td>3 ± 2.1</td>
<td>0.76</td>
</tr>
<tr>
<td>Clinically significant nausea or vomiting on postoperative day 1, n (%)</td>
<td>2.6</td>
<td>2.4</td>
<td>0.95</td>
</tr>
<tr>
<td>Time to Fluent (in hours), mean±SD</td>
<td>60.6 ± 20.4</td>
<td>54.5 ± 24.4</td>
<td>0.23</td>
</tr>
<tr>
<td>Clinical ileus, n (%)</td>
<td>10.8</td>
<td>14.6</td>
<td>0.62</td>
</tr>
<tr>
<td>Time to discharge (in hours), mean±SD</td>
<td>88 ± 44.5</td>
<td>89.7 ± 45.6</td>
<td>0.86</td>
</tr>
</tbody>
</table>
Methodology Patients with a suspected or proven gynecologic malignancy undergoing surgery through a midline laparotomy at one Canadian tertiary care centre were randomized to receive bilateral surgeon-administered, transperitoneal TAP blocks with a total of 40 mL of either 0.25% bupivacaine or normal saline (placebo), prior to fascial closure.

Results 38 patients were randomized to the bupivacaine arm, and 41 patients to the placebo arm. The mean age was 60 years and mean BMI was 29.3. A supra-umbilical incision was used in 38% of cases and bowel resection was performed in 12.7% of cases. Patient and surgical characteristics were evenly distributed. The patients who received the bupivacaine TAP block required 98±59.2 morphine milligram equivalents in the first 24 hours after surgery, while the placebo group received 100.8±44 MME (p=0.85). The mean pain score at 4 hours after surgery was 3.1±2.4 in the TAP group, versus 3.1±2 in the placebo group (p=0.93). Nausea and vomiting were reported in 2.6% vs 2.4% (p=0.95). Time to first flatus, rates of clinical ileus and length-of-stay were similar between subgroups. Subgroup analysis of patients with BMI <25 and patients who received an infra-umbilical incision did not show a difference.

Conclusion In this trial, surgeon-administered bupivacaine TAP block was not superior to placebo in reducing postoperative opioid requirements or improving other postoperative outcomes. These results differ from previous reports evaluating ultrasound-guided TAP block administration. Surgeon-administered TAP should not be considered standard of care in postoperative multimodal analgesia.

Gynecological malignancy cases were twice higher refusal rate to COVID vaccine compared to the breast cancer cases 13.5% vs 6.1% P < 0.01.

Multivariate analysis showed that CTH treatment increased risk of COVID 19 infection P <0.001, Odds Ratio 4.6, 95% CI (2.3, 9.4).

Injection site pain reported by 66.7%, fever, flu like symptoms were reported in 20.8% 12.5% respectively. Vaccine side effects reported with AstraZeneca & Pfizer 41.7%, 37.5%, respectively, while 16.7% of cases received Sinovac reported any side effects P < 0.001.

Gynecological cancer cases were at a higher risk to develop side effects post COVID 19 vaccination 29.2%, P < 0.01 with odds ratio 3.54 and 95% CI (1.2, 10.1). 90% of reported severe COVID 19 infection were diagnosed with advanced malignancy P <0.05.

Conclusion Higher vaccination refusal reported among elder patient with advanced stage gynecological cancers. Patients with cancer have increased risk to COVID 19 infection. There are no major safety concerns to receive COVID19 vaccination during CTH.

Introduction/Background Intraoperative multimodal analgesia.

METHOD "A CASE REPORT"

UTERUS WITH INTRACARDIAC EXTENSION:

Methodology A 46-year-old woman (G6:2–2) was admitted to the Gynecologic Oncology Department complaining of pain in her left thigh and swelling of her left leg. Previously (2012–2013) the patient was treated for non-Hodgkin’s lymphoma stage IV; progression of lymphoma or other malignant neoplasia was suspected. Performed CT angiography (CTA) of the pelvis, abdomen and chest, as well as transthoracic echocardiography. A solid tumor was found in the pelvis and a tumor thrombus in the left iliac veins, inferior vena cava with a transition to the right atrium.

Results In connection with the volumetric formations visualized on CTA in the pelvis and veins, a diagnostic laparotomy was performed. Laparotomy revealed uterine masses, a tumor biopsy and bilateral salpingo-oophorectomy were performed, and the diagnosis of IVL was morphologically confirmed. After an interdisciplinary consultation, the patient underwent a radical operation using cardiopulmonary bypass: hysterectomy with removal of a tumor thrombus from the pelvic veins, inferior vena cava and heart. Within 6 months there was no recurrence.

Conclusion Intraoperative multimodal analgesia is an extremely rare disease affecting predominantly premenopausal women. It should be suspected in women with uterine leiomysma presenting with signs of heart failure and tumor thrombus. An