and conducted a web-based survey on thromboprophylaxis practice. We adjusted the reported risk estimates for thrombo-
prophylaxis and follow-up length to determine baseline cumu-
lative incidence at 4 weeks post-surgery for each procedure.
We stratified VTE risk by patient risk factors as low (no
patient risk factors), medium (age >75, BMI >35, or VTE in
a 1st degree relative), or high (any combination or personal
VTE history). We used the GRADE approach to rate evidence
certainty.
Results We identified 7,556 titles and abstracts, of which 188
proved eligible, reporting on 37 gynaecological cancer surgery
procedures. The quality of evidence was generally very low or
low. 4-week risks of major bleeding and especially of VTE
varied widely between procedures, and between approaches
within the same procedure (tables 1–2).

Conclusion Our results suggest that extended thromboprophyl-
laxis is warranted in many gynaecological cancer procedures,
such as ovarian cancer surgery, total hysterectomy with lym-
phadenectomy and radical hysterectomy. In some procedures,
such as laparoscopic total hysterectomy without lymphadenec-
tomy, the risks of VTE and bleeding are closely balanced. In
these cases, decisions depend on individual risk prediction and
patient values and preferences.
previously operated area, which is more difficult to achieve with minimally-invasive approaches. Our aim was to describe the technical aspects, feasibility and complications derived from the application of the radioguided occult lesions localization (ROLL) in gynecologic oncology recurrence excision.

**Methodology**
All consecutive patients bearing localized relapses of a gynecologic tumor that were considered candidates for surgical excision were assessed to undergo a ROLL procedure. After multidisciplinary review of images and surgical indication, patients were considered as suitable for ROLL. Injection of the relapsed tumor was performed by ultrasonography or CT guidance. Relapses were localized using a gammaprobe by minimally-invasive surgery (laparoscopic or robotic surgery) when located in the abdomen, or percutaneously when located in the groin. Intraoperative and early (up to postoperative day 30) complications were prospectively recorded, and complications were graded according to Common Terminology Criteria for Adverse Events (CTCAE) version 5.0.

**Results**
A total of 8 patients underwent the procedure. Median age was 59 years (range: 35–87). Four patients had abdominal relapses, while four patients presented groin relapses. Mean operative time was 120 minutes (range: 30–190), while median estimated blood loss was 5 cc (range: 0–150 cc). All of the targeted lesions were successfully removed. No intraoperative complications were reported. One postoperative complication (inguinal lymphocele) was reported after surgery, corresponding to CTCAE grade 2 severity.

**Conclusion**
ROLL surgery is feasible for excision of recurrences of gynecological tumors.

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**Comparing Thoracic Epidural Analgesia to Surgeon-Administered Continuous Transversus Abdominis Plane Blocks in Gynaecologic Oncology Patients: A Retrospective Cohort Study**

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**Introduction/Background**
Post-operative analgesia comprises of a thoracic epidural (TEA) with multimodal adjuncts. Literature has shown transversus abdomen plane blocks (TAP) offer equivalent analgesia with potential secondary benefits. Our study assessed whether surgeon-administered continuous TAP blocks (cTAP) provided equivalent post-operative analgesia in Gynecologic Oncology patients undergoing abdominal surgery.

**Methodology**
A retrospective cohort study of patients undergoing abdominal surgery at McGill University Health Centre from January 2018–2022 was completed. During the CoVID-19 pandemic, an institutional practice change was made in January 2020 to offer a cTAP with IV rescue patient-controlled analgesia. Patients in the TEA group were treated per standardized Department of Anesthesia protocols. Patients in the cTAP group received a surgeon-administered TAP catheter insertion prior to fascial closure with infiltration of bupivacaine 2-2.5 mg/kg 0.5% diluted 1:1 NS + 10 mg dexamethasone divided bilaterally followed by an infusion of 5-10 cc/hour. Our primary outcome was self-reported pain (numerical rating scale (NRS 0–10)) at 24 h; secondary outcomes included NRS at 1 h, first flatus and bowel movement, vomiting, hospitalization length, and analgesia-related complications. Univariate and multivariate analyses were completed, adjusting for age, body mass index, estimated blood loss, and operative time.

**Results**
Two-hundred forty-four patients met study inclusion criteria: 135 and 109 patients received a TEA and cTAP, respectively. There was no difference in pain scores at 24 h between groups unadjusted (p=0.668) and adjusted (p=0.795). The cTAP group had significantly earlier flatus (-0.3 days, p<0.05), bowel movement (-0.7 days, p<0.05), hospital discharge (-1.4 days, p<0.05), less vomiting events (OR 0.5, p>0.05), and higher NRS at 1 h (1.3, p<0.05). The TEA group had more adverse events, hypotension, and inadequate pain control (p<0.05).

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**Abstract 2022-RA-993-ESGO Table 1**
Baseline demographic and clinical characteristics by types of anesthesia

<table>
<thead>
<tr>
<th></th>
<th>Epidural Group (n=135)</th>
<th>Tap Block Group (n=109)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>58.0 (48.0, 67.0)</td>
<td>58.0 (49.5, 66.0)</td>
</tr>
<tr>
<td>BMI</td>
<td>27.0 (23.5, 32.5)</td>
<td>26.6 (22.8, 32.2)</td>
</tr>
<tr>
<td>OR time</td>
<td>190.0 (152.0, 228.0)</td>
<td>218.0 (170.0, 256.0)</td>
</tr>
<tr>
<td>Estimated blood loss</td>
<td>400.0 (250.0, 800.0)</td>
<td>400.0 (250.0, 775.0)</td>
</tr>
<tr>
<td>Pain on day 1</td>
<td>2.0 (0.0, 3.0)</td>
<td>2.0 (0.0, 4.0)</td>
</tr>
<tr>
<td>NRS 1 hour</td>
<td>1.0 (2.0, 4.0)</td>
<td>4.0 (2.0, 5.0)</td>
</tr>
<tr>
<td>Day of first void</td>
<td>2.0 (1.0, 2.3)</td>
<td>1.0 (1.0, 2.0)</td>
</tr>
<tr>
<td>Urinary retention event</td>
<td>10 (7.4)</td>
<td>8 (7.3)</td>
</tr>
<tr>
<td>Day of Flatus</td>
<td>2.0 (2.0, 3.0)</td>
<td>2.0 (1.0, 3.0)</td>
</tr>
<tr>
<td>First BM</td>
<td>3.0 (2.0, 5.0)</td>
<td>3.0 (2.0, 4.0)</td>
</tr>
<tr>
<td>Vomiting event</td>
<td>52 (38.5)</td>
<td>30 (27.5)</td>
</tr>
<tr>
<td>Ileus event</td>
<td>14 (10.4)</td>
<td>5 (4.6)</td>
</tr>
<tr>
<td>Day of ambulation</td>
<td>2.0 (1.0, 3.0)</td>
<td>2.0 (1.0, 3.0)</td>
</tr>
<tr>
<td>Duration of admission</td>
<td>6.0 (5.0, 8.0)</td>
<td>6.0 (5.0, 7.0)</td>
</tr>
</tbody>
</table>