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 pecutaneously 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.

2022-RA-993-ESGO COMPARING THORACIC EPIDURAL ANALGESIA TO SURGEON-ADMINISTERED CONTINUOUS TRANSVERSUS ABDOMINUS 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 abdominus 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 bupivicaine 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 ($p<0.05$).

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

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

Abstract 2022-RA-993-ESGO Table 2 Unadjusted and adjusted for Age, BMI, EBL and OR time Primary Outcome and Secondary Outcomes

	Unadjusted (95% CI)	P-value	Adjusted (95% CI)	P-value
Primary Outcome				
Pain on day 1	0.1 (-0.5, 0.7)	0.668	0.1 (-0.5, 0.7)	0.795
Secondary Outcomes (Continuous)				
NRS 1 hour	1.2 (0.7, 1.8)	*<0.001*	1.3 (0.8, 1.9)	*<0.001*
Day of first void	-1.2 (-2.9, 0.5)	0.155	-1.3 (-2.9, 0.4)	0.124
Day of Flatus	-0.3 (-0.6, -0.01)	*0.042*	-0.3 (-0.6, -0.04)	*0.025*
First BM	-0.7 (-1.2, -0.3)	*0.003*	-0.7 (-1.1, -0.2)	*0.006*
Day of ambulation	-0.2 (-0.6, 0.2)	0.314	-0.3 (-0.7, 0.1)	0.137
Duration of admission	-1.2 (-2.3, -0.2)	*0.025*	-1.4 (-2.5, -0.3)	*0.011*
Secondary Outcomes (Dichotomous)	OR (95% CI)	P-value	OR (95% CI)	P-value
Urinary retention event	1.0 (0.4, 2.6)	0.984	1.2 (0.4, 3.2)	0.792
Vomiting event	0.6 (0.4, 1.1)	*0.072*	0.5 (0.3, 1.0)	*0.035*
Ileus event	0.4 (0.2, 2.2)	0.103	0.4 (0.1, 1.1)	0.073
Secondary Outcomes - Complications	Epidural Group (n=135)	Tap Block Group (n=109)		P-value
Adverse events	57 (42.2)	9 (8.3)		*<0.001*
Hypotension	19 (14.1)	3 (2.8)		*0.002*
Inadequate analgesia pain	29 (21.5)	6 (5.5)		*<0.001*
Day of catheter discharge	3.0 (2.0, 4.0)	2.0 (2.0, 3.0)		*<0.001*

Conclusion Our study offers a unique comparison of surgeon-administered cTAP blocks, showing similar analgesic effects with secondary benefits. Further prospective studies are needed to assess utilization of the cTAP block as routine post-operative analgesia.

2022-RA-1001-ESGO ANALYSIS OF POSTOPERATIVE WOUND INFECTIONS IN MALIGNANCIES OF THE FEMALE INTERNAL TRACT

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Introduction/Background Approximately 10% of all malignancies in women originate from the internal genitalia. Surgery is the main therapeutic approach. These procedures tend to be extensive multivisceral interventions and are associated with up to 15% wound infection rates (O'Donnell et al, 2019). The aim of the study was to determine perioperative risk factors for surgical site infections (SSI). A potential relationship between the perioperative antibiotic prophylaxis, the occurring pathogen spectrum, the antibiotic treatment versus surgical revision and the oncological outcome was investigated to identify risk factors and to improve the outcome by optimizing these factors.

Methodology In a monocentric study, a retrospective explorative analysis of epidemiological, clinical histopathological and microbiological data was performed. 700 women over the age of 18 with malignancies of the internal genitalia who underwent surgical treatment were included. Follow-up time was 30 days after surgery.

Results Within the patient population and according to the CDC-classification, 10.1% (71/702) SSIs and 3.3% (23/702) cases of a superficial wound dehiscence were diagnosed. In total 86.6% (608/702) underwent a laparotomy and 13.4% (94/702) a laparoscopy. There was a significant association between obesity ($p<0.001$), staples versus sutures ($p=0.019$) and laparotomy ($p=0.017$) and an increased risk for SSIs. The main pathogens detected were *Escherichia coli*, *Enterococcus faecalis* and *Pseudomonas aeruginosa*. Therapeutically, the wound infections were mainly treated by surgical revision (47.9%, 34/71) and pure antibiotic administration (36.6%, 26/71).

Conclusion An increased body mass index (BMI), staples for wound closure and a laparotomy are associated with an increased risk of SSIs. The pathogen spectrum is dominated by enterobacteriales. Decreasing SSIs is important in order to optimize the outcome of adjuvant therapy and minimize the rehospitalisation rates.

2022-VA-1026-ESGO THE CASE OF LAPAROSCOPIC RETRANSPLANTAION OF THE URETER – BOARI FLAP TECHNIQUE

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Introduction/Background Presenting the method of laparoscopic retransplantation of the ureteron the case of deep infiltrating endometriosis (DIE) with the technique of Boariflap

Methodology 39 – year old lady with the history of multiple intervention due to DIE. The lastredical surgery with the huger rectovaginal nodule and ureteric dissection due tothe infiltration of parametrium and extended hysterectomy due to DIE. She hadprotective JJ stenting of the right ureter. 3 months later after removing of thestent she had stenosis of right ureter and repair surgery was needed.

Results The patient had proposed the laparoscopic procedure of repairing the ureter.She had CT scan of the pelvis and the location of the stenosis was localized.Due to lack of the lumen of the ureter on a UroCT on the 5 cm middle length ofthe ureter the Boari flap technique of the ureter retransplatation was proposed.And performed.JJ stent was removed from the ureter 6 weeks after surgery.

Conclusion The patient was completely free of complains and the proper lumen and functionof the ureter was confirmed on urography and in cystoscopy. Laparoscopy is aperfect method to repair the ureteric complication even with use of morecomplicated method.