Introduction/Background Perioperative morbidity is an undesirable but critical issue for gynecologic cancer patients. It may cause delay in subsequent treatment and escalate the cost of postoperative management. Various studies have identified potential risk factors for postoperative morbidity in non-gynecological surgery. The aim of this study was to assess the pattern of perioperative complications for diagnosed or suspected gynecological malignancy and to identify risk factors for morbidity and mortality within 30 days.

Methodology A prospective observational study of patients who underwent major surgery for diagnosed or suspected gynecological malignancy from November 2019 to December 2021. Details of age, BMI, comorbidities, ASA status, preoperative hematocrit, serum albumin, surgery, and complications were collected. Clavien-Dindo grade II-V post-op complications were included in the analysis. Univariable and multivariable regression was used to identify predictors of complications.

Results A total of 348 women were included in the analysis. The median age was 56 yrs, and 9.5% had an ASA grade ≥ 3. One hundred and thirty-five patients had carcinoma endometrium, 173 patients had carcinoma ovary, 7 patients had other pathologies. Intraoperative complications were reported in 61 patients with the majority being intraoperative hemorrhage (78.6%). Clavien-Dindo grade 2 or more postoperative morbidity was reported in 95 patients (27.3%) among whom 79 patients had grade 2 complications. Nine patients had grade 3 complications and 7 had grade 4 complications. On analysis, the independent predictors for perioperative morbidity were the complexity of surgery (p-value 0.47) and ASA score ≥ 3 (p-value 0.037).

Conclusion The independent predictors for perioperative morbidity in gynecological malignancy were the extent of surgical resection and the ASA status of the patient irrespective of age, BMI, or other comorbidities.

2022-VA-1291-ESGO HOW TO GET OUT AND SOLVE A CHALLENGING SURGICAL CASE OF ENDOMETRIAL CANCER ENTRAPPED IN AN ENDOMETRIOSIS BLANKET. A SYSTEMATIC AND REPLICABLE SURGICAL APPROACH

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Introduction/Background Laparoscopic hysterectomy with bilateral salpingoophorectomy represents the gold standard technique in endometrial cancer. An unusual situation such an associated deep endometriosis freezing the pelvis may occur making the procedure a challenge even for very expert surgeons.

Methodology A 48-year-old patient referred to our center with a histological diagnosis of endometrioid endometrial cancer G1, FIGO Ia, MMS (mismatch repair stability), p53 wild-type. The pre-clinical staging performed with transvaginal ultrasound and magnetic resonance, showed besides a picture of retro-cervical and rectum endometriosis and multiple pelvic adhesions. According to the guidelines the surgical planning is laparoscopic hysterectomy and bilateral salpingoophorectomy.

Results The operation situ showed an extremely complex situation, thus the so-called frozen pelvis. Neither the uterus nor the adnexa were identifiable. The anterior compartment was overturned by the bladder that was cranially stretched totally covering the uterine fundus. The posterior compartment was even more subverted by strong adhesions and fibrosis that brought the sigma to cover the uterus until the fundus. The adnexa were inextricably embedded to the sigma, the pararectal tissue, the posterior broad ligaments and uterosacral ligaments. During the procedure a large endometriosis nodule was detected between the uterosacral ligaments and the broad posterior ligament infiltrating the retro cervical tissue, pararectal tissue e anterior rectal wall at two different levels creating a clepsydra rectal stenosis. The ureters appeared medialized frozen the fibrosis without sign of infiltrating endometriosis.

Conclusion Our surgical approach requires carefully evaluation and systematic and replicable steps that will help mostly in any situation. This video will show, with a step by step short description, how to perform a challenging mini-invasive surgery.