Intrathecal morphine, a way to achieve opioid-free pain management within an era

Introduction/Background
The main aim of the study was to evaluate whether intrathecal morphine (ITM) can replace systemic opioids in postoperative pain control in patients undergoing radical surgery for gynaecological cancers.

Methodology
This is a retrospective, single center study analyzing perioperative data of patients who underwent surgery for a gynaecologic malignancy from January 2019 to December 2021. We reviewed use of systemic opioids in 24 hours after surgery, visual analog scale (VAS, 0–10) assessing pain during the first 24 hours and time from ITM application to the first VAS 3 or more was measured. We analyzed the most frequent side effects of ITM — incidence of pruritus, nausea and vomiting, hypotension and respiratory depression during the first 24 hours after ITM administration.

Results
Intrathecal morphine in dose 0.2 – 0.5 mg was used in 170 patients before the surgery for postoperative analgesia. Systemic opioids were administered during the first 24 hours after surgery in 3 cases. 65 patients had one or more side effects. 3 patients had pruritus, 46 patients suffered from nausea or vomiting. Postoperative hypotension with vasopressors treatment was reported in 26 cases. There was no case of respiratory depression requiring mechanical ventilation.

Conclusion
Our results show that intrathecal morphine is an effective method of postoperative analgesia in patients undergoing radical oncogynecologic surgery. We managed to minimize the use of systemic opioids with a very low frequency of side effects.

Comparison of prognostic risk scoring systems to predict outcomes in gynecologic oncology patients

Introduction/Background
Surgery remains the main therapeutic module in many gynecologic malignancies. During the last decades, the operations have shifted to more radical and extensive procedures with multivisceral resections. This trend has come with increased complication rates, hospitalization, and healthcare costs. Multiple risk score systems have been proposed in order to identify high risk patients for adverse outcomes and Charlson comorbidity index (CCI) is widely accepted as highly accurate. This study compares CCI against Memorial Sloan Kettering-Frailty index (MSK-FI).

Methodology
Retrospective analysis of 975 patients that have been operated in the Gynecologic Oncology Unit of our Department. The records of the patients were reviewed for risk factors and the department’s readmissions and ICU admissions and deaths were retrieved from the complications database of the unit.

Results
26.3% of the patients had complications. Univariate analysis showed that older patient and patients of stage 3 and 4 and those with greater CCI had greater probability of complication. CCI but not MSK-FI, remained significant in multiple analysis. Twenty-two patients (2.3%) died. Multiple logistic regression showed that Greater age, CCI and MSK-FI were significantly associated with greater probability of dying. 1.7% of the patients were admitted to ICU. Greater age, CCI or MSK-FI were significantly associated with greater probability of being admitted to ICU. From multiple logistic regression emerged that only greater CCI was significantly associated with greater probability of being admitted to ICU. Median duration of hospitalization was 7 days (IQR: 5–10 days). Greater age, stage, CCI or MSK-FI were significantly associated with greater duration of hospitalization. When multiple linear regression was conducted it was found that CCI was significantly associated with greater duration of hospitalization.

Conclusion
From our analysis MSK-FI is less accurate in identifying high risk patients for complications, ICU admission, increased hospitalization or complications related death.

Minimally invasive versus open pelvic exenteration in gynecological malignancies: A propensity-matched survival analysis

Introduction/Background
The primary endpoint of the present study was to compare the disease-free survival (DFS) of patients undergoing open versus minimally invasive pelvic exenteration (PE). Secondary endpoints cancer-specific survival (CSS) and peri-operative morbidity.

Methodology
Multi-center, retrospective, observational cohort study. Patients undergoing anterior or total PE for gynecologic cancer by minimally invasive and open approach between 2010–2021 were included. Positive para-aortic/inguinal lymph nodes and with distant metastases were excluded. A 1:2 propensity match analysis between patients undergoing minimally invasive and open PE was performed to equalized baseline characteristics.

Results
117 patients were included, 78 (66.7%) and 39 (33.3%) in the open and minimally invasive group, respectively. No significant difference in intra- and post-operative complications was evident between the two study groups (trend toward higher incidence of complications in open
approach patients). Patients undergoing open PE received higher number of intra-operative transfusions (p=0.013). Median DFS was 17.0 months versus 17.0 months in open versus minimally invasive group, respectively (p=0.632). Median CSS was 30.0 months versus 26.0 months in open versus minimally invasive group, respectively (p=0.800). Positive surgical margins at final histology was the only significant factor influencing the risk of recurrence (HR:2.378, 95%CI 1.313-4.308) (p=0.004), while tumor diameter ≥50 mm at time of PE was the only significant factor influencing the risk of death (HR:1.833, 95%CI 1.080-3.111) (p=0.025).

Conclusion No survival difference was evident when minimally invasive was compared to open PE in patients with gynecological cancer. No difference in peri-operative complications, but higher intra-operative transfusion rate in open group, was evident.

2022-RA-1350-ESGO ROBOTIC COMPARED TO LAPAROSCOPIC ERGONOMICS IN PATIENTS WITH GYNECOLOGICAL CANCER

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Introduction/Background Robotic surgery has advantages over laparoscopic surgery, including 3D vision, greater precision, articulated instruments, improvement of the surgical field and ergonomics. The aim of this study is to evaluate if robotic surgery improves ergonomic in different surgical procedures compared to laparoscopic surgery in gynecological cancer.

Methodology Comparative study between robotic and laparoscopic surgery carried out in a tertiary hospital from 2007 to 2019. Data from a survey completed by surgeons after each surgical procedure for gynecological cancer were analyzed. Patients operated were diagnosed of endometrial, ovarian or cervical carcinoma. The survey evaluated ergonomics parameters with scores between 1 and 10 in both surgical approaches in different surgical procedures. Surgical procedures were grouped according technical difficulty: hysterectomy with double adnexectomy, hysterectomy with lymphadenectomy (pelvic or pelvic and para-aortic), radical hysterectomy and para-aortic lymphadenectomy. Basic demographic characteristic and ergonomics were compared between both approaches.

Results A total of 534 surveys were collected, 347 in the robotic group and 187 in conventional laparoscopic group. Patients in the robotic surgery group had a higher BMI, greater morbidity and therefore higher ASA scores. No differences were observed between robotic and laparoscopic surgery groups regarding the question related to the degree of difficulty of the surgery perceived by the surgeon (p=0.151). The group of robotic surgery obtained lower scores on questions related to fatigue (Robotic 3.2 vs Laparoscopic 5.5), comfort (Robotic 9.1 vs Laparoscopic 6.4), and limb (Robotic 1.3 vs Laparoscopic 4.4) and back pain (Robotic 1.8 vs Laparoscopic 4.3). Statistically significant differences were observed in questions related to the surgeon’s fatigue (p=0.000), the degree of comfort (p=0.000) and limb or back pain (p=0.000).

Conclusion Robotic surgery improves the ergonomics of surgery for gynecological cancer patients in different surgical procedures with several degrees of difficulty.

2022-RA-1397-ESGO COVERING ALL ANGLES; A CASE REPORT DEMONSTRATING WHY LATERAL PORT ENTRY MUST BE PERPENDICULAR

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Introduction/Background Over 14 million minimal access surgeries (MAS) are performed globally each year, with its use continually rising. MAS are often preferred due to reduced length of hospital stay, reduced infection rates and minimal scarring. Although rare, postoperative port site bowel herniation can occur and has serious consequences. The Royal College of Obstetricians and Gynaecologists guidance recommends perpendicular port entry and rectus sheath closure for any non-midline port >7 mm.