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.

**Introduction/Background**

Robotic surgery has advantages over laparoscopic surgery in gynecological cancer. No difference in peri-operative complications, but higher intra-operative transfusion rate in open group, was evident.

**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.

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**Conclusion**

Robotic surgery improves the ergonomics of surgery for gynecological cancer patients in different surgical procedures with several degrees of difficulty.
Methodology This is a report of a 77-year-old lady who presented with intestinal obstruction following robotic hysterectomy for high-grade endometrial cancer. The surgical notes, surgeons’ reflection and patient’s management were critically appraised and key notes were reviewed to prevent future similar complication.

Results A patient underwent a robotic total hysterectomy and bilateral salpingo-oophorectomy for presumed stage 1B endometrial cancer. Day 5 post-discharge, she re-presented with abdominal pain, vomiting and constipation. Computerised tomography scan showed dilated bowel loops, in-keeping with bowel obstruction, due to an incarcerated left incisional hernia. She had an explorative laparoscopy, which identified a left iliac fossa port site hernia. The small bowel loops were reduced and showed no evidence of ischaemia. Interestingly, the port site measured 15 mm, despite a 7 mm incision being previously performed. The port site was closed using ‘Prolene’ suture. Postoperatively, the patient’s symptoms resolved and she was discharged. On reflection, the surgeon recalls using a bevelled entry technique to insert the port, which may have increased the diameter of the incision. Furthermore, the robotic arm movement may have increased torque at the port site and the rectus sheath was not sutured when closing despite the port site being >7 mm.

Conclusion Surgeons must acknowledge the risk of lateral port site herniation, ensure lateral port site entry is always perpendicular and suture the rectus sheath if the opening is >7 mm.

Abstract 2022-RA-1410-ESGO Table 1

<table>
<thead>
<tr>
<th>Class Indicator 1 (LDH tot vs. UMG)</th>
<th>Indicator 2 (UMG vs. LDH5)</th>
<th>Indicator 3 (p)</th>
<th>(c) UMG &gt; 40 – 0.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDH</td>
<td>LDH5</td>
<td>p (LDH5, UMG)</td>
<td>UMG</td>
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<td></td>
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</table>

Abstract 2022-RA-1410-ESGO Figure 1

Conclusion An accurate risk assessment in uterine lesions would suggest clinicians which is the most appropriate diagnostic and therapeutic approach for each affected woman. The new patented algorithm R.A.U.L., once validated by prospective studies, would allow to better stratify the risk of sarcoma in order to limit open approaches and offer conservative treatment in women with no or low-risk and ensure oncological safe procedures in women at high-risk.

Abstract 2022-RA-1417-ESGO

EVALUATION OF THE GYNAECOLOGY ONCOLOGY SURGERIES COMPLICATIONS AT UHL

Introduction/Background University Hospital of Leicester (UHL) is a tertiary centre for gynaecology oncology, we aim to evaluate the complication rates across different operative modalities that was performed by the gynaecology oncology