

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  $\geq 50$  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-1365-ESGO CAN WE REDUCE THE RISK OF ANASTOMOTIC LEAKAGE IN THE BOWEL SURGERY BASED ON 100 CASES OF MODIFIED ICG TECHNIQUE USED IN DEEP INFILTRATED ENDOMETRIOSIS?

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**Introduction/Background** Anastomotic leakage is one of most serious complications of intestinal surgery. Our task is to compare two laparoscopic techniques in different risk factors of bowel anastomosis leakage in DIE patients.

**Methodology** We divided 138 patients into 2 groups: Group A: 30 patients with classical 'surgical' technique of bowel resection. Group B: 100 patients who had laparoscopic 'tailored' bowel segmental resection with ICG vascular visualization and fibrin sealant use. Both groups were divided into subgroups due to complexity of the surgery. Different risk factors of anastomotic leakage were taken into analysis.

**Results** (1) The occurrence of bowel anastomosis leakage was higher in group A 3/30 (10%) than in group B – 2/100 (2%) (2) Low localisation of the tumor (below 60 mm) – 4 cases in group A was connected with 1 leakage (25%), in group B – 10 cases, - 1 – leakage (10%) (3) Complexity of the surgery and anastomotic leakage – group A1 – only bowel – 12,5% (2/16) of leakage, group A2 – bowel and uterus – 7,2% (1/14), group B1 – only bowel- no leakage, group B2 – bowel and uterus- 2,7% leakage (1/36), group B3 – bowel and urinary tract organ – no leakage (0/5), group B4 – bowel with urinary tract organ and uterus – 5.2% (1/19) of leakage, group B5 – multiple segments of bowel with uterus and urinary tract organs – no leakage.

**Conclusion** (1) The 'tailored' bowel resection, with ICG visualization and usage of fibrine material reduce the number of anastomosis leakage to 2% (2) Complexity of the surgery has the impact on the risk of leakage. (3) The low localisation of the endometriotic changes has the impact on higher risk of anastomosis leakage, but using modified laparoscopic technique reduces it compared with classical one.

### 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.

**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 salpingoophorectomy 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.

**2022-RA-1410-ESGO THE NEW ALGORITHM FOR THE RISK ASSESSMENT IN UTERINE LESIONS (R.A.U.L)**

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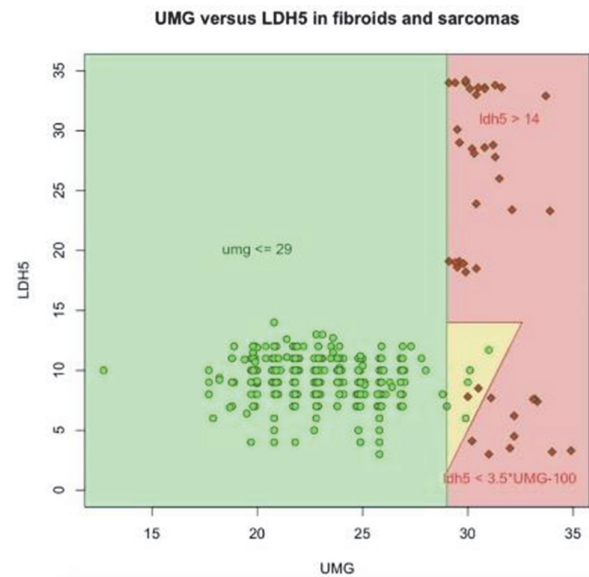
**Introduction/Background** The Uterine mass Magna Graecia (U.M.G.) risk index, resulting from the inverse relationship between LDH1 and LDH3, help clinicians in discriminating between no-risk and high-risk uterine masses. The aim of the present study was to verify whether other LDH isoenzymes interact with the U.M.G. index in better stratifying the risk of uterine sarcoma.

**Methodology** The U.M.G. database, (data from 2254 patients, 2211 uterine fibroids and 43 sarcomas) was assessed again. A detailed exploratory analysis was performed and a machine learning technique was employed for identifying which were the most accurate indicators to classify, in association with the U.M.G. risk index, the risk of malignancy among uterine masses.

**Results** Tree indicators of sarcoma risk were identified: total LDH, LDH5 and point 'p' [p(LDH5, UMG)] (figure 1). Table 1 shows cut-off values for each indicator. UMG risk index, total LDH, LDH5 and point 'p', were integrated into an algorithm for the Risk Assessment in Uterine Lesions (R.A.U.L.) that allows to classify our population of women, with an accuracy closed to 100%, into 3 classes of risk: class A (no-risk), B (low-risk) and C (high-risk). When two or three indicators are in 'class c' there is a high risk of sarcoma; when three indicators are in 'class a' there is no risk of sarcoma;

when indicators do not fall into the above two conditions, a low risk of sarcoma has to be considered 'class b'.

**Abstract 2022-RA-1410-ESGO Table 1** Class Indicator 1 (LDH tot vs. UMG) Indicator 2 (UMG vs. LDH5) Indicator 3 (p) (c) UMG > 40 – 0.05



**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.

**2022-RA-1417-ESGO EVALUATION OF THE GYNAECOLOGY ONCOLOGY SURGERIES COMPLICATIONS AT UHL**

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