

### 2022-RA-1511-ESGO ENDOMETRIAL STROMAL SARCOMAS – A 12 YEAR SINGLE CENTRE EXPERIENCE

Dimitrios Giannouloupoulos, Sofia Lekka, Kalliopi Kokkali, Dimitrios Korfiatis, Eugenia Karavioti, Christos Iavazzo, George Vorgias. *Gynaecological Oncology Department, Metaxa Cancer Hospital, Piraeus, Greece*

10.1136/ijgc-2022-ESGO.457

**Introduction/Background** Endometrial stromal tumors (EST) represent less than 1% of all uterine malignant neoplasms. Those include endometrial stromal nodule (ESN), low-grade stromal sarcoma (LGESS), high-grade stromal sarcoma (HGESS), undifferentiated uterine sarcoma (UUS), uterine adenocarcinoma (ADENOSA) and uterine tumor resembling ovarian sex cord tumor (UTROSCT). Treatment typically includes a combination of surgery and chemotherapy. Radiotherapy may be also used for local control. Herein we present a case series of 14 patients.

**Methodology** We found a total of 14 patients (median age 60.4). 7 patients had stage I disease, 2 stage II, 1 stage III and 5 stage IV. Early stage patients were mostly managed with surgery with/without adjuvant endocrine therapy and chemotherapy. Advanced disease patients received endocrine therapy and/or chemotherapy.

**Results** 2 ADENOSA patients are still in remission 3 years after surgery alone and 2 UTROSCT patients are in remission 1 and 3 years after surgery alone. 1 stage I UUS patient is free of disease 5 years after surgery and adjuvant chemotherapy. 1 patient with stage I LGESS, 1 patient with stage II LGESS and 1 patient with stage IV LGESS were lost to the follow up. 1 patient with LGESS stage I experienced distant relapse 3 months postoperatively and has been receiving multiple regimens of chemotherapy for 3 years ever since, with rapidly progressive disease nonetheless. 1 patient with stage II LGESS experienced pelvic recurrence 2 months post surgery, she was managed with chemoradiation and has developed upper abdominal disease 3 years postoperatively. 2 patients with extensive metastatic disease stage IVb were referred to palliative care. 2 patients with stage IVb LGESS and HGESS were managed with endocrine therapy and chemotherapy; however, they died at the one year mark.

**Conclusion** Endometrial stromal tumors are rare neoplasms; a combination of surgical cytoreduction, endocrine therapy and chemotherapy is the standard treatment approach.

### 2022-VA-1522-ESGO NEW KEYSTONE FLAP APPLICATION IN VULVO-PERINEAL RECONSTRUCTIVE SURGERY FOR VULVAR CANCER

<sup>1</sup>Alfonso Altieri, <sup>1</sup>Giuseppina Fais, <sup>1</sup>Giulia Carboni, <sup>1</sup>Giuseppe Deo, <sup>1</sup>Maria Luisa Fais, <sup>1</sup>Andrea Ungredda, <sup>2</sup>Andrea Figus, <sup>1</sup>Valerio Mais, <sup>1</sup>Stefano Angioni, <sup>1</sup>Michele Peiretti. <sup>1</sup>Department of Surgical Sciences, Division of Gynecology and Obstetrics, University of Cagliari, Cagliari, Italy; <sup>2</sup>Department of Surgical Sciences, Plastic Surgery and Microsurgery Unit, University of Cagliari, Cagliari, Italy

10.1136/ijgc-2022-ESGO.458

**Introduction/Background** This report aimed to illustrate the video-guided application of the Keystone perforator island flaps (KPIF) technique in a patient with diagnosis of vulvar cancer.

**Methodology** Eight patients were selected for the study: seven of them underwent radical vulvectomy for vulvar squamous cell carcinoma (SCC), and one underwent vulvar wide excision

for Paget disease. The Keystone perforator island flaps technique was adopted for all these vulvar reconstruction. The team approach comprised both a gynecologic oncologist and a plastic surgeon in all procedures. The defects were successfully covered by the Keystone flap technique in all patients.

**Results** Bilateral Keystone flaps were taken from the medial and proximal region of the thighs, with incision lines coinciding with the natural skin folds. When flaps vitality was determined, each one was positioned along the perineal midline for labia majora and vaginal opening reconstruction. Final reconstructive step coincided with skin and vaginal mucosa suture. No post-operative short complications in the described case were observed.

**Conclusion** The Keystone technique is an extremely simple and effective solution, easily applicable and reproducible. KPIF technique warrants an excellent vascular supply and does not require delicate perforator dissection. Additionally, it is associated with minimal morbidity in donor sites, a lower risk of flap necrosis and lower intraoperative and postoperative complications. Keystone flap method also yields good aesthetic and functional results by preserving shape and contour, avoiding differences in skin coloration and preserving sensitivity with an excellent cosmetic outcome in terms of patient satisfaction and postoperative scars and with an acceptable complication rate. Further studies with larger sample size are required to evaluate the efficacy of this technique.

### 2022-RA-1523-ESGO TO STUDY THE IMPACT OF IMPLEMENTATION OF ENHANCED RECOVERY AFTER SURGERY (ERAS) PROTOCOL ON PERIOPERATIVE OUTCOMES IN GYNECOLOGY ONCOLOGY SURGERY PATIENTS

<sup>1</sup>Urvashi Miglani, <sup>2</sup>Dipali Taneja, <sup>1</sup>Poonam Lul. <sup>1</sup>Obs and Gynae, DDU Hospital, New Delhi, India; <sup>2</sup>Anaesthesia, DDU Hospital, New Delhi, India

10.1136/ijgc-2022-ESGO.459

**Introduction/Background** ERAS guideline 2019 outlines the most current recommendations of the ERAS Society Group for the perioperative management of patients undergoing gynaecologic/oncology surgery, and is based on the best available evidence. The primary clinical benefits of implementing these protocols are shorter hospital, length of stay and reduced post-operative complications (including respiratory complications) in low, medium and high complexity gynaecologic oncology surgeries. In view of the above facts, the present study is planned to study the influence of implementation of ERAS protocol on postoperative recovery and outcome in gynaecologic oncology patients.

**Methodology** The study population comprises of all gynaecologic oncology patients more than 18 years of age who undergo laparotomy with a provisional or proven diagnosis of cancer of the uterus, cervix or ovary. The patients were randomized in two groups by block randomization: Group E-ERAS protocol and Group C- Conventional protocol The following measures were taken for Group E patients: preoperative bathing, no preoperative sedative medication, preoperative antibiotic within 60 minutes of incision, no long-acting opioids, no drains or nasogastric tube, compression stockings postoperatively, low molecular weight heparin given postoperatively, use of chewing gum in postoperative phase,