# 2022-RA-1511-ESGO

**ENDOMETRIAL STROMAL SARCOMAS – A 12 YEAR SINGLE CENTRE EXPERIENCE**

Dimitris Giannouloupoulos, Sofia Lekka, Kalliopi Kokkelos, Dimitrios Kosfias, Eugenia Karavioti, Christos Iavazon, George Vorgias. Gynaecological Oncology Department, Metaxa Cancer Hospital, Piraeus, Greece

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**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 adenosarcoma (ADENOSA) and uterine tumor resembling ovarian sex cord tumor (UTROSC). 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 UTROSC 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.

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# 2022-VA-1522-ESGO

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**TO STUDY THE IMPACT OF IMPLEMENTATION OF ENHANCED RECOVERY AFTER SURGERY (ERAS) PROTOCOL ON PERIOPERATIVE OUTCOMES IN GYNECOLOGY ONCOLOGY SURGERY PATIENTS**

1Urvashi Miglani, 2Dipali Taneja, 1Poonam Laul. 1Obs and Gynaec, DDU Hospital, New Delhi, India; 2Anaesthesia, DDU Hospital, New Delhi, India

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**Introduction/Background**

ERAS guideline 2019 outlines the most current recommendations of the ERAS Society Group for the perioperative management of patients undergoing gynecologic/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 gynecologic oncology patients.

**Methodology**

The study population comprises of all gynecology 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,