Conclusions Advanced stage at diagnosis was more prevalent in Arabs compared to Jewish women with cervical cancer, whereas stage-specific survival was similar. Possible attributing factors to the observed disparity, such as: health-care access, socioeconomic status, education, culture, molecular and genetic mechanisms, should be further investigated.

Objectives To evaluate racial differences in long-term survival of stage III ovarian cancer patients treated on clinical trials.

Methods Data on patients with optimally cytoreduced stage III ovarian cancer from three Gynecologic Oncology Group prospective clinical trials (GOG 114, 158, 172) were utilized. Chi-squared and multivariate Cox models were employed for analyses.

Results Of 1,432 patients, 94.1% were White (n=1,347) and 5.9% Black (n=85). Compared to Whites, Blacks were younger (64.7% less than age 57 vs 47.7%, p=0.002) and had more mucinous (7.1% vs 1.9%) and endometrioid (12.9% vs 10.2%) histologies (p=0.011). There was no difference in extended long-term survival (>15 year) for Blacks vs. Whites with regard to progression free survival (PFS, 10.6% vs. 15.1%, p=0.352) or overall survival (OS, 20.0% vs. 23.8%, p=0.245). On multivariate analysis, younger age (HR 0.82; 95% CI [0.73,0.93]; p=0.002), endometrioid histology (HR 0.69; 95% CI [0.56,0.86]; p=0.001), and grade I tumors (HR 0.64; 95% CI [0.51,0.80]; p<0.0001) were independent predictors of improved survival. However, race was not predictive of PFS (HR 1.11; 95% CI [0.87,1.40]; p=0.40) or OS (HR 1.17; 95% CI [0.91,1.50]; p=0.22) after adjusting for clinical factors.

Conclusions Black and White patients with optimally cytoreduced stage III ovarian cancer treated in clinical trials had comparable long-term survival. Younger age, endometrioid histology, and lower grade predicted improved survival outcomes.

Objectives Black patients with uterine cancer are less likely than White patients to be diagnosed with localized tumors. To inform reasons for such disparity, we compared the quality of diagnostic evaluation received by Black versus White patients with uterine cancer.

Methods Using 2008–2019 MarketScan Multi-State Medicaid Database, we identified 858 Black and 1,749 White patients with uterine cancer presenting with abnormal uterine bleeding (AUB). Quality of diagnostic evaluation was measured by delayed diagnosis (time between AUB reporting and uterine cancer diagnosis >1 year), not receiving guideline-recommended diagnostic procedures, and delayed time to first diagnostic procedure (time between AUB reporting and first diagnostic procedure >2 months). The association between race and the quality indicators was examined by logistic regressions adjusting for patient age, concurrent gynecologic conditions, comorbidities, and other characteristics.

Results Black patients were more likely than White patients to experience delayed diagnosis (11.3% versus 8.3%, p=0.01; adjusted OR, 1.71, 95% CI, 1.27–2.29) or to not receive guideline-recommended diagnostic procedures (10.1% versus 5.0%, p<0.001; adjusted OR, 1.94, 95% CI, 1.40–2.68). Even when they did receive recommended diagnostic procedures, Black patients were more likely than White patients to experience delay in time to first diagnostic procedure (10.9% versus 9.1%, p=0.16; adjusted OR, 1.46, 95% CI, 1.09–1.97). A lower proportion of Black than White patients underwent hysterectomy (32.4% versus 39.6%, p<0.001) and transvaginal/pelvic ultrasound (61.8% vs. 73.3%, p<0.001).

Conclusions Black and White patients with uterine cancer differed in the quality of diagnostic evaluation received, which may be one plausible reason for their disparity in stage at diagnosis.

E-poster viewing: Surgical techniques and perioperative management

Objectives Major open surgery for gynaecological cancer usually extensive and induced severe postoperative surgical site pain (POSP). We investigated whether perioperative wound infiltration system along with general anaesthesia effectively decrease POSP compared with traditional general anaesthesia followed by opioid in gynecologic oncology patient.

Methods This is prospective case control study includes 230 patients who underwent extensive pelvic surgery during gynaecologic cancer surgery. Study was conducted over one year (April 2016 to March 2017), where the wound infiltration...
group (n=115) which received (0.5% bupivacaine Hcl) as a single dose by subcutaneous infiltration at the site of incision before the skin closure, where the patients were still anaesthetized. Control group was treated with standard of care post operative systemic pain medication. The degree of pain was assessed by using visual analogue pain scores (1–10). On early postoperative day opioid consumption was also significantly reduced. Other elements of postoperative phase of ERAS program is also improved. Chi-square (x2) test, Fischer’s exact test, student t test were used in data analysis.

Results The group treated with perioperative wound infiltration with bupivacaine Hcl has lower pain score (<0.001), lower the consumption of opioid (<0.05), earlier mobilization (p <0.001), fewer consumption to bed (p <0.001), better patient satisfaction (p <0.05) but no significant difference in complication rate.

Conclusions Wound infiltration with bupivacaine Hcl into surgical site effectively reduced pain and opioid consumption and PONV. Bupivacaine Hcl is safe, well tolerated and superior to traditional systemic pain medication in both self reported and clinical out come among the patient who underwent extensive pelvic gynaec oncological surgery and enhance ERAS program

**EP372/#1117**

**TOTALLY IMPLANTABLE CENTRAL VENOUS CATHETER IN ONCOLOGIC PATIENTS: A SINGLE-CENTER EXPERIENCE**

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10.1136/ijgc-2022-ijgcs.461

### Objectives
Central venous catheters play a significant role in the management of oncologic patients. Totally implantable ports (port-a-caths) are completely enclosed systems without external lines, implanted in the subcutaneous tissue of the chest wall. The optimal catheter tip location is in the superior vena cava (SVC), at or above its junction with the right atrium. This paper aims to review the experience of port implantation and related complications in a single institution.

### Methods
In this retrospective study, the data were collected from patients who received treatment for hematologic malignancies or solid tumors after searching our internal database from January/2019 to December/2021. All ports were single lumen. All the devices were implanted under procedural sedation combined with locoregional anesthesia.

### Results
A total of 309 port-a-caths were implanted in 306 patients. Most procedures were performed by a surgical oncologist (281; 90.9%), and the right internal jugular vein was accessed in 250 (80.9%) patients. Only 4 cases (1.2%) demanded vein dissection, all the remaining were achieved by the Seldinger technique. A total of 10 (3.2%) port-a-caths were removed prematurely due to complications. None of the patients died due to complications. Infection was the major reason for port removal (4 patients, 1.29%), followed by catheter fracture (3 patients, 0.97%), skin dehiscence (1 patient, 0.32%), and port chamber rotation (1 patient, 0.32%).

### Conclusions
In this study, port-a-caths implanted with the Seldinger procedure, by surgical oncologists, through the right internal jugular vein, were safe and highly feasible for patients requiring infusional chemotherapy, in a single institution.

**EP373/#1103**

**CONCURRENT LAPAROSCOPIC HYSTERECTOMY AND BARIATRIC SURGERY FOR EARLY-STAGE ENDOMETRIAL CANCER AND ENDOMETRIAL INTRAEPITHELIAL NEOPLASIA: EARLY RESULTS FROM A PROSPECTIVE FEASIBILITY TRIAL**

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10.1136/ijgc-2022-ijgcs.462

### Objectives
The objective of this prospective study is to examine the feasibility of expedited referral to a bariatric surgeon and concurrent laparoscopic hysterectomy and bariatric surgery in obese women with presumed early-stage grade 1 endometrial carcinoma (EC) or endometrial intraepithelial neoplasia (EIN).

### Methods
Patients are recruited from the Brigham and Women’s Hospital gynecologic oncology clinic. Women with EIN or grade 1 EC and BMI ≥40 or BMI ≥35 with one or more obesity-related comorbidities are eligible. Patients are then referred to a bariatric surgeon with a goal of undergoing concurrent laparoscopic hysterectomy and bariatric surgery within 8 weeks for women with grade 1 EC, 12 weeks for EIN, and 6 months for EIN with IUD in situ.

### Results
Ten patients were screened and four enrolled. The average age of enrolled patients was 54.5 years old, and BMI was 44.11. Obesity-related comorbidities included hypertension, insulin-dependent diabetes, and obstructive sleep apnea. Average time between initial visit with a gynecologic oncologist and bariatric surgeon was 6.25 days. All women had EIN pathology. Patient #1 was unable to undergo either procedure because of an incidental gastric neuroendocrine tumor and failed cardiac stress test. Patient #2 declined bariatric surgery for personal reasons. Patient #3 was denied coverage by insurance for both procedures. Patient #4 has been approved by insurance and will undergo her concurrent surgeries.

### Conclusions
Early results demonstrate feasibility of an expedited referral process to a bariatric surgeon for obese women with EIN or grade 1 EC. The outcome of concurrent surgery remains to be seen.

**EP374/#164**

**A DOUBLE-BLIND RANDOMIZED TRIAL COMPARING SURGEON-ADMINISTERED TRANSVERSUS ABDOMINS PLANE (TAP) BLOCK WITH PLACEBO AFTER MIDLINE LAPAROTOMY IN GYNECOLOGIC ONCOLOGY**


10.1136/ijgc-2022-ijgcs.463

### Objectives
Surgeon-administered Transversus Abdominis Plane (TAP) block is a contemporary approach to providing postoperative analgesia. We evaluated its efficacy in a double-blind, randomized, placebo-controlled trial, hypothesizing that TAP blocks would decrease total opioid use in the first 24 hours postoperatively. Secondary outcomes included pain scores,