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 peri operative wound infiltration with bupivacaine HCl has lower pain score (<0.001), lower the consumption of opioid (<0.05), earlier mobilization (p < 0.01), fewer consumption to bed (p < 0.01), 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 outcome among the patient who underwent extensive pelvic gynaecological surgery and enhance ERAS program.

EP372/#1117
TOTALLY IMPLANTABLE CENTRAL VENOUS CATHETER IN ONCOLOGIC PATIENTS: A SINGLE-CENTER EXPERIENCE

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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%) of 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 BARIATIC SURGERY FOR EARLY-STAGE ENDOMETRIAL CANCER AND ENDOMETRIAL INTRAEPITHELIAL NEOPLASIA: EARLY RESULTS FROM A PROSPECTIVE FEASIBILITY TRIAL

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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/#1164
A DOUBLE-BLIND RANDOMIZED TRIAL COMPARING SURGEON-ADMINISTERED TRANSVERSUS ABOMINS PLANE (TAP) BLOCK WITH PLACEBO AFTER MIDLINE LAPAROTOMY IN GYNECOLOGIC ONCOLOGY


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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,