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 per operative 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 oncogical surgery and enhance ERAS program

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**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 editor referred process to a bariatric surgeon for obese women. Early results demonstrate feasibility of an expedited referral process 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).

**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 morbidities 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.

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**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-igcs.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 morbidities 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.

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


10.1136/ijgc-2022-igcs.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,
postoperative nausea and vomiting, incidence of clinical ileus, time to flatus, and hospital length-of-stay.

Methods Patients with a suspected or proven gynecologic malignancy undergoing surgery through a midline laparotomy at one Canadian tertiary care centre were randomized to receive bilateral surgeon-administered, transperitoneal TAP blocks with a total of 40 mL of either 0.25% bupivacaine or normal saline (placebo), prior to fascial closure.

Results 38 patients were randomized to the bupivacaine arm, and 41 patients to the placebo arm. The mean age was 60 years and mean BMI was 29.3. A supra-umbilical incision was used in 38% of cases. Patient and surgical characteristics were evenly distributed. The patients who received the bupivacaine TAP block required 98±59.2 morphine milligram equivalents in the first 24 hours after surgery, while the placebo group received 100.8±44 MME (p=0.85). The mean pain score at 4 hours after surgery was 3.1±2.4 in the TAP group, versus 3.1±2 in the placebo group (p=0.93). Nausea, time to first flatus, rates of clinical ileus and length-of-stay were similar between groups.

Conclusions In this trial, surgeon-administered bupivacaine TAP block was not superior to placebo in reducing postoperative opioid requirements or improving other postoperative outcomes. Surgeon-administered TAP should not be considered standard of care in postoperative multimodal analgesia.

Abstract EP375/#834 Table 1 ERAS elements and surgical variables

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N=60 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovary</td>
<td>55(91.7)</td>
</tr>
<tr>
<td>Primary Peritoneal</td>
<td>23(3)</td>
</tr>
<tr>
<td>Endometrium with peritoneal metastases</td>
<td>11(17)</td>
</tr>
<tr>
<td>Fallopian tube</td>
<td>11(17)</td>
</tr>
<tr>
<td>Recurrent Ovary</td>
<td>0(0)</td>
</tr>
<tr>
<td>Surgery</td>
<td>35(58.3)</td>
</tr>
<tr>
<td>CRS+HIPEC</td>
<td>25(41.7)</td>
</tr>
<tr>
<td>PCI (M)</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Objectives There is a lack of prospective evidence supporting recently published guidelines on the use of ‘enhanced recovery after surgery’ (ERAS) pathways in patients undergoing cytoreductive surgery (CRS) with or without Heated Intra peritoneal Chemotherapy (HIPEC). We assess the feasibility of ERAS in patients undergoing CRS with/or without HIPEC for ovarian/falloplian tube/primary peritoneal cancer.

Methods This study was carried out at three Indian centres, where a predefined ERAS protocol based on the ERAS-CRS-HIPEC guidelines was used. The complexity of the surgery was classified according to the surgical complexity score(SCS) by Aletti.

Results Sixty patients were included in the present analysis from January 2021 to March 2022 (table 1). 56.6% had a high SCS, 11.6% intermediate SCS and 31.6% a low SCS. The compliance to prehabilitation and intraoperative ERAS elements was nearly 100%. Carbohydrate preloading was not done in any of the patients. Mechanical bowel preparation and intra-abdominal drains were both used in 70% of the patients. Foley’s catheter was retained for over 24 hours in 98% and the nasogastric tube in 60% of the patients. The mean ICU stay was 2.5 ± 3.7days, and the mean hospital stay was 10.9 ± 6.7days. Grade 3-4 complications were seen in 16.7% of patients.

Conclusions The application of the ERAS protocol was selective with low compliance for the postoperative elements. This could be attributed to the complexity of the surgical procedure (>50% patients with a high SCS) and the lack of evidence for the safety of these practices in these complex procedures.

Abstract EP376/#727 THE EFFECT OF TRANSVERSUS ABDOMINIS PLANE BLOCK ON POSTOPERATIVE OPIOID USE IN GYNECOLOGIC ONCOLOGY PATIENTS UNDERGOING LAPAROTOMY WITH ENHANCED RECOVERY AFTER SURGERY (ERAS)

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Objectives To characterize the effect of transversus abdominis plane (TAP) blocks on opioid use and pain score in the first 48 hours following laparotomy for gynecologic malignancy.

Methods This retrospective cohort study assessed patients who underwent laparotomy by gynecologic oncology service from 2016–2017, and in 2020. Patients on long-acting opioids were excluded. Data were abstracted from the electronic health record and ERAS Interactive Audit System. Opioid consumption was converted to oral morphine equivalent dose (MED) in milligrams. Maximum pain was reported from 0 -10 on visual analogue scale (VAS). Mean opioid use at 12, 24, and 48 hours postoperatively was compared between patients with TAP block to those without using t-test. Stratification by