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.

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**ENHANCED RECOVERY PROTOCOL IN PATIENTS UNDERGOING CYTOREDUCTION WITH/WITHOUT HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY: A FEASIBILITY STUDY**

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**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 Intraperitoneal Chemotherapy (HIPEC). We assess the feasibility of ERAS in patients undergoing CRS with/without HIPEC for ovarian/fallopian 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 ± 3.7 days, and the mean hospital stay was 10.9 ± 6.7 days. 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.