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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**EP375/#834 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.

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**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.
postoperative NSAID use was performed to adjust for confounding.

**Results** 671 patients were included, 555 had a TAP block, 116 did not. Opioid use was reduced in patients with TAP blocks compared to those without TAP blocks at 12 hours (27.7 vs 20.5 mg MED, p=0.006), 12–24 hours (19.3 vs 12.3 mg MED, p=0.0004), and 24–48 hours postoperatively (27.7 vs 15.4 mg MED, p<0.0001). There was no statistically significant difference in max pain score. Stratification demonstrated a reduction in opioid use at 12 hours (20.3 vs 34.8 mg, p=0.017), 12–24 hours (14.5 vs 32.3 mg, p<0.001), and 24–48 hours (18.7 vs 56.0 mg, p<0.001) in patients not receiving NSAIDs (n=99) but not in patients who received NSAIDs (n=572) (p=NS).

**Conclusions** TAP blocks significantly decreased opioid use in patients not receiving NSAIDs undergoing gynecologic oncology laparotomy on an ERAS protocol.

**EP377/#246 INVOLVEMENT OF MESORECTAL LYMPH NODES IN PATIENTS UNDERGOING MODIFIED POSTERIOR EXENTERATION OR LOW ANTERIOR RESECTION FOR GYNECOLOGIC MALIGNANCIES**

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**Objectives** Determine the incidence of positive mesorectal lymph nodes and rectal wall invasion in patients undergoing a standardized surgical approach.

**Methods** A retrospective study of patients submitted to either modified posterior exenteration (MPE) or low anterior resection (LAR) for gynecologic malignancies, performed in one center, was performed.

**Results** Forty-one patients had undergone either MPE or LAR for gynecologic malignancies during the study. Forty-one percent of these underwent primary surgery, 39% interval surgery and 20% were submitted to surgery in the recurrence setting. Primary tumor site was ovary 87.7%, endometrium 10% and uterine corpus 2.3%. Sixteen patients had positive mesorectal lymph nodes at the time of total pelvic exenteration and 13 of these had rectal wall involvement (mucosa, submucosa or muscularis) (p <0.001). Only 6 patients without involvement of mesorectal lymph nodes had rectal invasion (p <0.001).

**Conclusions** Although the mesenteric is not a common pathway of lymphogenous metastatic spread in patients with primary gynecologic neoplasms, the mesenteric lymph nodes may be affected. We found that mesorectal lymph nodes were frequently positive for malignancy and this finding was more common if patients had rectal wall invasion. There is paucity of data regarding the optimal surgical approach in gynecologic cancers and studies are needed to determine the prognostic significance of positive mesorectal lymphnodes. One strength in our study was the standardized surgical approach, done by the same team, thus ensuring reproducibility. The authors acknowledge the limited sample size and the need to mature data to evaluate patterns of recurrence and its potential relation with our findings.

**EP378/#781 ADVANTAGES OF LAPAROSCOPY IN GYNECOLOGIC SURGERY IN ELDERLY PATIENTS**

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**Objectives** Older patients are at a higher risk for postoperative morbidity and mortality compared to younger patients. Laparoscopic surgery has been widely used as a minimally invasive method to reduce postoperative morbidity. However, it is prone to higher cardiopulmonary morbidity in elderly patients.

**Methods** This study included patients who received gynecologic surgery at over 55 years of age from 2010 to 2020. Surgeries with vaginal approach and operations for ovarian cancer were excluded. Surgical outcomes were compared between the open surgery and laparoscopy group. To consider age, the age cut-off was set as 65 which showed the most discriminative power in surgical outcomes between the younger and older groups.

**Results** Among 2983 patients, 28.6% underwent open surgery and 71.4% underwent laparoscopic surgery. In both young and elderly groups, the perioperative outcomes of laparoscopic surgery were better than those of the open surgery. In both open and laparoscopic surgery groups, patients older than 65 showed overall worse surgical outcomes. However, the age-related difference in the perioperative outcomes was less severe in the laparoscopic group. In linear regression analysis, the differences in EBL, transfusion, and hospital days between the younger and older groups were smaller in laparoscopy than in open surgery.

**Conclusions** Although the surgical outcome was worse in the older patients, the difference between the age groups was smaller when surgery was performed with laparoscopy. Laparoscopic gynecologic surgery offers more advantages and safety in elderly patients over 65 years of age.

**EP379/#1028 EXPECTATIONS AND CONCERNS OF WOMEN PRIOR TO NON-RECONSTRUCTIVE BREAST CANCER SURGERY**

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**Objectives** We aim to identify patient concerns and expectations, especially regarding their body image and their reproductive and sexual life prior to non-reconstructive breast cancer surgery to include such information in the patients’ preoperative counselling.

**Methods** This is a single-institution cross-sectional observational study based on a paper questionnaire to collect quantitative and qualitative data from a cohort of women due to undergo non-reconstructive breast cancer surgery between February 2022 and April 2022.