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.

### 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 path-way 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 frequent 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.

### 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. So, we compared surgical outcomes of open and laparoscopic gynecologic surgeries 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 laparoscopy 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.

### 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.