

(case 67, control 71) were included in this analysis and all patients underwent fascial closure as assigned. Baseline and surgical variables including portion of cancer surgery (51/67 [76.1%] vs. 62/71 [87.3%]; $p=0.088$), mean wound length (24.3 cm vs. 25.1 cm; $p=0.587$) and mean surgery time (219.4 minutes vs. 243.2 minutes; $p=0.257$) were balanced. The incidence of incisional hernia up to 1-year post-surgery was similar between case and control groups (0/67 [0.0%] vs. 1/71 [1.4%]; $p>0.999$). No treatment-related adverse events other than incisional hernia, pain, wound infection and dehiscence were reported.

Conclusion/Implications Fascia closure using barbed suture showed zero incisional hernia up to 1 year in patients who underwent midline laparotomy for gynecological disease, but fail to reduce incisional hernia compared to conventional method.

EP397/#420

TRANSVAGINAL NATURAL ORIFICE TRANSLUMINAL ENDOSCOPIC SURGERY (VNOTES) FOR EARLY STAGE ENDOMETRIAL CANCER

Shuk Tak Kwok*, Siew Fei Ngu. *The University of Hong Kong, Queen Mary hospital, Oandg, Hong Kong SAR, Hong Kong PRC*

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Introduction Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) has gained popularity in benign gynaecological conditions. The main advantage of vNOTES is to overcome the limitations of traditional vaginal hysterectomy, particularly on limited exposure and poor visualization. As vNOTES is a relatively new surgical approach, the experience with vNOTES in gynaecological malignancies is still lacking. The aim of this study was to evaluate the feasibility and safety of vNOTES in managing women with early-stage endometrial cancer and to evaluate the short-term oncologic outcome.

Methods A retrospective review was conducted on women who had vNOTES total hysterectomy and bilateral salpingo-oophorectomy (THBSO) for atypical endometrial hyperplasia or early-stage endometrial cancer at a university-affiliated gynaecologic oncology centre from January 2021 to February 2022. Demographics data, perioperative complications and oncologic outcome were reviewed.

Results 13 women had vNOTES THBSO done for atypical endometrial hyperplasia ($n=2$) and endometrial cancer ($n=11$). The mean age was 65.7 years [standard deviation (SD) 10.0] and the mean body mass index was 29.0 kgm² (SD 5.9). The mean blood loss and operative time were 200 ml (SD 130.1) and 175 minutes (SD 40) respectively. Two (15.4%) women required conversion to conventional laparoscopy. There were no perioperative complications including visceral injury, re-laparotomy or readmission reported. The mean length of hospital stay was 1.5 days (SD 0.5). The mean follow-up period was 15 months (SD 4.5), and there was no recurrence of endometrial cancer reported.

Conclusion/Implications vNOTES THBSO appeared to be a feasible and safe surgical approach for atypical endometrial hyperplasia and early-stage endometrial cancer.

EP398/#161

AIR TRAVEL AND THROMBOEMBOLISM AMONG POSTOPERATIVE GYNECOLOGIC CANCER PATIENTS: TEN-YEAR SINGLE-CENTRE EXPERIENCE PRIOR TO THE ERA OF POSTOPERATIVE EXTENDED THROMBOPROPHYLAXIS

¹Melissa Lavecchia*, ²Gabrielle Trepanier, ³Waldo Jimenez. ¹McMaster University, Division of Gynecologic Oncology, Hamilton, Canada; ²McMaster University, Department of Oncology, Hamilton, Canada; ³Juravinski Cancer Centre, McMaster University, Hamilton, Gynecologic Oncology, Hamilton, Canada

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Introduction Air travel and cancer surgery are associated with increased risk of venous thromboembolism (VTE). We sought to investigate the incidence of postoperative VTE in gynecologic oncology patients who flew before and after surgery, prior to the era of routine postoperative extended VTE prophylaxis.

Methods A retrospective cohort study identified 136 patients having travelled by air to and from surgery between 2008–2017. All patients underwent laparoscopy or laparotomy for suspected or confirmed gynecologic malignancy at a single tertiary cancer care centre. Medical records were reviewed for demographic, medical and outcome data, including diagnosis of VTE within 30 days of surgery.

Results The combined incidence of VTE (deep venous thromboembolism or pulmonary embolism) was 1.5%. One patient experienced a pulmonary embolism and one an upper extremity deep vein thrombosis. Both had advanced ovarian cancer and underwent debulking surgery (primary debulking and interval debulking). Only five patients in this cohort were discharged with extended duration anticoagulation due to a history of previous VTE. Sixty-two percent underwent laparotomy, of which 52% were debulking surgeries. Among these patients, 67% received neoadjuvant chemotherapy. Sixteen percent of patients had upper abdominal surgery and 48% a pelvic and/or para-aortic lymph node dissection.

Conclusion/Implications Although extended VTE prophylaxis was not routinely administered, the incidence of postoperative VTE was low. Within the Canadian context, where centralized cancer care often requires patients to travel long-distances to access specialized services, these findings offer additional reassurance that the postoperative risk of VTE is low even in this high-risk population.

EP399/#1266

COMPARATIVE STUDY OF ABDOMINAL SURGICAL APPROACH TRANSVERSE AND VERTICAL INCISION IN PELVIC TUMOR SURGERY

Delfina Ramirez Jimenez*, Gilberto Lopez Galvez, Isaac Luna Benitez, Jose Cruz Ramos. *Instituto Jalisciense de Cancerología, Ginecología Oncológica, El Retiro, Guadalajara, Jal., Mexico*

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Introduction To evaluate and compare the results of the transverse incision (TI) and the vertical incision (VI) in postoperative morbidity, resectability, and satisfaction in patients with pelvic tumors suspected of malignancy.

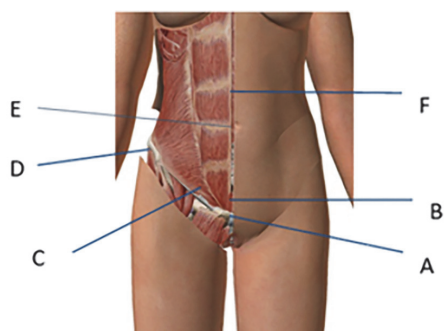
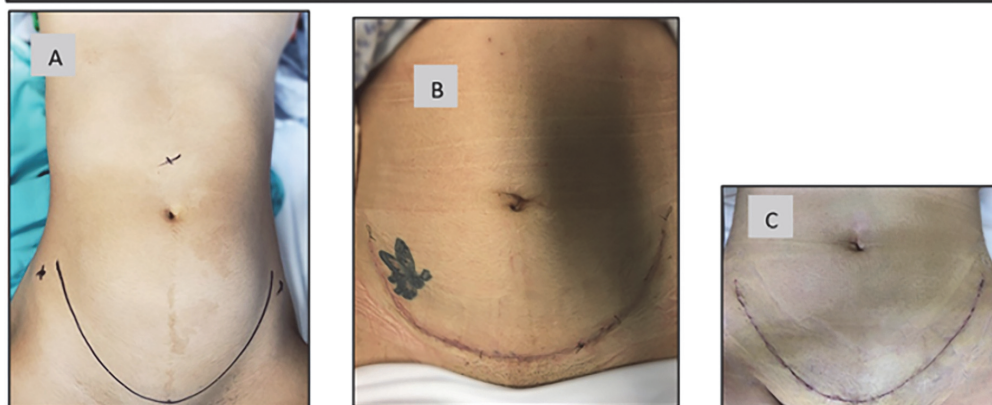


Figure 3.1 Surgical Limits of the Transverse Incision

A. Symphysis pubis B. 2 cm above symphysis pubis (lower limit) C. Outer edges of rectus abdominis muscle where it begins to ascend towards the iliac crest D. Iliac crest E. Umbilical scar F. Upper level of dissection

Figure 3.2 Photographs of the transverse incision A. Marking of the incision to be made and the surgical limits shown in a cross B. Scar 8 days after surgery C. Scar 10 days after surgery



Abstract EP399/#1266 Figure 1

Methods An open, non-randomized, prospective, and longitudinal clinical trial was carried out. Female patients treated at the morning and evening Pelvis clinic service of the Jaliscense Institute of Cancerology were included, with suspicion or confirmation of a malignant pelvic tumor, and were taken to a surgical procedure, in the period from November 1, 2017, to November 31, 2017. December 2018.

Results 41 patients, two groups, VI (n = 23) and those with a TI (n = 18). The results of surgical exposure, resectability, surgical times, morbidity, pain, and a questionnaire to assess patient satisfaction according to the aesthetic appearance of the incision made were compared. Patients with (VI) were older (p=0.000), weighed more (p= 0.011), and had a higher BMI (p= 0.000). No significant differences were found between the two groups in terms of surgical exposure, resectability, bleeding, surgical margins, number of pelvic or para-aortic nodes, postoperative complications, or pain. The level of satisfaction reported by the patient for the incision made was higher in the (IT) group (p= 0.000).

Conclusion/Implications Due to similar clinical results, the decision to perform a vertical or transverse incision should be made between the surgeon and the patient, taking into account the surgical procedure to be performed, the patient's characteristics, and the assessment of probable post-surgical complications.

EP400/#284

THE IMPORTANCE OF DEVELOPING THE CONTENT AND PROGRAM TO IMPROVE THE EFFECTIVENESS OF CADAVER SURGERY TRAINING

Masato Tamate*, Motoki Matsuura, Takaki Adachi, Nagisa Wada, Kazuma Yorozu, Sachiko Nagao, Shoko Kurokawa, Taishi Akimoto, Tsuyoshi Saito. *Sapporo Medical University, Gynecology, Sapporo, Japan*

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Introduction With the diversity of surgical techniques, off-the-job-training has also become more diverse. Among them, there have been many reports that cadaver surgery training (CST) is useful for surgical education. However, it is important for surgical education to have a purpose and to receive appropriate education. We report that it was necessary to have the program and content for each physicians' proficiency level.

Methods We have held five CST seminars at our hospital. This time, we analyzed the past CST questionnaires and questions. We examined how effective the program was in each physician proficiency level, with surgeon background as a qualitative factor and anatomical knowledge as a quantitative factor. Forty-five physicians participated in the study, divided by whether they were pre- or post-specialty, oncologist, or certified endoscopist. The number of experienced cases, number of complications, and motivation were also asked, and anatomical questions were answered on the web before and after CST.