



# IGCS 2022 Abstracts: Featured Surgical Films

Featured surgical film presenters will present their films in the below sessions.

Registered Delegates will have access to the surgical films within the Meeting Portal for on-demand viewing from 24 hours after the session ends until December 28, 2022.

## Surgical Session: Video Highlights

- Thursday, September 29, 2022
- 10:40 AM - 11:25 AM EDT
- Hall 405

## Surgical Session: Best Oral Film Submissions

- Saturday, October 1, 2022
- 10:05 AM - 11:05 AM EDT
- Hall 405

FF001 / #573

**Surgical Films**

**SURGICAL SESSION: VIDEO HIGHLIGHTS**

**29-09-2022 10:40 AM - 11:25 AM**

**NEAR-INFRARED ANGIOGRAPHY FOR ASSESSMENT OF RECTOSIGMOID ANASTOMOSES IN GYNECOLOGIC SURGERY**

Tiffany Sia, Oliver Zivanovic, Emeline Aviki

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**Introduction :** Rectosigmoid resections are frequently needed to achieve complete disease clearance during surgery for ovarian cancer. A severe complication from rectosigmoid resections is anastomotic leakage. Near infrared angiography (NIR) has been introduced to assess perfusion of vascular pedicles. Given the interest in usage of NIR to evaluate perfusion during rectosigmoid anastomoses, we have put together an instructional video demonstrating the setup and usage of this technology.

**Description:** Intraoperative setup for NIR will require a PINPOINT endoscopic fluorescence imaging system including a 10mm laparoscope, a PINPOINT rigid scope introducer, and 25 mg of indocyanine green (ICG) dye. After the segment of colon with disease is isolated and divided, perfusion is tested in the proximal limb by injecting 5 mL of the reconstituted ICG intravenously, allowing one minute for the dye to mobilize, and visualizing the bowel with the 10mm laparoscope. A perfusion defect is identified, and the decision is made to further resect the segment of bowel without perfusion. After this step, the trimmed proximal limb is brought down to the pelvis and anastomosed with the distal limb. Perfusion is tested after anastomosis by bringing placing the PINPOINT rigid scope introducer over the 10mm laparoscope and introducing the scope through the anus until the anastomotic ring is identified. 5mL of ICG is reinjected. Perfusion is tested again and found to be adequate.

**Conclusion/Implications:** Assessment of rectosigmoid anastomoses performed for gynecologic surgery using NIR with ICG is feasible, can be performed without the need for numerous additional instruments.

FF002 / #1121

**Surgical Films**

**SURGICAL SESSION: VIDEO HIGHLIGHTS**

**29-09-2022 10:40 AM - 11:25 AM**

**PRINGLE MANEUVER IS A SIMPLE AND USEFUL TECHNIQUE FOR HEPATIC RESECTIONS DURING OVARIAN CANCER CYTOREDUCTION**

Pedro Henrique Fernandes<sup>1</sup>, Rossini Lyria<sup>1</sup>, Claudio Lucena<sup>2</sup>, Fernanda Bomfati<sup>1</sup>, José Linhares<sup>3</sup>, Reitan Ribeiro<sup>4</sup>, Simoni Shiomi<sup>5</sup>, Audrey Tsunoda<sup>3</sup>

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**Introduction :** In selected cases, surgical removal of hepatic lesions should be performed in order to achieve a complete cytoreductive surgery for ovarian cancer patients. A Pringle maneuver consists in clamping temporarily the portal triad, composed by the hepatic artery, portal vein and the common bile duct. It significantly reduces bleeding with hepatic tissue preservation.

**Description:** In this video, we demonstrate how to easily apply a reversible Pringle maneuver with daily use resources. A xifo-pubic incision was performed for cytoreductive procedure, exposing the entire abdominal cavity. After identification of the epiploic (or Winslow) foramen, from lateral to medial, the lesser omentum was sectioned to safely access the portal triad. A Foley catheter, without the connection extremity, was inserted posteriorly to the hepatoduodenal ligament structures. A loop with the tip of the catheter passed through the lateral opening offers an adequate tourniquet for intermittent blood supply interruption, at the end of the procedure the tourniquet is relieved by pulling the loose end through the catheter opening. The second Pringle maneuver was performed with a laminar drain and a segment of a catheter, clipped with a vascular clamp. Both techniques can be applied by laparoscopy, and are detailed in another video

**Conclusion/Implications:** This video demonstrates the useful Pringle maneuver, performed with simple and reproducible technique.

**FF003 / #788**

**Surgical Films**

**SURGICAL SESSION: VIDEO HIGHLIGHTS**

**29-09-2022 10:40 AM - 11:25 AM**

**RADICAL TRACHELECTOMY WITH Laterally Extended Endopelvic Resection for Locally Advanced Cervical Cancer**

Min Young Park<sup>1</sup>, Soo Jin Park<sup>2</sup>, Hee Seung Kim<sup>1,3</sup>

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**Introduction :** Although radical trachelectomy after neoadjuvant chemotherapy is considered for fertility preservation in patients with locally advanced cervical cancer (LACC), its efficacy and safety are still controversial. Since R0 resection based on ontogenetic compartment theory can control tumor effectively, laterally extended endopelvic resection (LEER) during radical trachelectomy can be considered as a treatment option for loco-regional control without adjuvant radiotherapy in LACC and fertility preservation.

**Description:** A 28 year-old woman with cervical cancer visited the clinic hoping for fertility preservation. She had a 5 cm sized cervical mass with left parametrial invasion (PM) and pelvic lymph node metastasis (LM), suggesting stage IIIC1 disease. After neoadjuvant chemotherapy using five cycles of weekly cisplatin, left PM remained despite LNM regression. Due to her strong desire for fertility, we conducted radical trachelectomy with LEER.

**Conclusion/Implications:** We performed type C1 parametrectomy with mesometrial resection while preserving uterine artery on the right side and LEER on the left side during radical trachelectomy. As surgical margin was free after R0 resection, the patient received adjuvant chemotherapy using paclitaxel and carboplatin without radiotherapy. She showed regular menstruation without recurrence after five years and received assisted reproductive technology for pregnancy. Radical trachelectomy with LEER is a feasible treatment option for LACC patients who show tumor response after neoadjuvant chemotherapy with a strong desire for fertility.

FF004 / #603

**Surgical Films**

**SURGICAL SESSION: VIDEO HIGHLIGHTS**

**29-09-2022 10:40 AM - 11:25 AM**

**SURGICAL TECHNIQUE OF TWO-STEP PELVIC AND PARA-AORTIC SENTINEL LYMPH NODE MAPPING IN EARLY STAGE ENDOMETRIAL CANCER; LAPAROSCOPIC, ROBOTIC AND OPEN METHOD**

Jeong-Yeol Park, Yoon-Jung Cho, Joo-Hyun Nam

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**Introduction :** Since sentinel lymph node mapping in endometrial cancer is becoming more widely used, the need of standardizing surgical technique is needed. The objective of this surgical video is to describe the procedure of two-step pelvic and para-aortic sentinel lymph node mapping using indocyanine green and fluorescent camera in endometrial cancer, in three versions of surgical modality, which is laparoscopic, robotic, and open.

**Description:** The patients in the surgical video are diagnosed with biopsy-proven endometrial cancer, with early stage according to the preoperative MRI and PET-CT scan. After collecting washing cytology, bilateral salpinges were clamped with endo-clip to minimize tumor spillage. Gauze packing in PCDS was done in order to minimize the spillage of indocyanine green dye during paraaortic sentinel lymph node mapping, which may interrupt nodal mapping. ICG dye was injected in bilateral uterine fundus, to detect isolated paraaortic sentinel lymph node pathway. After bilateral paraaortic sentinel lymph node was sampled, cervical injection of ICG dye was done in 3 o'clock and 9 o'clock direction, both superficially and deeply, 2 mL in each side. After dissecting off the obliterated umbilical ligament, developing para-vesical and para-rectal spaces, and identifying ureter, uterine artery, and internal and external iliac vessels, bilateral pelvic sentinel lymph node was then sampled.

**Conclusion/Implications:** This surgical video clip provides specific steps of pelvic and para-aortic SLN mapping. By standardizing surgical technique of SLN mapping, we look forward to shorten the learning curve of surgeons and to improve the accuracy of sentinel lymph node mapping.

**FF005 / #830**

**Surgical Films**

**SURGICAL SESSION: VIDEO HIGHLIGHTS**

**29-09-2022 10:40 AM - 11:25 AM**

**SYSTEMATIC APPROACH TO IDENTIFYING AND THE DISSECTION OF A POSTERIOR CHAIN SENTINEL LYMPH NODE IN ENDOMETRIAL CANCER.**

Danendran Krishnan, Michael Burling

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**Introduction :** The use of sentinel lymph node biopsy (SLNB) in endometrial cancer is expanding and has been incorporated into international gynaecological oncology management guidelines [1, 2]. Prospective trials and a meta-analysis have found that the SLNB with indocyanine green has a high sensitivity and low false negative rate for the detection of pathological lymph nodes, especially when undertaken with micro-sectioning and immunohistochemical staining [3, 4].

**Description:** We record all SLNB in our unit for quality assurance and training purposes. We review these videos for unanticipated challenges during identification of sentinel lymph nodes. We created this surgical teaching video to demonstrate a systematic approach to identify and dissect the posterior chain SLNB during laparoscopy.

**Conclusion/Implications:** It is vital for surgeons to completely and systematically inspect pelvic lymphatic channels to identify sentinel lymph nodes in endometrial cancer patients to ensure accurate staging. Video footage and still photographs were gleaned from unedited surgical films recorded at our institution and from institutional artists' illustrations. Patients with early-stage uterine cancer, undergoing laparoscopic staging surgery using intracervical dye for SLN mapping, were included.

**FF006 / #223**

**Surgical Films**

**SURGICAL SESSION: BEST ORAL FILM SUBMISSIONS**

**01-10-2022 10:05 AM - 11:05 AM**

**RADICAL CYTOREDUCTIVE SURGERY OF THE UPPER ABDOMEN FOR ADVANCED OVARIAN CANCER**

Ryan Kahn, Dennis Chi, Vance Broach

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**Introduction :** Volume of residual disease following cytoreductive surgery for patients with advanced ovarian, fallopian tube, and peritoneal carcinoma is one of the most important factors for overall survival. Extensive upper abdominal resections was not initially part of the surgical armamentarium of advanced ovarian cancer management for Gynecologic Oncologists. Large-volume upper abdominal tumor involving the diaphragm, liver, and/or spleen was deemed “unresectable,” and the patient was left with suboptimal residual disease. The incorporation of upper abdominal comprehensive surgical techniques has led to a significant improvement in optimal cytoreduction rates, and ultimately improved progression-free and overall survival.

**Description:** In this film we demonstrate the steps of open abdominal radical debulking surgery for high-grade ovarian carcinoma including a splenectomy, pancreatectomy, and full thickness diaphragm resection with excision of a cardiophrenic lesion. We also demonstrate potential complications as well as strategies to repair and limit these.

**Conclusion/Implications:** This surgical film demonstrates the feasibility and techniques involved for performing a splenectomy, pancreatectomy, and full thickness diaphragm resection with excision of a cardiophrenic lesion. Additionally, we demonstrate strategies to limit and manage post-operative complications associated with these surgeries. We hope this video will provide physicians with tools to incorporate into their practice in order to improve outcomes for their patients.

FF007 / #962

**Surgical Films**

**SURGICAL SESSION: BEST ORAL FILM SUBMISSIONS**

**01-10-2022 10:05 AM - 11:05 AM**

**MODIFIED RADICAL VULVECTOMY WITH LOTUS PETAL FLAP RECONSTRUCTION**

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**Introduction :** Vulval Cancer sometimes presents with large growths. Taking adequate margin amounts to large defects, which can be easily covered by Lotus Petal Grafts. It can be unilateral or bilateral as required.

**Description:** Lotus Petal flap is a fasciocutaneous flap taken from the perinium. It is based on the rich arterial blood supply in the perineal area arising from the terminal branches of the internal pudendal vessels. It requires isolation and preservation of deep perforators. Hence energy sources are avoided during raising the flap. The width of the flap should be at least equal to the width of the defect & Length AB= Length AC This is robust, simple to perform, and cosmetically extremely acceptable. It is easy to learn and minimal complications. It heals with a very aesthetic scar without any deformity and sexual dysfunction.

**Conclusion/Implications:** It is easy to learn and reproduce procedure. It produces extremely fine scar without any deformity. Every Gynec oncologist doing vulval cancer surgery must know this procedure.



**FF008 / #1092**

**Surgical Films**

**SURGICAL SESSION: BEST ORAL FILM SUBMISSIONS**

**01-10-2022 10:05 AM - 11:05 AM**

**USE OF MODIFIED FASCIOCUTANEOUS MARTIUS FLAP FOR VAGINAL RECONSTRUCTION: A CASE REPORT**

Renato Moretti-Marques<sup>1</sup>, Priscila Queiroz<sup>2</sup>, Luisa Martins<sup>1</sup>, Guilherme Barbosa<sup>2</sup>, Ana Carolina Falcão<sup>2</sup>, Pedro Ernesto De Cillo<sup>2</sup>, Fernando Nobrega<sup>2</sup>, Vanessa Bezerra<sup>2</sup>

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**Introduction :** The vaginal morbidity caused by radical surgeries and, or radiotherapy is a significant distress cervical cancer treatment-related. Developing techniques that can reestablish sexual function is essential for providing a better quality of life for those patients.

**Description:** The purpose of this video is to highlight a robotic-assisted modified Martius fasciocutaneous flap technique for vaginal reconstruction. A 27-year-old patient, FIGO IIC1 cervical carcinoma referred for concurrent platinum-based chemoradiation and treated successfully. After treatment, she developed severe vaginal stenosis becoming unable to have vaginal sexual intercourse. Five years later, she underwent vaginal reconstruction using two simultaneous approaches—an abdominal robotic total hysterectomy with bilateral salpingo-oophorectomy and total colpectomy. Perineal access was used to make a modified Martius fascio-cutaneous flap to create the neovagina. The distal portion of the neovagina was attached to the remaining uterosacral ligaments robotically. The surgery took 4 hours and the patient was discharged from hospital on the next day. She recovered well and in the follow up visit, the measurement of the neovagina was 9 cm. She successfully had sexual relations with penetration 6 months after the procedure.

**Conclusion/Implications:** The primary purpose of this video article is to demonstrate the step by step technique of the modified Martius fasciocutaneous flap as an alternative vaginal reconstruction for patients with severe vaginal stenosis after being treated with radiotherapy or radical primary surgical procedure. This technique is relatively simple and has minor morbidity, allowing the gynecologist to restore the patient's sexual function without engaging other types of specialists in the procedure.

**FF009 / #275**

**Surgical Films**

**SURGICAL SESSION: BEST ORAL FILM SUBMISSIONS**

**01-10-2022 10:05 AM - 11:05 AM**

**ROBOTIC RADICAL HYSTERECTOMY WITHOUT UTERINE MANIPULATOR OR VAGINAL TUBE**

Naery Kim, Kang Gungu, Ji Yeon Choi, Yang Eun Jung, A Jin Lee, So Kyeong A, Lee Sun Joo, Tae Jin Kim, Seung Hyuk Shim  
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**Introduction :** The purpose of this study is to introduce robotic radical hysterectomy with tagged uterine suture instead of using a uterine manipulator or vaginal tube.

**Description:** A total of 4 ports were used; first port was located left at 8cm from umbilicus, second port was 20mm sized at umbilicus, third port was located right at 8cm from umbilicus, and fourth was located right at 8cm from the third port (near the right flank). Uterus was tied with needle-straightened multifilament Vicryl 2-0 and tagged uterus was manipulated by fourth arm of the robot. If additional traction is required, instrument was inserted though the umbilical trocar site. During operation, the tagged uterus was successfully manipulated and appropriate parametrial space was exposed. Pathologically, all surgical margins were not involved with cancer. No tumor cells were seen in cytologic exam before and after the colpotomy.

**Conclusion/Implications:** Robotic radical hysterectomy can be easily and safely done with the traction of tagged uterine suture.

**FF010 / #287**

**Surgical Films**

**SURGICAL SESSION: BEST ORAL FILM SUBMISSIONS**

**01-10-2022 10:05 AM - 11:05 AM**

**MULTIDISCIPLINARY APPROACH FOR ROBOTIC REPAIR OF RECTOVAGINAL FISTULA IN A PATIENT WITH HISTORY OF RECTAL CANCER AND FAILED PREVIOUS ENDOSCOPIC REPAIR.**

Shadi Seraji, Farr Nezhat

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**Introduction :** This is a 65-year-old female with history of invasive rectosigmoid adenocarcinoma status post low anterior resection complicated by anastomotic dehiscence and pelvic abscess. She underwent sigmoidoscopy with closure of dehiscence with Endo suture. Patient was asymptomatic for 3 years when she presented with rectovaginal fistula, status post failed attempted sigmoidoscopy with Endo suture.

**Description:** Under general anesthesia first cystoscopy was performed and ureteral catheters were placed and indocyanine green was injected for identification of the ureters . Uterine manipulator with cup was placed to assist in identification of the rectovaginal space. Laparoscopic portion of the operation started with mobilization of the omentum from the hepatic flexure for later use. Using the images technology ureters were identified and proceeded with posterior cul-de-sac dissection to identify the fistula tract. After the fistula track was identified, surgical clips and sutures from previous failed repair were removed. The rectovaginal space was fully developed and necrotic and nonviable tissue from the vagina and rectal edges were completely removed . Placement of the uterine manipulator in the vagina and the rectal sizer in the rectum facilitated identification of these two organs better. The vagina was closed transversely with one layer of 0 barb sutures and rectum was close in two layers. Finally, mobilized omentum was brought down and placed and secured between the rectum and vagina.

**Conclusion/Implications:** Patient had no complication intraop and postop and was discharged home on postop day 2. She was seen 2 and 6 weeks postop with no fistula recurrence and is doing well.