



# **IGCS 2022 Abstracts: On-Demand Surgical Films (Surgical Film Cinema)**

Registered Delegates will have access to the on-demand surgical films within the Meeting Portal from September 28, 2022 (09:00 am EDT (New York)) until December 28, 2022.

**SF001 / #49**

**ON-DEMAND SURGICAL FILM CINEMA**  
**BREAST CANCER**  
**28-09-2022 1:00 PM - 1:30 PM**

**ICG FIRE FLY BASED SLNB SENTINEL NODE FOR CARCINOMA BREAST USING HAND HELD ICG FLOUROSCENCE PROBE : NEW TECHNIQUE LYMPHA**

Sp Somashekhar

Manipal Comprehensive Cancer Centre, GyneC And Surgical Oncology, Bangalore, India

**Introduction :** SLNB is standard of care in Early Breast cancer. Traditionally dual technique, using Radiocolloid and hand held gamma probe and Blue dye is used. Disadvantage is its expensive and cumbersome and need for mandatory dependency on nuclear medicine department is requiree and its not dynamic imaging but static. so Low energy resourse setting countries cannot use it . So hand held ICG flourescence imaging probe and ICG SLNB for breast cancer is cost economical and easy and no need for nuclear medicine department and easy to replicate and dynamic imaging per op LYMPHA surgery to prevent lymphodedmea

**Description:** SLNB is standard of care in Early Breast cancer. Traditionally dual technique, using Radiocolloid and hand held gamma probe and Blue dye is used. Disadvantage is its expensive and cumbersome and need for mandatory dependency on nuclear medicine department is requiree and its not dynamic imaging but static. so Low energy resourse setting countries cannot use it . So hand held ICG flourescence imaging probe and ICG SLNB for breast cancer is cost economical and easy and no need for nuclear medicine department and easy to replicate and dynamic imaging per op LYMPHA primary LVA surgery using ICG hand held probe to prevent Lymphoedema

**Conclusion/Implications:** This video shows technique of ICG flourescence SLNB for breast cancer and primary LVA Lympho venous anastamosis LYMPHA using hand held ICG probe

**SF002 / #87**

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**SINGLE-SITE LAPAROSCOPIC RADICAL TRACHELECTOMY WITHOUT A UTERINE MANIPULATOR**

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**Introduction :** Report regarding single-site laparoscopic radical trachelectomy (RT) is still absent at the present stage, for which the feasibility and safety of this surgery remains a question. We herein introduce the single-site laparoscopic RT without a uterine manipulator for a nulligravida patient with early-stage cervical cancer to preserve fertility without compromising the oncology outcomes.

**Description:** A 29-year-old woman who was diagnosed with stage IB1 (FIGO 2018) cervical cancer underwent the single-site laparoscopic (RT) plus pelvic lymphadenectomy without the manipulator. We used our expertise with single-site laparoscopic technique to perform space development as much as possible before the ligaments were resected. First, the bilateral round ligaments were sutured to form a coil, and the uterus was suspended by sutures from different directions according to the different operative requirements. Second, prior to colpotomy, a vagino-purse-string suture was formed to avoid spreading of tumor cells. The operative time was 300 minutes, and blood loss was 20 mL. No perioperative complications occurred and the residual cervix and vagina were restored to its original anatomy after 6 months. Postoperative pathological results suggested that the patient did not need radiotherapy or chemotherapy. So far, the surgical scar becomes invisible and the patient has resumed normal menstruation and sexual life.

**Conclusion/Implications:** Single-site laparoscopic RT plus pelvic lymphadenectomy without the manipulator should be deemed as a safe and feasible therapeutic option for patients with early-stage cervical cancer for fertility preservation. More cases shall be in place to better evaluate the postoperative efficacy and pregnancy outcomes of such procedure to a further step.

**SF003 / #669**

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**ROBOTIC-ASSISTED RADICAL VAGINAL TRACHELECTOMY**

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**Introduction :** Early-stage cervical cancer cases are still recorded among young age patients despite awareness about screening and vaccination. Fertility preserving surgery is the management of choice for those age group. Previously, radical trachelectomy was done with different approaches. Nowadays, Robotic-assisted surgery is replacing previous techniques for better outcomes. This video is representing Robotic-assisted radical vaginal trachelectomy.

**Description:** Robotic Phase : - Sentinel pelvic lymph-node sampling - Dissection of pelvic spaces ( Para-vesical, para-rectal ) - Ureterolysis - Dissection of vesicouterine ligaments, cardinal ligaments, uterosacral lligaments - Colpotomy ..... Vaginal Phase: - Cervical amputation - Cervical Cerclage - Utero-vaginal anastomosis

**Conclusion/Implications:** To enhance the Robotic approach for such cases.

**SF004 / #1120**

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**SENTINEL LYMPH NODE MAPPING WITH INDOCYANINE GREEN DYE WITH NEAR INFRARED TECHNIQUE**

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INCAN, Guatemala, Guatemala, Guatemala

**Introduction :** In our department, the technique of sentinel lymph node with indocyanine green guided by infrared technique is currently being validated, the advantages and benefits that it will have in surgical and postoperative morbidity for the patient makes it significant, as well as the subsequent ultrastaging of these sentinel nodes in case it is negative due to the possible implications that it will have in the adjuvant treatment, on this occasion a 31-year-old woman. Gesta 2 para 2, whit a 2 month history of irregular vaginal bleeding that presented in our departament. The patient had no prior cervical cancer screening. Physical examination reveal a 2 cm exophytic mass. Biopsies were performed and histopathology revealed squamous-cell cervical carcinoma. CT of the thorax and abdomen revealed no distant metastasis. She was staged according to the International Federation of Gynecology and Obstetrics staging of cancer of the cervix uteri (2018) as FIGO IB1. The patient was scheduled for Radical Hysterectomy (type C1) + Sentinel Lymph Node Mapping with Indocyanine green dye with near infrared technique + Pelvic Lymphadenectomy (currently validation study for SLN mapping).

**Description:** a surgical film that includes the administration of the dye for sentinel mapping, the development of the paravesical and pararectal spaces, whose adequate development is vital for the identification of the sentinel nodes, and the different forms that can be visualized.

**Conclusion/Implications:** Importance of sentinel mapping has on surgical/morbidity is what gives significance to this technique, with ultrastaging we will not lose low-volume-disease and we will be able to provide adequate adjuvant treatment

SF005 / #592

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**ROBOTIC-ASSISTED REMOVAL OF METASTATIC BULKY PELVIC LYMPH NODES FOLLOWED BY CONCURRENT CHEMORADIATION IN A PATIENT WITH FIGO STAGE IIIC2R CERVICAL ADENOCARCINOMA**

Eun-Ju Lee

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**Introduction :** Radiotherapy is preferred in the cases if lymph node involvement is detected before surgery. However, radiotherapy with standard dose is insufficient to sterilize bulky lymph nodes > 2cm. The resection of bulky lymph node metastasis before radiotherapy has been proposed to provide a therapeutic benefit.

**Description:** A sixty-four-year-old woman had been diagnosed of cervical adenocarcinoma with a biopsy. Gynecological examination and computed tomography detected both parametrial involvement and metastatic nodes about 3.3 cm and 2.1 cm in size at bilateral obturator fossa. Concurrent chemoradiation therapy was planned after the removal of the bulky nodes. A two-trocar transperitoneal approach with accessory port for assistant was used. After establishing retroperitoneal space, the ureter was retracted medially. Right node that was 3.3cm in size was between the external iliac vein and internal iliac artery and extended to the obturator fossa. The operation was followed by the left pelvic node removal. The robotic-assisted operation time was 124 minutes and the hospital stay was four days. The patient received concurrent chemoradiation therapy and had well been for one year with no evidence of disease.

**Conclusion/Implications:** The bulky lymph nodes which were difficult to be eradicated with standard radiation therapy were successfully resected with robotic-assisted surgery. The removal of bulky nodes followed by radiation therapy may provide a therapeutic benefit.

SF006 / #821

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**RADICAL TRACHELECTOMY: IMPORTANCE OF ROUND LIGAMENT AND SAMPSON'S ARTERIES TO UTERINE BLOOD SUPPLY EVALUATION BY INDOCYANINE GREEN FLUORESCENCE**

Tyrone Cesar Silva Junior<sup>1,2,3</sup>, Audrey Tsunoda<sup>4,5</sup>, Reitan Ribeiro<sup>6,7</sup>, José Linhares<sup>4</sup>, Leticia Pedrini<sup>4</sup>, Giovanna Lopes<sup>4</sup>, Fernanda Schamne<sup>7</sup>, Luana Santiago<sup>4</sup>, Joao Tavares<sup>2</sup>  
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**Introduction :** Radical Trachelectomy is a choice for cervical cancer treatment and preserve fertility in selected cases. Good uterine perfusion is necessary for fertility. Sampson's arteries preservation may be a good way of uterine perfusion. Blood flow evaluation by indocyanine green fluorescence on round ligament and uterus shows uterine perfusion through Sampson's arteries after clipping uterine arteries for radical trachelectomy.

**Description:** Preserve round ligaments and Sampson's arteries when performing radical trachelectomy. Blood flow evaluation by indocyanine green fluorescence on round ligament and uterus.

**Conclusion/Implications:** •Sampson's arteries may be a good option of uterine perfusion •We could preserve round ligament for good uterine blood supply

SF007 / #518

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**THE IMPLICATIONS OF LIGHTED URETERAL STENT IN ROBOTIC SINGLE-SITE RADICAL HYSTERECTOMY FOR EARLY CERVICAL CANCER**

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**Introduction :** The standard treatment for patients from FIGO stage Ia2 to IIa1 cervical cancer who do not wish to preserve fertility is radical hysterectomy with pelvic lymph node dissection. During radical hysterectomy, the risk of ureter injury is increased. IRIS U-kit (Stryker, Kalamazoo, MI, USA) is a lighted ureteral stent comprising a 6 F translucent ureteral sheath for the bilateral ureters, with optical fibers inserted into the ureteral sheath, and a device for light source. It is placed in the bilateral ureters using cystoscopic approach. It enables the visualization of the bilateral ureter lining during surgery. L10 AIM light source (Stryker, Kalamazoo, MI, USA) was used in this case. We report a case report of robot assisted single-site radical hysterectomy by inserting lighted ureteral stent for cervical cancer treatment.

**Description:** A 41-year-old woman who was diagnosed with cervical cancer FIGO stage Ib1 underwent robotic single-site modified radical hysterectomy (type II) with insertion of lighted ureteral stent. da Vinci® Xi Surgical system (Intuitive Surgical, Sunnyvale, CA, USA) platform was used for the surgery. Both ureters were fully visualized during the radical hysterectomy. Total operation time was 105 minutes and time taken for lighted ureteral stent insertion was 7 minutes. There was no immediate or delayed complication.

**Conclusion/Implications:** A prophylactic lighted ureteral stent insertion in robotic single-site radical hysterectomy for early cervical cancer treatment may be a safe and cost-effective procedure option. The lighted ureteral stent insertion helps to safeguard against intraoperative ureteral injury and overcome the limitation of single site operation may have.



SF008 / #1153

**ON-DEMAND SURGICAL FILM CINEMA**  
**CERVICAL CANCER**  
**28-09-2022 1:30 PM - 2:00 PM**

**COMPLICATIONS DURING SENTINEL LYMPH NODE MAPPING: OBTURATOR NERVE INJURY**

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**Introduction :** Among the complications of sentinel node mapping is the injury to the obturator nerve. With an incidence between 0.5 and 2%. Reported consequences vary in severity. As for the mode of repair, there are only a few standardized recommendations: how to avoid nerve tension, and that the fibers do not twist. However, there are few case reports in the literature. This is a surgical video of an injured obturator nerve during a sentinel node mapping with its repair in the same surgical procedure through the laparoscopic approach.

**Description:** We present the case of a 66-year-old patient diagnosed with cervical cancer, IB1 FIGO 2018 stage. Once in the abdominal cavity, after the cervical injection of Indocyanine green, the retroperitoneum is opened, the ureter and iliac vessels are identified. The right sentinel node is identified, and during its sectioning with a bipolar device, an almost complete sectioning of the right obturator nerve is observed. We performed neurolysis of the nerve, and a tension-free end-to-end epineural anastomosis is performed with 6-0 polypropylene with separate stiches, in the same laparoscopic procedure. A neurologic assessment was done in the immediate postoperative and on day2, no alteration of motor function or any neurological deficiency was found.

**Conclusion/Implications:** Obturator nerve injury is a rare complication. Laparoscopic repair is feasible. It is important to recognize the injury intraoperatively, maximizing the feasibility of simultaneous repair. Careful dissection and a good understanding of pelvic anatomy are essential for its prevention

SF009 / #282

**ON-DEMAND SURGICAL FILM CINEMA**  
**ENDOMETRIAL/UTERINE CORPUS CANCERS**  
**28-09-2022 2:00 PM - 2:30 PM**

**“OUTSIDE-IN” APPROACH – EXTRAPERITONEAL LYMPH NODE DISSECTION WITH VNOTES  
HYSTERECTOMY BILATERAL SALPINGO-OOPHORECTOMY OMENTECTOMY FOR SURGICAL  
STAGING OF ENDOMETRIAL SARCOMA**

Yu Hui Lim, Maili Qi

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**Introduction :** A 65 year old female with BMI of 35 kg/m<sup>2</sup> presented with postmenopausal bleeding for 3 months. An endometrial biopsy revealed endometrial sarcoma. Her staging CT scan showed a 6.6cm endometrial mass distending the cavity. There was no lymphadenopathy or distant metastasis. She had a history of open umbilical hernia repair with a large mesh in 2019. In view of sarcoma on the histology, she was counselled for full surgical staging including total hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy and omentectomy.

**Description:** We needed to avoid disruption of the large mesh across the umbilicus during surgical staging of this patient, as well as avoid potential bowel adhesions in the central region. We wanted to perform this using a minimally invasive approach. Therefore, we decided to adopt an “outside-in” approach whereby we performed an extraperitoneal pelvic lymph node dissection first followed by completion hysterectomy bilateral salpingo-oophorectomy and omentectomy via the VNOTES route. The surgery took a total of 206 minutes with an estimated blood loss of 200 mls. The patient recovered well post-operatively with minimal pain and no complications. She was discharged on post-operative Day 3. Final histology revealed Stage 1B low grade adenosarcoma. 14 lymph nodes were harvested with no metastasis. She was recommended for close observation and surveillance.

**Conclusion/Implications:** This “outside-in” approach is a safe and novel minimally invasive method of surgical staging for gynaecological cancers. It confers an advantage for technically difficult cases, such as multiple previous midline abdominal surgeries and morbid obesity.

**SF010 / #688**

**ON-DEMAND SURGICAL FILM CINEMA  
ENDOMETRIAL/UTERINE CORPUS CANCERS  
28-09-2022 2:00 PM - 2:30 PM**

**SENTINEL LYMPH NODE MAPPING FOR UTERINE CANCER: AN APPROACH TO FULFIL THE SURGICAL COMPETENCY ASSESSMENT TOOL.**

Michael Burling<sup>1</sup>, Dan Krishnan<sup>2</sup>

<sup>1</sup>Westmead Hospital, Gynaecological Oncology, Westmead, Australia, <sup>2</sup>Liverpool Hospital, O&g, Liverpool, Australia

**Introduction :** Sentinel lymph node dissection is widely used in the staging of endometrial cancer. Moloney et al [1] published the paper on identifying mandatory and prohibited steps of sentinel lymph node (SLN) dissection in endometrial cancer. This video is incorporating the quality assessment tool used in this paper to develop a systematic approach to SLN dissection. References Moloney K, Janda M, Frumovitz M, et al. Development of a surgical competency assessment tool for sentinel lymph node dissection by minimally invasive surgery for endometrial cancer. International Journal of Gynecologic Cancer 2021;31:647-655.

**Description:** This video is an attempt at trying to fulfil the surgical steps of the sentinel LN tool but also an approach that can be useful in training fellows to continue to develop the avascular spaces and identify the anatomy prior to resecting the sentinel lymph nodes. 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. Using the 10 steps that has been taken from the surgical assessment tool is used to demonstrate a systematic approach to SLN dissection.

**Conclusion/Implications:** A systematic approach to SLN dissection is paramount. The use of this systematic approach is important in teaching of our fellows but also to maintain surgical competency in SLN dissection.

SF011 / #764

**ON-DEMAND SURGICAL FILM CINEMA  
ENDOMETRIAL/UTERINE CORPUS CANCERS  
28-09-2022 2:00 PM - 2:30 PM**

**SENTINEL LYMPH NODE MAPPING PRIOR TO FROZEN SECTION FOR SUSPECTED  
ENDOMETRIAL CANCER**

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**Introduction :** Frozen section is a common tool used in cases of suspected but unconfirmed endometrial cancer. Indocyanine green allows identification of pelvic and para-aortic sentinel lymph nodes prior to hysterectomy, but the mapped nodes are removed before the hysterectomy per usual protocol. If sentinel nodes are mapped but not removed prior to the hysterectomy, the dye can spread and identification of the original sentinel node is not possible. Additionally, the dye cannot be injected after the hysterectomy is performed.

**Description:** We demonstrate mapping and tagging of the sentinel lymph nodes to allow for removal in the event of a positive frozen section or to avoid unnecessary lymph node dissection in the event of a negative frozen section.

**Conclusion/Implications:** Mapped sentinel nodes can be tagged with a clip for removal after hysterectomy. This allows the operator to perform sentinel lymph node biopsy after frozen section confirms malignancy, improving operating time and morbidity. In cases of benign pathology on frozen section, the risks associated with node biopsy or dissection can be avoided.

SF012 / #581

**ON-DEMAND SURGICAL FILM CINEMA**  
**ENDOMETRIAL/UTERINE CORPUS CANCERS**  
**28-09-2022 2:00 PM - 2:30 PM**

**THE USE OF ICG LYMPHATIC CHANNELS TO IDENTIFY THE UTERINE ARTERY DURING SENTINEL LYMPH NODE MAPPING FOR UTERINE CANCER.**

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**Introduction :** A novel approach to use of the ICG lymphatic channels to identify uterine artery at every dissection of the SLN in endometrial cancer surgery.

**Description:** The surgical steps of the sentinel LN dissection are an useful approach to training fellows to continue to develop the avascular spaces and identify the anatomy prior to resecting the sentinel lymph nodes. It also allows them to always identify the uterine artery and ligate it at its origin hysterectomies for endometrial cancers. 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. This demonstrates a systematic approach to the development of the pelvic avascular spaces and using the ICG to isolate the uterine artery prior to ligation.

**Conclusion/Implications:** The use of ICG tracts during dissection of SLN in endometrial cancer allows for clear identification of the uterine artery. Using this systematic approach to dissecting the uterine artery and ligating it during hysterectomies is a useful tool in teaching fellows and trainees.

SF013 / #869

**ON-DEMAND SURGICAL FILM CINEMA**  
**FERTILITY/PREGNANCY**  
**28-09-2022 2:30 PM - 3:00 PM**

**ROBOTIC DOUBLE CERCLAGE DURING PREGNANCY FOLLOWING RADICAL TRACHELECTOMY:  
A CASE REPORT**

Renato Moretti-Marques<sup>1</sup>, Luisa Martins<sup>1</sup>, Vanessa Bezerra<sup>2</sup>, Ive Franca<sup>2</sup>, Fernanda Asencio<sup>2</sup>, Fernando Nobrega<sup>1</sup>, Aley Talans<sup>2</sup>, Guilherme Barbosa<sup>2</sup>

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**Introduction :** This video demonstrates a robot-assisted double cerclage during pregnancy after a radical vaginal robotic-assisted trachelectomy followed by a failed laparoscopic free needle cerclage

**Description:** A 34-year-old IB1 FIGO stage squamous cell cervical cancer underwent a combined robotic laparoscopic-vaginal radical trachelectomy with enclosed colpotomy and without manipulator. After spontaneous pregnancy, she underwent a laparoscopic free needle cerclage. The pregnancy progressed with preterm amniotic membranes rupture and fetal loss at 19 weeks. Another spontaneous pregnancy occurred and an elective abdominal cerclage with Mersilene double suture by robotic-assisted laparoscopic technique was done. Ultrasonographically, the internal os, the endocervix, and the gestational sac were maintained under visualization throughout the procedure. At the same time, two robotic needle holders drove two needles symmetrically, passing from the posterior to the anterior portion of the cervical isthmus junction perpendicularly to the uterine axis and a blockage suture sequencing knots were made on the remaining cervix. Another identical suture was performed caudally. At 31 weeks, asymptomatic premature cervical dilatation was noted, and the patient was hospitalized. C-section was performed at 33 weeks and two days, and a healthy male infant was born.

**Conclusion/Implications:** The cervix is a fundamental structure for the development and the maintenance of a pregnancy. Different from patients with cervical incompetence, where there is data sustaining cervix cerclage, the literature is poor on the maintenance of pregnancy in post trachelectomy patients. This was a case report of a favorable evolution of pregnancy after cerclage in a patient with surgical removal of the cervix as cancer treatment.

**SF014 / #934**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**USEFUL TIPS FOR A SAFE DIAPHRAGMATIC PERITONEAL STRIPPING**

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**Introduction :** A complete cytoreductive surgery significantly impacts prognosis for ovarian cancer patients. Diaphragmatic peritoneal stripping is a key step to achieving complete macroscopic resection in the upper abdomen. To describe this technique, the literature is scarce and the training centers are limited.

**Description:** In this video, our patients were placed in a low lithotomy position, with a xifo-pubic incision, under general anesthesia. All patients received pre-operative physiotherapy and nutritional support. The liver lobes were mobilized (described in another video\*), and the margin between normal and involved peritoneal surface was marked with monopolar energy. It is important to identify the avascular plane between the diaphragmatic muscle and the affected peritoneum. Entering the muscle is indicated only if there is muscle infiltration by macroscopic tumor. Allis or Collin clamps supported manual traction to the borders of the peritoneum, while the liver is retracted medially. A small rounded surgical sponge may be used to push the muscle off the peritoneal surface (blunt dissection), reducing the need for monopolar energy. When the Morison pouch is involved, the same principles may be applied. For the left diaphragmatic stripping, the left lobe is mobilized, and the infiltrated peritoneum is similarly removed.

**Conclusion/Implications:** This video demonstrates some useful tips to achieve a complete cytoreductive procedure that includes hepatorenal pouch, and right and left diaphragmatic peritoneal stripping.

**SF015 / #341**

**ON-DEMAND SURGICAL FILM CINEMA  
OVARIAN CANCER  
28-09-2022 3:00 PM - 3:30 PM**

**SECONDARY LAPAROSCOPIC CYTOREDUCTION FOR RECURRENT OVARIAN CANCER IN CASE OF LAPAROSCOPIC PRIMARY DEBULKING SURGERY**

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**Introduction :** To investigate the feasibility of laparoscopic secondary cytoreduction in patients with recurrent ovarian cancer with previous laparoscopic primary debulking surgery

**Description:** Patients: A 52-year-old Korean woman underwent laparoscopic secondary cytoreduction for recurrent ovarian cancer and previous laparoscopic primary debulking surgery Interventions: Laparoscopy Measurements/Results: A 52-year-old Korean woman had a laparoscopic primary optimal debulking surgery. The FIGO stage IIIC was confirmed and she received 12 cycles of paclitaxel/carboplatin chemotherapy. Since then, it had been checked as NED state for 6 months. During follow up, lab results showed elevation of CA125, and recurrence was confirmed by PET-CT imaging. We performed LAVH with BSO, CDS mass excision, pelvic and para-lymphadenectomy during primary debulking surgery. In addition, diaphragm and omentectomy were performed. She received adjuvant chemotherapy with paclitaxel/carboplatin for 12 cycles. We performed the laparoscopic secondary cytoreductive surgery on November 28, 2017. Peritoneal cavity and diaphragm were clear and showed no metastatic nodule. Metastatic lymph nodes were confirmed along the left iliac vessels like seen in the previous PET-CT imaging and we resected them. What was seen as recurrence around right para-colic gutter area were metastatic nodule on the cecum surface. We removed the nodules and repaired the bowel serosa. She is receiving chemotherapy with stable disease at this time.

**Conclusion/Implications:** Our experience indicate that laparoscopy is a feasible and safe approach to optimal cytoreduction for patients with recurrent ovarian cancer in case of laparoscopic primary debulking surgery.



**SF016 / #728**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**ROLE OF THORACOSCOPY IN PATIENTS WITH EPITHELIAL OVARIAN CANCER AND STAGE IVA  
IN A DEVELOPING COUNTRY**

Juan Lalinde<sup>1</sup>, Pedro Calderon<sup>2</sup>, Monica Medina<sup>1</sup>, Oscar Suescun<sup>2</sup>, Adriana Almeciga<sup>1</sup>, Diana Santana<sup>1</sup>, Santiago Vieira<sup>2</sup>, Jesus Acosta<sup>1</sup>, Catherin Salazar<sup>1</sup>, Franco Ruiz<sup>1</sup>, David Viveros<sup>2</sup>, Fernando Alvarado<sup>2</sup>, Miguel Buitrago<sup>1</sup>, Santiago Rueda<sup>1</sup>

<sup>1</sup>Instituto Nacional de Cancerologia, Gynecology Oncology, Bogota, Colombia, <sup>2</sup>Cl. 1 #9-85, Bogotá D.c., BOGOTA - BOGOTA, Colombia

**Introduction :** Ovarian cancer is the most lethal gynecologic malignancy and in 75% of cases are diagnosed in advanced stages unfortunately 30% of patients with advanced ovarian cancer present pleural effusion at the time of initial diagnosis, that has been associated with worse disease-free survival and overall survival.

**Description:** A 48-year-old women who present a 3-month history of bloating and abdominal pain. Tomography of the abdomen and chest showing left pleural effusion with bilateral adnexal masses, peritoneal carcinomatosis and a ca 125 of 1753. The patient was given 4 chemotherapy cycles with partial imaging and serological response. Control images showed persistence of pleural effusion in the left hemithorax that was previously compromised by adenocarcinoma, so it was decided to perform left thoracoscopy to define secondary pleural involment. The main finding during thoracoscopy is evidence of a 5 cm lesion at the level of the left diaphragmatic peritoneum with full full thickness infiltration with no other lesiones in pleura cavity. The patient was taken to a complete abdominal cytoreduction by laparotomy with an adequate clinical evolution pending the restart of chemotherapy.

**Conclusion/Implications:** It is important to mention that metastatic involvement of pleural effusion has a high correlation with pleural involvement. The main prognostic factor for overall survival in ovarian cancer is complete cytoreduction, thats why we must establish the areas affected by this neoplasm and define the possibility of undergoing surgery. Video asisted thoracoscopy is a low-morbidity procedure that allows us to evaluate pleural and mediastinal involvement in patients with pleural effusion.

**SF017 / #387**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**OMENTECTOMY AND PARAAORTIC LYMPHADENECTOMY**

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**Introduction :** Omentectomy and paraaortic lymphadenectomy is an integral part of surgical staging of ovarian cancer. Gynaecologists practicing oncology need to learn and adapt this procedure.

**Description:** omentectomy is started by cephalad displacement of omentum and starts from the hepatic flexure and continued upto the splenic flexure. it can be accomplished by many technologies starting from plain scissors to vessel sealer device. pancreas that comes into view needs to be identified and protected. spleen is also dealt gently. para aortic lymphadenectomy starts from mobilization of caecum and systematically proceeded cephalad upto renal vein. The ip ligament, ureters and nerve plexuses need to be identified and preserved.

**Conclusion/Implications:** It is easy to learn omentectomy and paraaortic lymphadenectomy. various types of energy sources can be used with utter safety.

**SF018 / #345**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**LAPAROSCOPIC RESTAGING SURGERY FOR OVARIAN CANCER MIMICKING A PARASITIC MYOMA DISCOVERED DURING LAVH FOR UTERINE ADENOMYOSIS AFTER HIFU**

Joong Sub Choi, Jeong Min Eom, Un Suk Jung, Jaeman Bae, Won Moo Lee, Yeon Kyoung Kim  
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**Introduction :** To present laparoscopic restaging surgery for ovarian cancer mimicking a parasitic myoma discovered during LAVH for huge uterine adenomyosis after HIFU.

**Description:** A 49-year-old Korean woman with severe dysmenorrhea and abnormal uterine bleeding to our department. She had received High intensity focused ultrasound (HIFU) for adenomyosis six years ago. Pelvic MRI showed typical adenomyosis feature with huge uterus with ill-defined myometrial lesion. We planned to perform laparoscopically assisted vaginal hysterectomy on September 13 2021. We discovered small mass mimicking parasite myoma on right paracolic gutter. After hysterectomy, we removed the myoma like mass and the mass was sent frozen section histological analysis revealed a diagnosis of serous carcinoma. We performed abdominal exploration and washing cytology. Additionally, we discovered small tumor nodules on both ovarian surface covered by huge adenomyoma. We finished the initial surgery to do baseline study for ovarian cancer. We performed the laparoscopic restaging surgery for ovarian cancer after baseline study on September 30, 2021. The FIGO stage IIIC was confirmed based on the final histopathological result.

**Conclusion/Implications:** Laparoscopic restaging surgery for ovarian cancer mimicking a parasitic myoma discovered during LAVH for huge uterine adenomyosis after HIFU was safe and successful.

**SF019 / #1087**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**LAPAROSCOPIC STAGING FOR OVARIAN CANCER**

Léa Pauly<sup>1</sup>, Fabien Reyat<sup>1</sup>, Enora Laas<sup>1</sup>, Jean Guillaume Feron<sup>1</sup>, Virginie Fourchette<sup>1</sup>, Fabrice Lecuru<sup>1,2</sup>  
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**Introduction :** Exploratory laparoscopy is an essential step for surgical staging in advanced ovarian cancer With two objectives : -to determine the best therapeutic strategy by evaluating the possibility of primary debulking surgery -to perform biopsies to confirm the diagnosis and to allow molecular analysis We propose a step by step video about laparoscopic staging in advanced ovarian cancer.

**Description:** We present a step-by-step laparoscopic exploration of the abdominal cavity for staging in advanced ovarian cancer, using Peritoneal Carcinomatosis Index, areas by areas. We want to show what are the pitfalls and blocking points for a primary debulking surgery.

**Conclusion/Implications:** We wish to show how to perform a rigorous exploration of the abdomen and how to make efficient and safe biopsies for a better management of the patients in advanced ovarian cancer.

**SF020 / #48**

**ON-DEMAND SURGICAL FILM CINEMA**  
**OVARIAN CANCER**  
**28-09-2022 3:00 PM - 3:30 PM**

**TECHNIQUE OF QUADRANT WISE ULTRA RADICAL OPTIMAL CYTOREDUCTION TECHNIQUES WITH TOTAL PARIETAL PERITONECTOMY AND HIPEC FOR EPITHELIAL OVARIAN CANCER**

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**Introduction :** Optimal Cytoreduction CCO is the only sure Prognostic marker of good DFS and OS that is available with Gynecological oncologist in advanced Ovarian cancer. But it's not what we do in Pelvis alone that matters, but what we do and how we handle upper abdomen and diaphragm and Pott's hepatitis and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonectomy and upper abdomen Optimal CRS quadrant wise to achieve Optimal CRS with HIPEC

**Description:** Optimal Cytoreduction CCO is the only sure Prognostic marker of good DFS and OS that is available with Gynecological oncologist in advanced Ovarian cancer. But it's not what we do in Pelvis alone that matters, but what we do and how we handle upper abdomen and diaphragm and Pott's hepatitis and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonectomy and upper abdomen Optimal CRS quadrant wise to achieve Optimal CRS. the Glisson capsulectomy with Diaphragm resection and Mesenteric stripping and managing Pott's Hepaticus and Pouch of Douglasectomy and retro grade hysterectomy. and then HIPEC

**Conclusion/Implications:** We have done over 500 advanced ultra radical surgery with HIPEC and 1100 ultra radical upper abdominal CRS without HIPEC and morbidity and mortality is standardised after learning curve of 70 cases with these techniques of Ball Point cautery with 90 setting spray mode and systematic quadrant wise approach to high PCI ovarian cases. this video shares this technique in this

SF021 / #1115

**ON-DEMAND SURGICAL FILM CINEMA**  
**RARE TUMORS**  
**28-09-2022 3:30 PM - 4:00 PM**

**RECURRENT EXTRAMAMMARY PAGET'S DISEASE OF THE VULVA WITH PERIURETHRAL AND ANAL INVOLVEMENT**

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**Introduction :** Extramammary Paget's disease (EMPD) of the vulva is a rare neoplasm that usually arise from the apocrine gland bearing areas with high rates of recurrence. We report a case of a 67-year-old female who previously underwent wide excision of primary EMPD five years prior. The lesions recurred four years after, and showed a 14 by 18 cm erythematous lesion with red patches and plaques. "Cake-icing appearance" of the lesion spread from 2 cm above the urethral meatus up to 3 cm below the anal opening, to the right genitocrural fold and 3 cm from the left genitocrural fold. A wide excision involving distal urethrectomy, partial vulvectomy, anal mucosectomy with split-thickness skin grafting and sigmoid loop colostomy was done.

**Description:** A 2-centimeter margin was obtained around the lateral extent of the lesions. The incision involved a depth of 1 cm of subcutaneous tissues. The distal urethra was excised en bloc with the skin lesions including a 1-cm margin of anal mucosa. Following mucosectomy, the anal mucosa was then mobilized and pulled towards the external anal sphincters, to which it was anchored using circumferential interrupted Vicryl 3-0 sutures. Frozen section was done to check for adequacy of margins. It noted involvement at the 7 o'clock position of the anal mucosa, hence additional mucosa was excised. Laparoscopic sigmoid loop colostomy was performed followed by Split thickness skin grafting.

**Conclusion/Implications:** Wide local excision remains the mainstay treatment of EMPD. Positive margins may not be associated with recurrence or overall survival; limiting the resection margins may be considered.

**SF022 / #737**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**HUDSON POSTERIOR EXENTERATION, WITH THE USE OF ICG FLUORESCENCE TO ASSESS COLORECTAL ANASTOMOSIS AND URETERAL INTEGRITY**

Dong Bach Nguyen<sup>1,2</sup>, Sara Forte<sup>1</sup>, Andrew Zakhari<sup>2</sup>, Beatriz Navarro Santana<sup>1</sup>, Laurence Bernard<sup>1</sup>, Frédéric Guyon<sup>1</sup>

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**Introduction :** The surgical approach to hysterectomy for ovarian cancer has remained largely unchanged since Hudson described the en-bloc resection of fixed ovarian tumors using a retrograde technique in 1968. When a colorectal resection is required for optimal debulking, anastomotic leak remains a significant concern. While the traditional techniques used to evaluate for anastomotic perfusion lack accuracy, data from a recent systematic review and meta-analysis favours the use of ICG intra-op to reduce the incidence of anastomotic leak and associated need for re-intervention.

**Description:** The video aims to present the surgical steps to a Hudson procedure with colorectal resection, ending with the use of ICG fluorescence to assess the perfusion of the colorectal anastomosis and ureters. The surgical approach can be summarized in the following ten steps: (1) retroperitoneal dissection of the vascular pedicles and ureters, and transection of the IP ligament; (2) dissection of the paravesical and pararectal spaces; (3) lateral and pre-vesical peritonectomy; (4) ureterolysis and transection of the uterine vessels; (5) transection of the vesciouterine and uterosacral ligaments; (6) colpotomy; (7) mesorectal dissection and distal rectal transection; (8) proximal rectosigmoid transection; (9) vaginal vault closure and colorectal anastomosis; (10) assessment of colorectal anastomosis and ureteral vascularization by ICG fluorescence.

**Conclusion/Implications:** This video presented 10 reproducible steps to perform a Hudson procedure with colorectal resection for ovarian cancer. The use of ICG as an adjunct to assess the vascularization of the colorectal anastomosis appears to reduce the risk of anastomotic leak in colorectal surgery, and may be of interest in gynecologic-oncologic surgery.

**SF023 / #671**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**SURGICAL TECHNIQUE OF TOTAL MESOMETRIAL EXCISION FOR CERVICAL CANCER**

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**Introduction :** Total mesometrial excision is a surgical technique used for compartmental excision of mesometrium combining the radicality in the clearance of nodes and preserving the hypogastric plexus of nerves. This technique is indicated in the surgical treatment of early cervical cancers.

**Description:** This surgical film demonstrates the technique of total mesometrial excision of cervical cancers. The operation begins with retroperitoneal access, pelvic lymphadenectomy, dissection, and clearance of vascular and ligamentous mesometrium while preserving and safeguarding the ureter. This operation also includes the clearance of second echelon nodes from pre-sacral and common iliac nodal basins.

**Conclusion/Implications:** Total mesometrial excision involves the development of embryological planes around the Mullerian compartment with adequate clearance of paracervical and paracolpos for appropriate surgical management of cervical cancer. Adherence to the surgical principles and replication of classic techniques can minimize the morbidity associated with the radicality of the operation.



**SF024 / #960**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**STANDARDIZED EN-BLOC LYMPHADENECTOMY FOCUSING ON VESICOHYOGASTRIC FASCIA**

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**Introduction :** This video aims to demonstrate a technique for safe and easy en bloc pelvic lymphadenectomy, focusing on the vesicohypogastric fascia. Our technique make surgeons to perform simple and safe for bleeding and obturator nerve injury.

**Description:** • Dissecting the lymph node from the vesicohypogastric fascia, and external iliac vessels from the iliopsoas muscle • Dissecting the vascular sheath of external iliac vessels • Split adipose tissue and check the obturator nerve from the medial side • Ligate external/internal inguinal nodes and the obturator artery and vein • Dissecting the nodes of the levator ani muscle • Dissecting the internal iliac artery and bifurcation of the internal and external iliac arteries • Ligating the common iliac lymph node • Dissecting from the origin of inferior gluteal vessels • Dissecting the lymph node from the vesicohypogastric fascia

**Conclusion/Implications:** Key surgical concepts are that first, dissection of the medial and lateral borders, checking the obturator nerve on the caudal side, and dissection of the iliac artery bifurcation at late lymphadenectomy stages. Under the bifurcation, under the origin of obturator artery, there are lumbosacral trunk, gluteal vein. We should be conscious about these structures to avoid injury. Vesicohypogastric fascia is used as “natural retractor” for lymphadenectomy in minimally invasive surgery.

SF025 / #1165

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**LAPAROSCOPIC TYPE II RADICAL HYSTERECTOMY WITH LYMPHADENECTOMY FOR HIGH RISK ENDOMETRIAL CANCER: APPRECIATION OF DEEP PELVIC ANATOMY**

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**Introduction :** Use of laparoscopic staging surgery for localised endometrial cancer requires a thorough knowledge of the deep pelvic spaces. This gains more importance for cases with variant and uncommon pathology with variable involvement of parametrium.

**Description:** This video vignette highlights a smooth conduct of a similar staging procedure and focusses on the principles of total meso-metrial excision for high risk endometrial cancer. Our patient is a 62 years lady presented with post-menopausal vaginal bleeding. Endometrial biopsy showed a poorly differentiated carcinoma. Staging MRI showed disease limited to uterus with suspicious extension into parametrium. She underwent Laparoscopic Type II radical hysterectomy with bilateral pelvic lymphadenectomy and para-aortic lymph node sampling. Specimen was retrieved via vaginal route. Total blood loss was 300mL. Patient was discharged on post-operative day 3. Histopathology report showed serous carcinoma of the endometrium with free margins and no metastases to pelvic and retroperitoneal lymph nodes. Standardized conduct of an adequate staging surgery for endometrial cancer includes sequential conduct of the following steps: Total mesometrial excision with bilateral pelvic lymphadenectomy Dissection of the round ligament and infundibulo-pelvic ligament Dissection of lateral para-vesical space and obturator space Dissection of medial para-vesical space Ligation of uterine artery at origin from internal-iliac artery Dissection in Mackenrodt's tunnel Vaginal cut & Specimen delivery Vault closure Para-aortic lymph node dissection Infra-colic omentectomy (as indicated)

**Conclusion/Implications:** Orientation to anatomy of the deep pelvic spaces helps in a systematic conduct of a technically challenging procedure.

SF026 / #1076

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**DECOMPRESSION TECHNIQUE IN A LARGE OVARIAN CYST ASSUMED TO BE BENIGN: A SURGICAL APPROACH**

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**Introduction :** Ovarian neoplasms are common gynecological problems affecting females of all ages. Rapidly growing masses with malignant potential require surgical management. Avoiding the leakage of cystic contents for tumors has become a challenge. Therefore, exploratory laparotomy has been the most common surgical method to minimize the risk of spillage and intraperitoneal seeding in cases of possible malignancy. However, large incisions are prone to infection, dehiscence, prolonged hospital stay, and patient recovery. As such, mini-laparotomy through decompression of ovarian neoplasms has been done. This is a case of a 33-year-old nulligravid who sought consult due to increasing abdominal girth of five months with associated bloatedness and early satiety. Ultrasound showed an ovarian mass measuring 27.43 x 23.36 x 11.71cm with 1B and no M features by IOTA rules. The surgical plan was to do controlled decompression with limited tissue manipulation and tumor spillage using Dermabond Advance.

**Description:** An infraumbilical incision was done to expose the tumor surface. Dermabond was applied on an avascular area where a sterile glove was applied. A small incision was made at the base of the glove, adherent to the tumor, draining and collapsing the cyst, preventing spillage of tumor contents. Once the tumor was decompressed, it was exteriorized with the glove still attached. Left salpingo-oophorectomy was performed thereafter.

**Conclusion/Implications:** Our procedure provides further evidence of the safety and feasibility of spillage-free surgical techniques. Given the rarity of these conditions, other studies and cooperation among specialized centers are essential to define treatment standards.

SF027 / #683

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**LAPAROSCOPIC HUGE METASTATIC LYMPH NODE DISSECTION VIA RETROPERITONEAL SPACE**

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**Introduction :** This case is stage IIIA1(ii) ovarian cancer, and when retroperitoneal lymph node dissection is performed, open surgery is usually performed if the size is large. The authors want to show that successful resection can be achieved using the laparoscopic approach.

**Description:** In this surgical method, before entering the abdominal cavity completely, only the peritoneum was left. The space was expanded to approach the retroperitoneal space. 4 ports were used, and advanced bipolar, articulating forceps and metal clips were used. The metastatic lymph node was present on the left side and was approached from the left side, and the area where the ureter enters the kidney did not expand. The root of the metastatic lymph node was in the space between the posterior renal vein and the anterior renal artery. After blunt dissection was performed around it, the root was ligated with a metal clip.

**Conclusion/Implications:** When operating ovarian cancer, open surgery is performed if it is not in the early stage. Also, when lymph node dissection is performed, a ventral approach is used, and the bowel is lifted at this time, which may cause postoperative pain and complications.

However, if the retroperitoneal approach (side or dorsal) is performed, a sufficient field of view can be secured without directly touching the bowel, and the length of the incision can be shortened, thereby reducing complications after surgery.

This surgical approach is considered to be a method that should be considered if it is any indication.

**SF028 / #694**

**ON-DEMAND SURGICAL FILM CINEMA  
SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT  
28-09-2022 4:00 PM - 4:30 PM**

**LAPAROSCOPIC LEFT COMMON ILIAC VEIN INJURY AND REPAIR**

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**Introduction :** Injury to common iliac vessels is uncommon during gynecologic cancer surgery. However, resection of encasing metastatic lymph nodes will increase the risk. This video is representing a laparoscopic injury to the left common iliac vein during dissection of lymph nodes.

**Description:** How to repair a vessel injury laparoscopically : - Don't panic - Try to identify the site of injury  
- Chose the best angle to visualize the site of injury before starting the repair - Use prolene suture

**Conclusion/Implications:** How to deal with such a challenging complication.

**SF029 / #1053**

**ON-DEMAND SURGICAL FILM CINEMA  
SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT  
28-09-2022 4:00 PM - 4:30 PM**

**HEPATIC MOBILIZATION AND LIVER RESECTIONS DURING UPPER ABDOMINAL  
CYTOREDUCTIVE SURGERY IN OVARIAN CANCER**

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

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**Introduction :** Ovarian cancer is one of the most common gynecologic cancers and ranks eighth in mortality among women. More than 60% are detected in FIGO2018 stages III and IV. A complete cytoreduction is a significant prognostic factor. Eventual resection of liver implants becomes an essential knowledge for the surgical treatment of ovarian cancer.

**Description:** This video demonstrates surgical techniques using current surgical equipment for hepatic lobes mobilization, and access to the entire liver for non-anatomical resections. Initial mobilization of the right and left hepatic lobes is demonstrated, with division of the triangular and coronary ligaments. The falciform and the round ligaments are common sites of neoplastic involvement, and to reduce umbilical vessels bleeding, ligation of the round ligament was useful. After mobilization, we demonstrate the resection of Glisson's capsule implants, with manual hemostatic control and field exposure. Non-anatomical liver resections may benefit from an adequate vascular control of the hepatic hilum with a Pringle Maneuver. Manual and/or traction with stitches improve exposure for a nodule resection. Hemostasis was performed with Argon Beam energy (2;3). Surgical technique during laparoscopic resections is comparable, and in this video we used Ultrasonic scalpel with an active suction device exposure. Larger ducts and blood vessels should be clipped and ligated, and application of an hemostatic agent. Drainage was not indicated.

**Conclusion/Implications:** This video demonstrates reproducible standardized surgical techniques with simple materials for non-anatomical liver resections during ovarian cancer upper abdominal cytoreduction.

**SF030 / #801**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**ROBOTIC RESECTION OF VAGINAL ENDOMETRIAL ADENOCARCINOMA AFTER PREVIOUS HYSTERECTOMY FOR BENING DISEASE**

Gustavo Guitmann<sup>1</sup>, Lucca Martins<sup>1</sup>, Peter Carvalho<sup>2</sup>, Camilla Bandeira<sup>1</sup>, Luane Tavares<sup>1</sup>, Felipe Laterca<sup>1</sup>

<sup>1</sup>Americas Medical City, Gynecologic Oncology, Rio de Janeiro, Brazil, <sup>2</sup>Americas Medical City, Gynecologic Oncology, Rio De Janeiro, Brazil

**Introduction :** THIS VIDEO WILL SHOW A ROBOTIC RESECTION OF A FUNDUS VAGINAL ADENOCARCINOMA AFTER 20 YEARS PREVIOUS HYSTERECTOMY FOR BENING DISEASE

**Description:** THIS VIDEO WILL SHOW THE TECHNIQUE OF ROBOTIC RESECTION OF SUPERIOR THIRD OF VAGINA TUMOR IN A PATIETNT THAT HAD 20 YEARS BEFORE A HYSTERECTOMY FOR BEING DISEASE.

**Conclusion/Implications:** DUE TO THE RARITY OF THE CASE AND THE POSSIBILITY OF DEMONSTING THE TECHNIQUE AND ANATOMY BY ROBOTIC WAY THE VIDEO BECOME INTERESTING FROM THE DACTICAL POINT OF VIEW.

**SF031 / #895**

**ON-DEMAND SURGICAL FILM CINEMA  
SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT  
28-09-2022 4:00 PM - 4:30 PM**

**SINGLE-PORT ROBOTIC HYSTERECTOMY AFTER THE PREVIOUS TRACHELECTOMY**

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**Introduction :** Radical trachelectomy is the universal treatment for patients with early-stage cervical cancer desiring to maintain fertility. The mean recurrence rate after trachelectomy is 3.3~3.7%. We demonstrated a single-port robotic hysterectomy to a patient with a history of robotic trachelectomy. The condition of the uterus and other organs, recovery status, and the difficulty of reoperation can be reviewed.

**Description:** A 32-year nulliparous with recurrence of cervical cancer received the single-port robotic hysterectomy with bilateral salpingectomy. 9 years ago, she had a multi-port robotic radical trachelectomy with pelvic lymphadenectomy for stage IA1 cervical cancer. In the first video, we described the multi-port robotic radical trachelectomy. In December 2021, her pap-smear revealed adenocarcinoma. In the second operation, we used the DaVinci SP system to perform the hysterectomy and bilateral salpingectomy. There was an adhesion between the uterus and the ovary due to the previous operation. The uterus and bladder had moderate adhesions and were carefully exfoliated. Upon completion of the colpotomy, the thread that had undergone cervical cerclage performed in the previous operation was confirmed. The subsequent procedures were like that of a typical hysterectomy.

**Conclusion/Implications:** Single port robotic hysterectomy after the trachelectomy is a safe and effective approach for cervical cancer recurring patients. Finding the incision margin between the uterus isthmus and the upper vagina was difficult as there was adhesion between the uterus and the bladder, also due to the absence of the cervix of the uterus.



SF032 / #1166

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**GIANT OVARIAN MUCINOUS TUMOR: DECOMPRESSION TECHNIQUE USING PURSE-STRING SUTURE**

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**Introduction :** Giant ovarian neoplasms, described as tumors more than 20cms, have become rare due to the advent of modern imaging modalities. However, in low-resource settings, these neoplasms may still be missed. The limited number of cases poses management dilemmas in the absence of surgical guidelines.

**Description:** This presentation highlights the decompression technique using a purse-string suture in a 43 year-old with history of gradual and increasing abdominal girth. Ultrasound revealed a mass, benign by IOTA, measuring 53cms in diameter, containing 42,000cc. Surgical approach was mini-laparotomy with decompression. With only a limited surface area exposed, a purse-string suture was carefully placed on the outer layer of the cyst wall, ensuring not to go through and through the entire wall thickness that may cause inadvertent spillage. The sutures were circumferentially placed, then a small incision was made within to drain the cyst. Once decreased in size, the ends of the suture were tied securing closure of the purse-string opening. The mass was then easily manipulated and exteriorized for removal. The surgical team proceeded to doing a left salpingoophorectomy followed by hysterectomy with right salpingoophorectomy. The patient tolerated the procedure well, recovering without complications commonly found in wide abdominal incisions.

**Conclusion/Implications:** Giant ovarian neoplasms often pose a dilemma on surgical approach. While laparoscopy is the gold standard, it has been associated with increased risk of spillage and longer operating time for giant neoplasms. Decompression technique using a mini-laparotomy incision allows the surgeon to have adequate exposure, without the risks of inadvertent perforation and spillage.

**SF033 / #343**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
**28-09-2022 4:00 PM - 4:30 PM**

**THE IDENTIFYING RENAL ARTERY VARIANT DURING RETROPERITONEAL LAPAROSCOPIC  
PARA-AORTIC LYMPHADENECTOMY**

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**Introduction :** To demonstrate of identifying one of the renal artery variant, triple renal artery in left during laparoscopic para-aortic lymphadenectomy.

**Description:** Patients: A 54-year-old Korean woman with postmenopausal bleeding and thickened endometrium > 3cm presented to our department. The histopathology of biopsied endometrium revealed grade 2 endometrioid adenocarcinoma. The preoperative MRI shows an about 6cm sized large volume of tumor within the endometrial cavity. Interventions: We perform the laparoscopic staging surgery for endometrial cancer. Firstly we performed peritoneal washing cytology, LAVH, BSO, pelvic lymphadenectomy. We designated four area for para-aortic lymphadenectomy. During the procedure in area 4, it was confirmed that two left renal arteries were derived from the trunk of the aorta below the left renal vein. The left lower segmental artery was derived from the middle part of the inferior mesenteric artery and left renal vein. The middle segmental artery was derived just below left renal vein. The left main renal artery was located on the dorsal side of the left renal vein at its normal position. We carefully resected the para-aortic lymph nodes to prevent variant renal artery damage.

**Conclusion/Implications:** Laparoscopy is a feasible and safe approach to diagnosis of vascular anomaly during para-aortic lymphadenectomy for gynecologic malignancies. It is very important for the gynecologic oncologist to have knowledge of retroperitoneal vascular anatomy, experience in laparoscopic surgery, and an accurate surgical technique to avoid vascular injury during laparoscopic para-aortic lymphadenectomy.

**SF034 / #514**

**ON-DEMAND SURGICAL FILM CINEMA  
SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT  
28-09-2022 4:00 PM - 4:30 PM**

**THE BENEFIT OF USING MULTI-ARTICULATING INSTRUMENT, ARTISENTIAL, IN ROBOT  
GYNEOLOGIC CANCER SURGERY**

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**Introduction :** The usage of uterine manipulator should be avoided in order to prevent intrauterine seeding of tumor in pelvic cavity especially in endometrial cancer surgery. At single site robotic surgery by Xi, it is difficult to use additional assisting robot arm other than one camera and 2 robot arms. At single port robotic surgery by SP, we can use three robot arms other than one camera. But it is not easy to move or co-ordinate 3 robot arms for operator.

**Description:** We use blue cap, hegar(13) for immobilizing uterine cervix. We use multi-articulating instrument, artisential, to move tissue in single site robotic surgery by Davinci Xi, and single port robotic surgery by Davinci SP. In both robot surgery, artisential is useful instrument to perform PLND hysterectomy without uterine manipulator.

**Conclusion/Implications:** Using multi-articulating instrument is reasonable option to perform PLND hysterectomy without uterine manipulator by counteraction done.

**SF035 / #759**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
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**MANAGEMENT OF HUGE ADNEXAL CYSTADENOFIBROMA DURING PREGNANCY**

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**Introduction :** the choice of the surgical technique during pregnancy include considerations of uterine and fetal safety along with minimizing spillage technique this film will demonstrate an efficient safe surgical technique for huge cystadenofibroma during pregnancy

**Description:** This video describes a simple effective surgical approach to a huge cyst 17 liters during pregnancy. The tips and tricks include didactic demonstration of pre-operative evaluation, minimizing spillage technique and pathological results.

**Conclusion/Implications:** This is an efficient quick surgical solution with minimal morbidity for a huge adnexal cyst during pregnancy

**SF036 / #1064**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
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**SINGLE DOCKING, POSITION AND SAME PORT TECHNIQUE FOR ROBOTIC PELVIC AND PARA-AORTIC LYMPHADENECTOMY IN HIGH RISK ENDOMETRIAL CANCER**

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**Introduction :** In high risk endometrial cancer after radical hysterectomy and systematic pelvic nodal dissection, para-aortic nodes dissection upto renal veins is required. If central docking is done, the arms don't reach high par-aortic region upto renal veins, if side docking is done, it is not optimal for pelvic surgery. Most of the times, dual docking or change of position of both patient and robot is required. Intuitive recommended procedure card, ports placements fails to achieve this.

**Description:** So we describe modified port placement enabling both pelvic and para-aortic node dissection with the description of these procedure after radical hysterectomy in our video with single docking, single position and same port placement technique

**Conclusion/Implications:** This technique is advantages as it uses single docking and position with same ports for both pelvic and para-aortic nodal dissection, there by shortening the total time taken for the entire procedure and learning curve in the robotic surgeon.

SF037 / #1072

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
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**TECHNIQUE TO AVOID SPILLAGE IN A LARGE OVARIAN MASS**

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**Introduction :** Removal of large ovarian cysts has a high risk of spillage. Various techniques have been described for benign cysts, using plastic self-retractors or a laparoscopic bag. This video highlights a technique for safely draining and removing a large ovarian mass.

**Description:** 86 years old woman presented with abdominal distension and intraabdominal pressure symptoms for 6 months in Covid19 pandemic. She was anorexic, severely anaemic requiring blood transfusions, with severe bilateral pedal oedema. The eGFR=38. CT demonstrated a large abdominopelvic mass, with intraabdominal compression effect. A 10 cm midline laparotomy was performed. The suction tube was connected to the gas inflow valve of the 5 mm laparoscopic port. DERMABOND ADVANCED® skin adhesive was applied over the external area of the bowel bag. The cyst surface was dried. Further adhesive was applied over the cyst wall, followed by the bag, and a gentle pressure for 2 minutes for a good seal. Once complete coverage was secured, the port with the suction attached was inserted. Ten litres of fluid were aspirated, an 40x20 cm cyst removed, containing 4L of bloodstained fluid.

**Conclusion/Implications:** We recommend this technique because it is easy to perform, straightforward, and very simple in case of fluid filled enlarged ovarian cysts. The incision is small and there is a safe aspiration of the cyst contents. Patient's recovery is fast. It can be used for benign cysts, known malignant cysts, where the dissemination is not of a concern, and in palliative cases where the performance status does not allow a more complex operation.

**SF038 / #1037**

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
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**SPLENIC MOBILIZATION AND RESECTIONS IN CYTOREDUCTIVE SURGERY FOR OVARIAN CANCER**

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**Introduction :** More than 60% of all ovarian cancer patients are diagnosed in stages III and IV (FIGO 2018) (1). The vast majority will present upper abdominal disease, with splenic capsule, hilum or even parenchyma involvement. In this scenario, surgical techniques addressing partial or total splenectomy becomes an essential part of a complete cytoreductive surgery.

**Description:** This video demonstrates surgical techniques using routine materials for implants resection in the spleen, including partial and total splenectomy. The combination of preoperative imaging and surgical Peritoneal Carcinomatosis Index (PCI) evaluations may predict the precise technique indication. A posterior organ approach allows access to the splenocolic, splenophrenic, and splenorenal ligaments, which are identified and divided. Ligation of the short gastric vessels can be achieved with metallic clips or silk stitches. During a total resection due to parenchymal metastasis, dissection of the splenic hilum with ligation of the splenic artery followed by the splenic vein. We demonstrate two other cases with partial/capsular splenectomy with electrocautery and/or cold blade. Temporary clipping of the splenic vessels may be necessary for extended partial splenectomies, and will be described in another video.

**Conclusion/Implications:** This video demonstrates reproducible standardized techniques for total or partial splenectomy in ovarian cancer cytoreduction.

SF039 / #1171

**ON-DEMAND SURGICAL FILM CINEMA**  
**SURGICAL TECHNIQUES AND PERIOPERATIVE MANAGEMENT**  
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**LAPAROSCOPIC POSTERIOR INFERIOR MEDIASTINAL PRONE POSITION LYMPHADENECTOMY FOR RECURRENT GYNECOLOGIC CARCINOMA**

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**Introduction :** There is a potential oncological benefit related to isolated recurrences surgical resection. The aim of this video is to demonstrate a prone position laparoscopic approach to posterior inferior mediastinal lymphadenectomy.

**Description:** The patient had been treated for a pelvic gynecologic poorly differentiated carcinoma with a sarcomatoid component, 4 years before this salvage procedure. She had received a pelvic lymphadenectomy and a total hysterectomy. Her nodal recurrence was detected during follow-up and partially responded to platin-based chemotherapy. After a multidisciplinary discussion, surgical resection was offered. The patient was in a prone position, similar to the thoracic step for esophagectomy. Selective ventilation was followed by right side access (4 trocars). An anatomical review was performed as the pleural space was entered and the right lung collapsed with left selective ventilation. The dissection started with a mediastinal pleural dissection with regular bipolar and advanced bipolar, proximal to distal, from T10 to T12, between the thoracic aorta and the corpus vertebrae. Intercostal branches and azygos vein were preserved. All small vascular and lymphatic branches were sealed and/or clipped. The specimen was inserted into a bag and retrieved by the 12mm incision. A thoracic drain was placed. Surgical time was 96min, blood loss 12cc. Thoracic drain was retrieved on POD2 when the patient was discharged.

**Conclusion/Implications:** The laparoscopic prone surgical approach is safe, feasible, and standardized for the thoracic/upper digestive surgeon, and should be considered for posterior mediastinal approaches. \*This video was presented at AAGL 2021 annual meeting.



**SF040 / #1096**

**ON-DEMAND SURGICAL FILM CINEMA  
VULVAR AND VAGINAL CANCER  
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**RADICAL LEFT HEMIVULVECTOMY, SUPERFICIAL RIGHT HEMIVULVECTOMY AND SENTINEL LYMPH NODE WITH INDOCYANINE GREEN**

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**Introduction :** Vulvar cancer accounts for 3-5% of malignant diseases of the female genital tract. The surgical management remains complex, because it can concern two types of patients, on the one hand elderly patients with heavy comorbidities, on the other hand younger patients with a high risk of alteration of the quality of life and sexuality.

**Description:** We present the case of a 68 year-old woman, treated for a 20 mm squamous cell carcinoma of left hemivulva and high-grade vulvar intraepithelial neoplasia of left and right labia minora and clitoris. This patient is eligible for a sentinel node procedure. This surgical film shows a left radical hemivulvectomy, a right superficial hemivulvectomy and identification of bilateral sentinel lymph node with indocyanine green.

**Conclusion/Implications:** Improvements like sentinel lymph node procedure in treatment of vulvar cancer contribute to the decrease of mortality and morbidity. The possibility of performing a hemivulvectomy also allows to reduce the consequences of vulvar surgery in a de-escalation strategy.

SF041 / #1128

**ON-DEMAND SURGICAL FILM CINEMA**  
**VULVAR AND VAGINAL CANCER**  
**28-09-2022 4:30 PM - 5:00 PM**

### **ROBOT-ASSISTED RADICAL COLPOPAREMETRECTOMY IN VAGINAL CANCER**

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**Introduction :** Vaginal cancer is rare, and robotic-assisted surgical treatment is an exploratory field. The objective of this case report is to describe the robotic technique and the oncological results of a 37-year-old patient, two gravida two deliveries, who underwent a simple hysterectomy due to a persistent high-grade cervical lesion.

**Description:** Three years later, she presented a high-posterior vaginal wall nodule. The colposcopy-guided biopsy revealed squamous cell carcinoma, while the MRI showed a 4.6cm mass with no suspicious pelvic lymph nodes or lateral extension. A robot-assisted laparoscopic radical colpoparemetrectomy with pelvic lymph node dissection and ovarian transposition was performed, combined with transvaginal closure of the vaginal cuff for oncologic safety. The procedure seemed feasible and standardized. The surgical length was 520 minutes with 100cc estimated blood loss. The patient was discharged on day-2, and the bladder function resumed on day-7. The final pathologic analysis revealed a 5.0cm tumor in the vaginal cuff extended to surrounding soft tissue, parametria bilaterally, and anterior and posterior surgical margins were microscopically compromised. There were six positive lymph nodes of the 21 removed. The following adjuvant radiotherapy and chemotherapy were based on the Star Trial, and the patient did not show pelvic recurrence after a 14-month follow-up. Although, she presented an isolated supramesenteric retroperitoneal metastasis outside of the radiotherapy field.

**Conclusion/Implications:** The development of robot-assisted techniques for the treatment of vaginal cancer becomes progressively more relevant considering the diffusion of robotic systems in surgical practice. The safety maneuvers could keep oncological principles in these surgeries.