



IGCS 2020 Abstracts: Surgical Film Cinema

Registered Delegates will have access to these surgical films located within the xDigital Meeting Portal from September 10 to September 24 (10 days after the meeting ends).

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Surgical Films

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Laparoscopic Management of Huge Ovarian Cyst; Novel Technique

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This is a case of 35 years old patient who presented with a massive ovarian mass. She underwent fertility-preserving ovarian cystectomy. The technique describes how to manage such ovarian masses while maintaining cancer hygiene and limitation of spillage risks.

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IGCS20_1435

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VNOTES (vaginal Natural Orifices Transluminal Endoscopic Surgery) for Ia1 cervical carcinoma.

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Introduction - The treatment of cervical squamous cell carcinoma, FIGO stage Ia, with no lymphovascular invasion is total hysterectomy with salpingectomy with/without oophorectomy, when there is no intention for fertility-sparing. Lymphadenectomy is usually omitted in those cases. Recently, Ramirez et al evidenced that minimally invasive radical hysterectomy was associated with lower rates of disease-free survival and overall survival than open abdominal radical hysterectomy among women with early-stage cervical cancer. After that work, the uterine manipulator was pointed as an important cause for these results by some authors and many of them proposed closing the vaginal cuff as the first step of the minimally invasive surgery. However, for patients with the Ia1 stage, there is no need for extensive vaginal margin. Moreover, performing laparoscopic hysterectomy without a uterine manipulator is challenging. In this context, vNOTES provides an easy solution.

Description - We performed a cervical cerclage invaginating the external cervix orifice followed by conventional vNOTES hysterectomy with bilateral salpingectomy. The patient was positioned in stirrups in Trendelenburg position and standard sterilization was performed. After cervical cerclage, a circular incision was made around the uterine cervix and the following structures were sealed and divided by an advanced bipolar device: uterosacral ligaments, anterior bladder pillars, parametria. Then, a self-constructed vaginal port with alexis® and surgical glove was inserted through the vagina. Pneumoperitoneum was inflated and the sealing/division of uterine arteries, round ligaments, ovarian ligaments, and broad ligaments were completed.

Conclusion – vNOTES may provide a safe minimally invasive hysterectomy for Ia1 cervical carcinoma.

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Laterally Extended Parametrectomy (LEP)

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Introduction. Laterally Extended Parametrectomy (LEP) was imagined by Ungar and Palfalvi as a more radical surgical procedure for the treatment of lymph node positive stage Ib and stage IIb cervical cancer. Methods. The aim of the technique is to remove the entire parametrial tissue containing lymphatic structures from the pelvic side wall. Results. LEP superposes to a type D Querleu-Morrow radical hysterectomy, extending the lateral limits of the dissection not only to the medial surface of hypogastric vessels, but to true borders of the pelvic side wall. Its rationale was to avoid the need of aggressive and deleterious postoperative radiotherapy for patients with positive pelvic lymph nodes or parametria in which the final histology suggested a complete removal of the potentially tumor containing lymph-vessel and lymph node containing fibro-fatty tissue. LEP may be also taken into consideration during pelvic exenteration, when the tumor involves the soft structures of the pelvic side wall, for a more extensive pelvic side wall dissection.

During LEP, together with the visceral branches of hypogastric vessels, all the parietal branches are also divided (ilio-lumbal, obturator, gluteal superior and inferior and internal pudendal vessels) at the level where the vessels leave or enter into the pelvis. LEP can be performed on one or both pelvic sides, depending on parametrial invasion or presence positive lymph nodes uni- or bilaterally. Conclusion, LEP provides a good chance for survival without the toxicity of radiotherapy for pelvic lymph node positive stage Ib or IIb cervical cancer patients.

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Laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy

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Objective: To present of laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy for the patient with endometrial carcinoma.

Patients: A 78-year-old woman with postmenopausal bleeding and thickened endometrium presented to our department. The histopathology of biopsied endometrium revealed grade 1 endometrioid adenocarcinoma. The MRI shows an about 5cm sized tumor within the endometrial cavity suspicious myometrial invasion.

Interventions: We perform the laparoscopic staging surgery. No intraoperative complications were recognized. However, on postoperative day 1, the color of intra-abdominal drainage change from serosanguinous to dark green. We strongly suspected small bowel perforation and perform secondary laparoscopic surgery immediately. We scrutinized the small bowel and found the perforation site on duodenum. The perforation occurred at the horizontal part of duodenum ventrally vena cava. We carried out laparoscopic primary repair with 3-0 vicryl. Double layer closure was done by interrupted suture in first layer and Lambert suture for second layer. Then, we placed drainage into the duodenal repair site and traced the small bowel meticulously. We reviewed the video of primary surgery. We thought that the thermal injury was occurred by ultrasonic cutting and coagulating device during the lymphadenectomy in pre-caval area just below duodenum or mechanical micro-perforation is made during lifting the duodenum by dissecting forcep. After duodenal repair, endoscopically guided placement of nasogastric tube was performed. Gastrography did not show any leakage at the site of duodenal repair on postoperative day 3.

Conclusions: Immediate laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy is safe and feasible.

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Laparoscopic resection of bulky para-aortic lymph node metastasis

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Objective: To present of laparoscopic resection of bulky para-aortic lymph node metastasis discovered during laparoscopic restaging surgery for unexpected ovarian malignancy

Patients: A 45-year-old woman with prior laparoscopic bilateral salpingo-oophorectomy, presented to our department with unexpected ovarian malignancy which was resulted from the high grade serous carcinoma. Preoperative PET CT scan shows enlarged lymph node in aorto-caval area and no abnormal finding in peritoneal cavity and previous operative site.

Interventions: We planned to perform laparoscopic restaging surgery to obtain knowledge about the stage. Laparoscopic restaging surgery included peritoneal washing cytology, LAVH, pelvic lymphadenectomy, para-aortic lymphadenectomy, omentectomy, appendectomy, and multiple peritoneal biopsies. We encountered about 6cm sized Isolated huge para-aortic lymph node metastasis just before the para-aortic lymphadenectomy. Peritoneal incision was made from right common iliac artery to the duodenum. The bulky nodes were encased and severely densely adhered to important aorta and inferior vena cava. We detached peri-nodal tissue from the vessels meticulously not to rupture of metastatic nodal capsule. Resected nodal specimen carried in the endo pouch was extracted though the opened vaginal vault. The final histopathological results showed lymph node metastases of 4 out of 44 para-aortic lymph nodes and the other of resected tissues were tumor-free. The final diagnosis was FIGO stage III C of ovarian serous carcinoma. She is receiving chemotherapy at this time and healthy since then.

Conclusions: Our experience indicate that laparoscopy is a feasible and safe approach to resection of bulky para-aortic lymph node metastasis during laparoscopic debulking surgery for gynecologic malignancies.

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Extraperitoneal Laparoscopic Pelvic Lymphadenectomy for Cervical Cancer Staging in Twin Pregnancy

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Introduction: In locally advanced cervical cancer the lymph node surgical staging is used to determine the disease spread before definitive treatment. Regarding pregnancy complicated by this neoplasm, a patient's wish should guide individualized approaches to possibly postpone chemoradiation and reduce fetal complications. The aim of this study is to demonstrate the extraperitoneal technique and to show the anatomy from an unusual angle in order to spread knowledge.

Methods: We present a case of a 39-year-old woman with squamous cell carcinoma staged as FIGO IB2 diagnosed at 8 weeks of gestation due to a vaginal bleeding. Her first ultrasonography revealed a monochorionic diamniotic twin gestation. At 16 weeks we performed an extraperitoneal pelvic lymphadenectomy with bilateral access followed by an amplified conization and cervical cerclage.

Results: The operative length was 320 minutes, 220 minutes for bilateral lymphadenectomy. Blood loss was minimal and the patient remained stable throughout the procedure. On the first postoperative day, she had moderate pelvic pain requiring opioid use. An obstetric ultrasonography was performed on the second postoperative day before hospital discharge, in which both fetuses had heartbeat, amniotic fluid was normal and the remaining cervix measured transvaginally was 1cm.

Conclusions: Despite being underused by surgeons, the extraperitoneal laparoscopic approach for pelvic lymphadenectomy is feasible. Particularly in twin pregnancies, where the uterus size may hinder access to pelvic spaces, this route becomes useful not only to avoid abdominal organs or vessels injuries but also to decrease future intestinal adhesions.

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LAPAROSCOPIC APPROACH FOR CERVICAL OR VAGINAL MALIGNANCIES IN PATIENTS WITH PREVIOUS HISTERECTOMY.

A REPORT OF THREE CASES

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Objective: To show three different cases of laparoscopic approach in patients with previous hysterectomy.

Settings: Three patients with cervical or vaginal cancer with previous hysterectomy, solved by laparoscopy.

Methods: The first patient has personal history of ovarian cancer, treated with surgery with subtotal hysterectomy and intraperitoneal chemotherapy. In oncological follow up she has cervical tumour whose biopsy indicates a relapse of her disease.

The second patient has a personal history of total hysterectomy in 2010 for high-grade squamous intraepithelial (HSIL) cervical lesions. In annual gynaecological control a posterolateral lesion was identified in the vaginal cuff. It's biopsy informed a squamous carcinoma.

The third patient has a history of subtotal hysterectomy for benign disease.

Annual pap smear shows HSIL. Cervical biopsy informed a squamous carcinoma. On physical examination the patient had a 2 cm tumor without evidence of parametrial involvement. IB1 FIGO stage

In all three cases we begin with an exploratory laparoscopy in order to discard intraperitoneal disease. we used a vaginal acrylic tube as a colpotomizer.

In each case, the radicality was adjusted to the disease the patients

Conclusion: After hysterectomy, cervical or vaginal malignancies could be diagnosed. In order to solve them, we choose the laparoscopic approach. Is important in this kind of surgeries, to have a colpotomizer that facilitates the procedure. In our cases we used a vaginal acrylic tube, resistant to the monopolar energy. The radicality of each surgery depends on the malignancy and the patient.

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Secondary laparoscopic cytoreduction for recurrent ovarian cancer in case of laparoscopic primary debulking surgery

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

Design: Case study. **Settings:** University hospital in Korea.

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 on September 22, 2015. 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.

Conclusions: 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

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Resection of Perianal CIS with V-Y Graft Reconstruction

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V-Y flap for reconstruction after perianal resection of CIS

Perianal CIS should be resected if the lesion is large, invasion cannot be ruled out or if it extends into the anal canal. Split thickness skin grafts do not take well around the anus and strictures may occur.

The V-Y advancement flap is ideal as it can be advanced 2-3 cm with an excellent blood supply.

This video will show the technique of resection of a large perianal CIS extending into the anal canal, preservation of the anal sphincter and reconstruction with V-Y flap.

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Robotic Assisted Inguinofemoral Lymphadenectomy for Vulval Carcinoma

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Introduction :

Vulval carcinoma accounts for 3-5% of all gynaecological cancers . The primary treatment of vulval carcinoma is local excision +/-inguinofemoral lymphadenectomy . Inguinal node status is an important prognostic indicator, this makes lymph node assessment important for all cases of vulval carcinoma except the superficially invasive carcinomas . Here we demonstrate our technique of robotic assisted inguinofemoral lymphadenectomy for vulval carcinoma .

Description :

The biggest problem with inguinofemoral lymphadenectomy is short term and long term morbidity associated with the procedure, especially wound complications . Various techniques have been tried to reduce morbidity like separate incisions, sentinel node mapping, saphenous sparing and video endoscopic approach . From December 2014 to March 2020 ,15 patients of vulval carcinoma underwent 21(9 unilateral and 6 bilateral) Robotic Assisted Inguinofemoral lymphadenectomy at our institute . Mean age of patients was 59 yrs (32-73) . Mean operative time was 69 min and mean blood loss was 40 ml . Mean number of node harvested were 13(8-23) . There was no conversion . No intraoperative complication was observed . Postoperative superficial wound infection was seen in 2/21 procedures and prolonged seroma aspiration was required in 4/21 procedures . Final histopathology showed metastasis in 4/21 cases. In this video we describe the patient positioning, port placement and technique of the procedure .

Conclusions :

Robotic assisted inguinofemoral lymphadenectomy is safe and feasible with less wound related morbidity than conventional procedure . Need multi institutional study to evaluate long term complications, safety and survival data.

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Standard laparoscopic bilateral pelvic sentinel lymph node detection with radiotracer, blue dye and permanent instruments

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Introduction: Pelvic sentinel lymph node (SLN) in initial stage endometrial cancer may result in higher rates of bilateral detection after a combination of radiotracer and blue dye. In this video we demonstrate a standardized and reproducible laparoscopic standard SLN technique, with permanent instruments, completely performed by surgeons in training.

Methods: A 69 years old patient presented a uterine Stage IA G2 endometrioid adenocarcinoma. Less than 50% myometrial invasion was observed at preoperative MRI. At board review, a minimally invasive class A hysterectomy with bilateral salpingoophorectomy and SLN was indicated. Technetium-99 was injected into the cervix the day before surgery, and scintigraphy confirmed bilateral pelvic nodes (external iliac on the right side and interiliac on the left side). At the operating room, patent blue (2cc in 2cc of saline), was injected at 3 and 9 o'clock in the cervix, just after trocar insertion.

Results: This video demonstrates a standard step-by-step laparoscopic SLN using double detection technique and permanent instruments. Pelvic lateral spaces dissection was important to identify all marked nodes. There were 2 blue nodes in each pelvic side: obturator/interiliac and external iliac. All 4 were positive in ex-vivo gamma-probe assessment. After the procedure, there were no other sites of gamma-probe detection.

Conclusion: SLN detection with combined blue dye and radiotracer may result in an adequate bilateral pelvic detection in early stage endometrial cancer. This standard technique may require only permanent laparoscopic instruments, representing less costs and high reproductibility.

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Robotic ileal neovagina

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Introduction: Patients submitted to pelvic exenteration with wet colostomy have limited options for vaginal reconstruction. The objective of this video is to demonstrate that vaginal reconstruction (neovagina) using the ileal segment as an alternative for these patients.

Methods: We present an educational video demonstrating step-by-step the technique for robotic ileal neovagina.

Results: A 28 years old patient was submitted to a pelvic exenteration and reconstruction with terminal wet colostomy due to a late central recurrence after chemorradiation for Stage IIIB cervical cancer. After 3 years of follow-up, there was no evidence of recurrence, and an ileal neovaginal reconstruction was performed. This video demonstrates a surgical technique, using approximately 25-30 cm of the distal ileum segment. This isolated segment formed the neovagina and was anastomosed to the remaining vaginal dome. The patient had good postoperative recovery and in a couple months recovered sexual function.

Conclusions: Robotic ileal neovagina is an option for patients who had pelvic exenteration with wet colostomy.

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Robotic Assisted Laparoscopic Resection of Rectovaginal Clear Cell Carcinoma Mass Arising from Endometriosis

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Introduction:

Increasing evidence indicates there is malignant transformation of ovarian and non ovarian endometriosis into mainly endometrioid, and clear cell histologies. Patients that have suspicious symptoms, physical exam findings, or abnormal imaging studies should be evaluated to rule out malignancy. We briefly review the patients history and surgical case as the disease can be elusive.

Methods:

This is a surgical case report involving a single patient. The provider is a Gynecologic Oncologist and minimally invasive surgeon that has extensive experience in the treatment of endometriosis. The surgical technique for endometriosis resection and ovarian cancer debulking is reviewed in this video.

Results:

Pathology specimens of the vaginal cuff/vagina, iliocecum, and appendix were positive for clear cell carcinoma. Negative margins were achieved at the vagina.

Patient was treated with adjuvant chemotherapy with whole pelvic and vaginal brachytherapy.

Conclusion:

Management of patients with cancer arising from endometriosis can be challenging. Patients with endometriosis should be evaluated for malignancy with suspicious imaging findings. Optimal surgical resection followed by adjuvant chemotherapy or/and radiation is the current recommendation. Robotic Assisted Laparoscopy is feasible and may be preferable for debulking/resection of complex masses in the rectovaginal space in obese patients.

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Uterine Transposition in a Case of Rectal Malignancy

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Uterine transposition is a surgical technique first described by Dr. Reitan Riberio. This is fertility preserving surgery for patients with rectal/anal cancer requiring pelvic radiation. The uterus is transported out of the field of radiation and repositioned when radiotherapy is completed.

Case Report

A 36 year old woman presented with new onset peri-anal pressure symptoms on a background of no significant medical history. Examination revealed a hard irregular circumferential rectal tumor from dentate line, 5cm in length. Histology reported a moderately differentiated adenocarcinoma. TNM stage T3cN2bM0. This case was discussed at the colorectal multidisciplinary team meeting. A plan was made for fertility-preserving uterine transposition and formation of loop colostomy. The patient would then commence pelvic radiation with concomitant chemotherapy. Following this the patient would undergo interval abdomino-perineal resection (APR) with re-implantation of uterus plus adjuvant chemotherapy.

Procedure

A video attached shows the procedure of uterine transposition and the subsequent repositioning. This was done laparoscopically, with ligation of the round ligaments and mobilisation of the gonadal vessels to the level of the kidney bilaterally. Uterine arteries were ligated and colpotomy performed. The uterus was then transported to the upper abdomen and fixed to the abdominal wall. A cervical stoma was then formed.

The second video demonstrates the repositioning of the uterus to the pelvis following the completion of radiotherapy. The round ligaments are reattached bilaterally. Intravenous Verdye was administered and preservation of the blood supply to the uterus was demonstrated through an infrared camera lens.

Conclusion

Uterine transposition represents a novel approach to fertility preserving surgery.

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Surgery for rectosigmoid peritonectomy in advanced ovarian cancer: surgical technique of visceral segmental serosectomy and 8-year experience

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Introduction: Tumors infiltrating rectosigmoid colon is commonly found during cytoreduction in ovarian cancer. Low anterior resection (LAR) or visceral serosal segmentectomy (VSS) can be performed for removing tumors on the rectosigmoid colon. LAR is associated with decreased bowel function, and conservatively ablating tumors on rectosigmoid colon by VSS might be safe without compromising the quality of life.

Methods: From Jan 2013 to June 2020, we performed 83 cases of stage IIB to IVB ovarian cancer surgery with resection of tumors involving the rectosigmoid colon. Also, VSS was considered when the length of the tumor extent of the rectosigmoid colon was less than 18cm, and there was no evidence of mucosal invasion, and in the other cases, LAR was performed.

Results: First, the rectosigmoid colon is mobilized, and then, mesorectal excision was done, and VSS can be performed. Exposure of the muscle layer or mucosal layer can be repaired. After that, tagging suture is done at the edge, and the resected serosa area is folded and form a bowel loop. A bubble leak test was performed after the serosal repair is completed. Among 83 patients, there were no differences in clinicopathologic characteristics between LAR (n=39) and VSS (n=44) group. In terms of surgical extent, LAR showed more combined procedures related to bowel surgery. Also, there were no differences in survival, recurrence pattern, and surgical complications.

Conclusions: Visceral Segmental Serosectomy is feasible and can be safely performed without significant complications and comparable survival outcomes.

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Laparoscopic approach to bulky pelvic lymph nodes: tips and ticks

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Introduction: With the increased use of minimally invasive techniques for advanced gynecological neoplasms, progressively more challenging lymph nodal debulking are being performed. Our objective is to present a detailed strategy to safely performed pelvic lymphadenectomy in patients with bulky lymph node metastasis.

Method: We present a video demonstrating tips and tricks to resect bulky pelvic lymph nodes using laparoscopy.

Results: Pelvic spaces dissection is the first step to achieve surgical field control during pelvic lymphadenectomy, specially in patients with bulky metastasis. After that, proximal and distal dissection of any vessels close to bulky lymph nodes is mandatory if there is risk of bleeding. Dissection of such nodes starts in the healthy tissue and not direct ate the any area adorned to major vessels. A combination of blunt and sharp dissection usually allows resection of most bulky lymph nodes without vascular resection. Some nerves may be dissected and preserved as well. In selected cases, harmonic energy may be useful.

Conclusion: Laparoscopic resection pelvic bulky lymph nodes is feasible, but can be demanding and requires different strategies in order to be safe and effective.

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Surgical Films

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Minimally invasive bleeding management during pelvic lymphadenectomy

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Introduction: Bleeding is certainly one of the most common complications in minimally invasive surgery for gynecologic cancer, specially during the pelvic lymphadenectomy. To master bleeding control is mandatory to all surgeons performing such procedures. The objective of these video is to demonstrate bleeding management alternatives during minimally invasive pelvic lymphadenectomy.

Method: We present a video demonstrating the basic and advanced principles of bleeding control, during pelvic lymphadenectomy.

Results: The first part of the video presents the basic principles of bleeding management including, compression, anatomy knowledge, proximal and distal dissection, and bipolar coagulation along surgical field control. The second part is focused in different techniques as clipping suturing.

Conclusion: Bleeding management using minimally invasive surgery is feasible. All surgeons have to master several different strategies to achieve bleeding control avoiding unnecessary conversion to open surgery.

Surgical Films

Retroperitoneal bleeding management during laparoscopic lymphadenectomy

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Introduction: Minimally invasive surgery (MIS) still an evolving technique and it has been used progressively more for complex procedures. At the same time, complications management using MIS is also evolving and conversion is becoming less common. It's important to master different strategies to approach complications, specially bleeding because this is one of the major causes of conversion. It's our objective to demonstrate different strategies to control venous and arterial bleeding during MIS.

Method: Using a series of videos we present the 4 most used techniques of bleeding control: compression, coagulation, clipping and suturing.

Results: Simple compression can control the majority of small retroperitoneal bleeding, sometimes associated with hemostatic agents. Bleeding from small tributary vessels can be controlled using bipolar energy. Another option is the use of clips, especially when there isn't a safe place to use bipolar energy or there is a defect in the vessel wall. It is important to avoid clipping large portions of the vessel wall, as well as to avoid adicional damage. For larger lacerations the suturing techniques is best approach. Before performing the suture, it is important to achieve control of the surgical area. In robotic assisted laparoscopy the same principles must be followed. Instead all the approaches shown, there is some cases that laparoscopic bleeding control is not possible and conversion is needed.

Conclusion: It is possible to achieve bleeding control by MIS in different ways. Each technique can be appreciated in different situations. It is very important to the surgeon to master all bleeding control strategies.

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Surgical Films

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Laparoscopic nerve sparing radical hysterectomy: Measure to prevent tumor spillage for better prognosis and preservation of voiding function based on clinical pelvic anatomy

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Introduction: LACC trial suggests intraoperative tumor manipulation and dissemination may compromise survival of early stage cervical cancer with total laparoscopic radical hysterectomy (TLRH). We examined oncological outcome of TLRH with abdominal radical hysterectomy (ARH) and evaluated our surgical technique.

Description: A case of cervical cancer T1b1 is presented in this video. Patient is 49 years old and endocervix tumor of 1.5cm is identified in uterine cervix. TLRH is done by Okabayashi method. Technique for good visual field is standardized to reproduce Okabayashi method in every case. TLRH is combined with measures to prevent tumor spillage: 1) avoidance of usage of uterine manipulator, 2) clipping of venous drainage from uterus before manipulating uterine cervix, and clipping central side of lymph drainage before pelvic lymph node dissection, 3) irrigate vagina and close vaginal cuff before colpotomy. Cox proportional hazard model confirmed that oncologic outcomes were similar between 2 groups (29 cases in TLRH group and 35 cases in ARH group), including disease free survival (DFS, HR: 0.2441, 95%CI: 0.02852-2.09, p=0.198) and overall survival (OS, HR: 1.676, 0.1045-26.85, p=0.7152). Local recurrence was observed in 4 cases of ARH group (11%) but none in TLRH group. Metastasis was observed in 1 case of ARH group and 1 case of TLRH group.

Conclusion/Implications: TLRH done by Okabayashi method is accepted when combined with preventive method of tumor spillage. Tumor should be isolated, and irrigation of vagina and vaginal cuff closure before colpotomy is needed in both groups.

Surgical Films

Laparoscopic Assisted Infralelevator Posterior Exenteration with Vulvovaginal Reconstruction

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Introduction:

Recurrent cervical cancer following surgery and pelvic radiotherapy is a complex disease to treat. It is also difficult to differentiate field change cancers of the lower genital tract from recurrent cervical cancer. Exenterative surgery is commonly indicated for central recurrences with no involvement of pelvic side wall structures or lymphnodes as complete resection is feasible with better oncological outcomes.

We present a surgical film of a unique case who developed disease (? recurrent/field change cancer) on the vulva with extension to posterior vagina and anal mucosa.

Methods:

A 50 year old lady presented with a malignant growth on the vulva extending to lower vagina and anal canal. She did not have lateral side wall disease or lymph nodal involvement or distant metastasis. She had undergone non radical hysterectomy for an undiagnosed cervical cancer and had received adjuvant pelvic radiation elsewhere 12 months prior to referral to our hospital. We performed Laparoscopic Assisted Infralelevator Posterior Exenteration with Vulvovaginal Reconstruction using V-Y advancement flaps.

Results:

Her postoperative recovery was uneventful. Histopathology confirmed squamous cell cancer and margins of resection were free of tumor. Two suspicious sub-centimeter nodules in the pelvic peritoneum was positive for tumor for which she received adjuvant chemotherapy.

Conclusion:

Laparoscopic Assisted Infralelevator Posterior Exenteration with Vulvovaginal reconstruction even though a complex procedure facilitates early postoperative recovery and timely administration of adjuvant therapy when indicated.

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Surgical Films

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Techniques of Quadrant Wise Cytoreductive Surgery In Advanced Epithelial Ovarian Cancer : Total Parietal peritonectomy + Retrograde hysterectomy + Mesentric stripping & Glissons capsulectomy

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Objective: Cytoreductive surgery is the cornerstone of therapy for advanced epithelial ovarian cancer. Optimal cytoreduction defined as removal of all visible macroscopic disease has shown to improve disease free & overall survival in several studies. Addressing the disease in the upper abdomen in ovarian cancer is of at most significance for optimal cytoreduction apart from lower abdomen disease. Surgery in the upper abdomen is very challenging and needs sound knowledge of surgical anatomy, standard practice of surgical techniques overtime for better outcomes.

Methods:

This video shows various techniques of cytoreductive surgery done quadrant wise with description of regional applied surgical anatomy and voice over by a experienced gynec-oncosurgeon over a period of 15 years.

Right upper quadrantectomy shows techniques of glissons capsulectomy, porta hepaticus dissection, diaphragm stripping and resection, lesser omentectomy & bursectomy.

Left upper quadrantectomy shows techniques of diaphragm resection, splenectomy and tail of pancreas resection, total supra-colic omentectomy & omental bursectomy.

Lower abdominal surgery shows techniques of retrograde hysterectomy with pouch of douglasectomy and pelvic peritonectomy, bowel resection and anastomosis.

Video also shows techniques of total parietal peritonectomy, mesenteric stripping & management of nodules on bowel surface.

This video also shows how to use different surgical gadgets and energy sources for optimizing the available resources to achieve optimal cytoreduction- use of CUSA, harmonics, monopolar cautery with sharp and round tip blades using high cautery setting, also single swab and double swab technique for peritonectomy.