

IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts: Featured Surgical Films

Featured surgical film presentations are included in the session listed below. The session will be recorded for on-demand viewing via the IGCS 360 Educational Portal.

Surgical Session 02: Featured Surgical Films

Thursday, November 6, 15:50 - 16:50 | Hall C | in-person & on-demand

FF001 / #927

Topic: AS02. *Clinical Disciplines* / AS02e. *Surgical Techniques & Perioperative Management*

NERVE SPARING TECHNIQUE FOR EN BLOC RESECTION OF OVARIAN CANCER

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Introduction: En bloc resection for ovarian cancer was first described in 1973 and is a specialty defining procedure important in the removal of confluent pelvic disease. The procedure addresses the exfoliative pattern of disease spread seen in ovarian cancer and exploits the superficial nature of peritoneal invasion. Since initial description, there has been minimal technical refinement. Recently, negative functional outcomes following rectosigmoid resection (or low anterior resection) has been identified, however the etiology has not been fully clarified. We hypothesize that autonomic nerve injury is responsible for bowel, bladder and sexual dysfunction, so nerve sparing techniques are needed.

Description: En bloc resection typically requires lateral pararectal space entry due to large, central pathology. Peritoneal stripping and medial progression to the retrorectal space represents a high-risk step for early, proximal hypogastric nerve transection. Specifically, the hypogastric nerves need to be identified and isolated before retrorectal space entry to avoid nerve transection. We present technical videos and detail important anatomic relationships to support nerve preservation using a fresh frozen cadaveric dissection. Accompanying graphics have been created to solidify educational highlights.

Conclusion/Implications: The hypogastric nerves are visible to the unassisted eye and can be preserved during peritoneal stripping and en bloc pelvic resection. When dissection of the lateral pararectal space is required, nerve identification before retrorectal space entry is necessary. Preference for limited ureterolysis may also assist hypogastric nerve preservation during its course through the pelvis. Measurement of patient reported outcomes related to bowel, bladder and sexual function is important to implement meaningful technical improvements.

FF002 / #433

Topic: AS02. *Clinical Disciplines* / AS02e. *Surgical Techniques & Perioperative Management*

ROBOTIC RESECTION OF A SOLITARY DIAPHRAGMATIC RECURRENCE OF ENDOMETRIAL CANCER

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Introduction: This surgical film demonstrates the robotic resection of a solitary diaphragmatic recurrence of endometrial cancer.

Description: The patient is a 67-year-old female with a history of advanced high-grade mixed endometrial carcinoma and synchronous leiomyosarcoma, previously treated with extensive surgery, chemotherapy, and radiation. Four years after completion of therapy, routine surveillance imaging revealed an isolated lesion at the junction of the liver dome and right hemidiaphragm. Given the lesion's suspicious features and proximity to critical structures, a minimally invasive robotic approach was chosen to achieve complete resection with negative margins while minimizing surgical morbidity.

Conclusion/Implications: This case highlights the feasibility and advantages of robotic surgery for the management of isolated upper abdominal recurrences in gynecologic oncology.

FF003 / #499

Topic: AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management

STANDARDIZED TECHNIQUE GUIDED BY NOVEL ANATOMICAL CONCEPT FOR SINGLE-PORT LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY

Hua Tu, Jihong Liu

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Introduction: We developed a standardized technique based on a novel anatomical concept to reduce the difficulty of single-port laparoscopic para-aortic lymphadenectomy (PAL).

Description: A modified Trendelenburg positioning was adopted with the operating bed tilted 30 degrees to the right. This positioned the small intestines in the upper right abdomen, creating an angle between the inferior mesenteric vein and the ascending duodenum. We named this the renal vein angle, as its apex accurately indicates the left renal vein's location, serving as a stable anatomical landmark for PAL. By suspending the peritoneum on strategically selected points, a stable surgical space could be achieved. This technique enabled precise and efficient PAL processing up to the left renal vein. From February 2022 to April 2025, 58 consecutive gynecological cancer patients underwent single-port laparoscopic surgeries involving PAL. The median age was 54 years (range 18-67). The median body mass index was 25.6 kg/m² (range 18.1-51.4). Skeletonization of left renal vein, inferior venous cava and aorta were successfully achieved via standardized technique in all patients. The median number of para-aortic lymph nodes dissected was 20 (range 11-37). The median operating time for PAL was 95 minutes (range 54-285). All surgeries were performed via single-port laparoscopy by a young gynecologic oncologist. There was no PAL-associated major complication. Eight patients had lymph node metastasis confirmed by postoperative pathology. No recurrence was observed after a median follow-up time of 14 months (range 1-38).

Conclusion/Implications: Our standardized technique provides a reliable and safe approach with reduced difficulty for single-port laparoscopic PAL.

FF004 / #720

Topic: AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management

TRANSUMBILICAL MIDLINE INCISION FOR OVARIAN CANCER CYTOREDUCTIVE SURGERY

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Introduction: Surgery for ovarian cancer is one of the most comprehensive surgical procedures due to the spread pattern of ovarian malignancies. Cytoreduction most commonly requires a large vertical midline incision to provide access to organs to which ovarian cancer can metastasize. The umbilicus is traditionally circumvented with a periumbilical midline laparotomy; however, the reason for this approach is unclear. No studies have demonstrated the benefit of a periumbilical incision compared to a transumbilical approach. Previous studies have found no significant differences in rates of wound infection, deep surgical site infection, or evisceration between these two techniques. In addition, studies have found that making a symmetrical curve around the umbilicus with a periumbilical incision can be difficult for surgeons to execute, as well as have demonstrated increased rates of incisional hernia among periumbilical incisions compared to transumbilical incisions.

Description: In this video, we explain why surgeons should consider a transumbilical approach versus a periumbilical incision during exploratory laparotomy; demonstrate steps and strategies to creating a transumbilical incision; and review the steps of fascial closure with an umboplasty following a transumbilical incision.

Conclusion/Implications: Circumventing the umbilicus with a periumbilical incision during a vertical laparotomy has no demonstrated purpose. The transumbilical incision is safe and feasible and may benefit patient outcomes, with improved aesthetics and reduced risk of herniation. Future prospective studies are needed to investigate this approach.

FF005 / #801

Topic: AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management

LAPAROSCOPIC TOTAL VAGINECTOMY

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Introduction: Primary malignant melanoma of the vagina is an extremely rare and aggressive neoplasm (< 1% of all melanomas and under 3% of all primary vaginal malignancies). It carries a poor prognosis due to its propensity for early lymphatic and hematogenous spread. Surgical excision remains the mainstay of treatment, often necessitating radical approaches such as vaginectomy.

Description: A 60-year-old woman presented with postmenopausal bleeding. On speculum examination, a 1 × 1.5 cm black, raised lesion was identified on the right vaginal wall, midway between the introitus and the vaginal vault. The cervix appeared normal. Biopsy confirmed malignant melanoma of the vagina, with immunohistochemistry positive for S100, HMB-45, and Masson Fontana. Metastatic workup including MRI pelvis, contrast-enhanced CT of the abdomen, and whole-body PET scan showed disease confined to the vagina. Following discussion in a multidisciplinary tumor board, the patient opted for surgical management. She underwent a laparoscopic radical hysterectomy with total vaginectomy and pelvic lymphadenectomy. The procedure lasted 4 hours with minimal blood loss (<50 ml), and the postoperative recovery was uneventful. Histopathology confirmed malignant melanoma (0.7 × 0.5 × 0.3 cm) with ulceration and a Breslow thickness of 1 mm; surgical margins were uninvolved. All lymph nodes were negative for metastasis.

Conclusion/Implications: Primary vaginal malignant melanoma is rare and aggressive. Minimally invasive surgical management can be considered in selected cases with localized disease. This case highlights the feasibility and safety of laparoscopic total vaginectomy as part of comprehensive oncologic surgery. The patient remains disease-free at 7 months of follow-up.

FF006 / #485

Topic: AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management

ROBOTIC-ASSISTED EARLY REPAIR OF VESICOVAGINAL FISTULA IN A PATIENT WITH COLON CANCER

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Introduction: This video demonstrates the surgical technique and operative outcome of a robotic-assisted repair of a vesicovaginal fistula (VVF) in a patient with colon cancer extending into the vaginal canal.

Description: A 70-year-old female diagnosed with colon carcinoma invading the vaginal wall. She underwent robotic-assisted sigmoid colectomy with colopectostomy, upper vaginectomy, and intra operative cystotomy repair. Post operatively, the patient developed a vesicovaginal fistula and she opted for definitive surgical repair before chemotherapy. Preoperative cystoscopy and stent placement was performed, followed by robotic-assisted fistula repair and interposition of an omental flap between the bladder and the vagina. There were no surgical complications, and the estimated blood loss was 200 mL. Four weeks post operative cystogram was normal and the patient started chemotherapy with oxaliplatin, 5-fluorouracil and adjuvant leucovorin.

Conclusion/Implications: Early VVF repair is typically delayed for around 12 weeks post primary pelvic surgery to allow inflammation to resolve, tissues to heal and surgical planes to become well-vascularised. In this case, however, due to patient preference the repair was performed just 4 weeks after initial surgery. This demonstrates that with careful evaluation and technique, earlier intervention can be feasible. It highlights the adaptability of robotic-assisted surgery in complex, recently operated fields and supports individualized, patient-centered surgical planning.