

IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts: On-Demand Surgical Films

Registered delegates will have access to the on-demand surgical films via the IGCS 360 Educational Portal, the Surgical Film Cinema in the Exhibition Area at the meeting venue, and the onsite E-Poster stations. To listen to the film narrations (where available), please visit the onsite Surgical Film Cinema or the online IGCS 360 Educational Portal.

OF001 / #888

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

ROBOTIC APPROACH TO CERVICAL NEOPLASIA IN A KIDNEY TRANSPLANT PATIENT: ONCOLOGICAL SAFETY AND FUNCTIONAL PRESERVATION.

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Introduction: Robotic total hysterectomy in kidney transplant recipients with cervical cancer is a rare and challenging scenario requiring highly specialized surgical expertise. Immunosuppressed patients are at significantly increased risk for persistent HPV infection and the development of genital neoplasias, such as invasive cervical carcinoma.

Description: In this case, the patient had a heterotopic renal transplant in the right iliac fossa, with pelvic anatomical distortion and perivascular adhesions that precluded conventional ipsilateral lymphadenectomy. The surgery was performed using a robotic approach, enabling enhanced visualization, precise control, and safe dissection of critical structures, including the ureter and graft vessels. Hysterectomy was performed without a uterine manipulator to avoid cervical tumor disruption. The sentinel lymph node technique using indocyanine green was employed, allowing for selective lymphadenectomy only on the contralateral side of the graft.

Conclusion/Implications: The robotic platform was essential to safely perform a technically complex procedure with oncologic adequacy and functional preservation of the renal graft. This case highlights the importance of individualized surgical planning and the role of robotic technology in the management of gynecologic malignancies in transplant recipients, balancing anatomical risk and oncologic control.

OF002 / #957

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

SURGICAL INNOVATION IN ENDOMETRIAL CANCER: ROBOTIC SURGERY WITH THE NEW DA VINCI® SP SYSTEM

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Introduction: Surgery through a minimally invasive approach is the mainstay of the initial management of endometrial cancer, while sentinel lymph node (SLN) technique enhances the already excellent outcomes of minimally invasive full surgical staging. The recent introduction of Robotic Single-port (SP) surgery using the fourth-generation Da Vinci® SP surgical system has provided a more innovative minimally invasive route. This surgical film presents our initial experience using Da Vinci® SP for early-stage endometrial cancer.

Description: We described a case of a patient diagnosed with endometrioid endometrial cancer, International Federation of Gynecology and Obstetrics (FIGO) grade 2 (p53 wild-type, mismatch repair-proficient). Preoperative imaging suggested a presumed FIGO 2009 stage IA. The patient underwent a full surgical staging including hysterectomy, bilateral salpingo-oophorectomy and bilateral SLN biopsy. The total operative time was 100 minutes, and the estimated blood loss was 30 mL. Pain assessment using the Visual Analog Scale (VAS) 6 hours after surgery showed a score of 1 and 0 at 12 and 24 hours. There were no intra or perioperative complications, and the patient was discharged 24 hours after surgery.

Conclusion/Implications: Based on our experience, robotic surgical staging for endometrial cancer using the Da Vinci® SP system is feasible, achieving optimal operative outcomes. This new robotic platform may offers several advantages, including wide instrument triangulation to prevent collisions and enhanced cosmetic outcomes with “scar-free surgery”. Our experience suggests that Da Vinci® SP platform may be a promising surgical option for treating early-stage endometrial cancer.

OF003 / #1065

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

RETROPERITONEAL LEIOMYOSARCOMA INFILTRATING THE VENA CAVA – PARTIAL VENA CAVA RESECTION AND RECONSTRUCTION WITH PERITONEAL PATCH

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Introduction: Radical surgical resection remains the most effective curative treatment for localized leiomyosarcoma (LMS), with 5-year survival rates dropping from 25-45% to 10-25% when residual disease remains after surgery. Poorer outcomes in certain anatomical sites, such as the retroperitoneum, are often due to the involvement of vital structures that complicate complete resection. This highlights the critical role of advanced surgical techniques to achieve negative margins in challenging locations.

Description: This video demonstrates an extensive surgical approach to achieve negative margins in the resection of a retroperitoneal LMS. The tumor infiltrated the ventral wall of the inferior vena cava (IVC), necessitating a partial IVC resection. Vascular continuity was restored using a peritoneal patch harvested from the upper right abdomen. The surgery was completed with a standard hysterectomy and an ileocecal resection with a stapled side-to-side anastomosis.

Conclusion/Implications: This case illustrates the technical feasibility of achieving clear margins in retroperitoneal LMS, even with invasion of major vascular structures such as the IVC. Successful outcomes depend on a multidisciplinary approach in high-volume expert centers, where complex resections and reconstructions can be performed safely to optimize the prognosis of the patients.

OF004 / #859

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

LAPAROSCOPIC RADICAL HYSTERECTOMY WITH INTERNAL ILIAC VESSEL RESECTION AND URETERAL REIMPLANTATION FOR LOW-GRADE ENDOMETRIAL STROMAL SARCOMA

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Introduction: Low-grade endometrial stromal sarcoma (LGESS) presents clinical challenges due to potential myometrial invasion and ureteral involvement. This case highlights the complexity in surgical intervention for a 36-year-old female with LGESS mass extending and involving the right parametrial vessels and ureter, which causes a significant hydroureteronephrosis, emphasizing the critical role of imaging prior to complex surgical planning.

Description: Following a laparoscopic myomectomy in October 2024, final pathology confirmed LGESS. Preoperative MRI demonstrated a complex uterine tumor with right parametrial and internal iliac vein involvement, along with ureteral compression causing moderate hydronephrosis. The surgical approach included dissection of the left external iliac sentinel lymph node and right pelvic lymphadenectomy, followed by radical hysterectomy with resection of the right internal iliac vessels distal to the superior gluteal artery, as well as removal of venous branches encroaching upon the sacral roots. The ureter, encased by tumor, was removed en bloc, and ureteral reimplantation was subsequently performed.

Conclusion/Implications: This case underscores the importance of thorough imaging in diagnosing and managing recurrent disease in LGESS. The surgical approach, incorporating advanced techniques such as laparoscopic resection and careful vascular management, signifies a step forward in treating gynecological malignancies with complex local infiltration.

OF005 / #496

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

LAPAROSCOPIC TOTAL MESOMETRIAL RESECTION IN CERVICAL CANCER-ANATOMICAL INSIGHTS

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Introduction: Total mesometrial Resection(TMMR) offers embryological planes of resection with a great potential of increasing the locoregional control in cervical cancer. Laparoscopy indeed has the advantage of improving short term outcomes and earlier recovery and shorter hospital stay.

Description: Methodology: Here the video describes laparoscopic TMMR is initiated with bilateral pelvic, common iliac, presacral nodal dissection along with all the fibrofatty tissue along endopelvic fascia.

Ureter along with mesoureter is dissected away from ligamentum mesometrium posteriorly.

This planes also helps in preservation of autonomic nerves.

Laterally this plane helps in ligation of uterine pedicle near the origin at internal iliac artery.

Anteriorly mesometrium is separated from mesobladder in embryological planes.

This plane of dissection helps to preserve autonomic nerves supplying the bladder.

With sufficient vaginal margin of 3cm, specimen is cut and vault is closed.

Results: Laparoscopic TMMR is a safe and effective technique which follows the principles of embryological planes of dissection and resection.

Patient did well in post operative period and got discharged on day 4.

Conclusion/Implications: Laparoscopic TMMR is a feasible approach with a potential advantage of oncologically radical resection with improved short term outcomes with the laparoscopic route.

OF006 / #319

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

LAPAROSCOPIC ANTERIOR EXENTERATION FOR MULTIFOCAL VAGINAL ADENOCARCINOMA

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Introduction: Vaginal carcinomas usually require multimodality therapy .They are rarely operable during presentation. Localised adenocarcinomas in general respond poor to radiation therapy and multifocal disease poses challenges in delivering radiation therapy and also increases significant toxicity to patient.

Description: Methodology: Multifocal localised vaginal adenocarcinoma is treated with anterior exenteration. Laparoscopically pedicles of bladder and uterus is dissected and secured. Laparoscopic mobilisation done for uterus and bladder. In lithotomy position, vulvo -vaginectomy done with dissection along recto vaginal septum. Specimen retrieved through perineal route.

Results: The video demonstrates important steps related to laparoscopic anterior exenteration with vulvo vaginectomy.

Conclusion/Implications: Localised multifocal vaginal adenocarcinomas can be safely treated with resection of bladder and uterus along with vagina and vulva.

OF007 / #185

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

ROBOTIC SECONDARY CYTOREDUCTION IN THE DIAPHRAGMATIC AREA - SURGICAL APPROACH, TIPS AND TRIKS

Reitan Ribeiro, Gabriel Levin, Laurence Bernard, Xing Zeng, Annie Leung, Lucy Gilbert McGill, Montreal, Canada

Introduction: In this video, we present a step-by-step guide to robotic retrohepatic diaphragmatic resection. The procedure for vaginal resection is briefly presented. Retrohepatic resections pose challenges due to the liver's access limitations to its posterior aspect. We discuss in detail the patient's positioning, trocar placement, hepatic mobilization, approach to diaphragmatic lesions, diaphragm repair, and postoperative care, including the use of a thoracic drain and the return to daily activities. The patient recovered well and was discharged home the following day.

Description: A 36-year-old woman was initially diagnosed in 2018. She underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, pelvic and para-aortic lymph node dissection, omentectomy and peritoneal implants resection. Pathological examination revealed Grade 1 endometrial endometrioid carcinoma Stage IV due to peritoneal implants. After surgery, she completed adjuvant treatment with six cycles of Carbo/Taxol. In October 2024, a recurrence was confirmed via a vaginal vault biopsy. An MRI revealed a 2 cm vaginal recurrence and a 1.4 cm nodule on the capsule of liver segment VII. A PET scan confirmed active disease at the vaginal vault but no significant liver involvement. In response, she underwent robotic partial vaginectomy and retrohepatic diaphragmatic lesion resection, as the supposed liver lesion was actually on the diaphragm.

Conclusion/Implications: Robotic surgery may facilitate retrohepatic diaphragmatic resections in selected patients with limited recurrences, offering a minimally invasive option that can reduce recovery time and improve surgical outcomes.

OF008 / #711

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

SURGERY FOR PLACENTA ACRETTA SPECTRUM DISORDER

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Introduction: Novel technique on hysterectomy for a patient with placenta accreta spectrum disorder. This technique 1st presented by Dr David Atallah.

Description: A hysterectomy technique with minimal blood loss and surgical morbidity for patients with placenta accreta spectrum disorder.

Conclusion/Implications: Technique associated with minimal surgical morbidity and blood loss.

OF009 / #665

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

RETROPERITONEAL PELVIC LYMPHADENECTOMY VIA SUPRA-INGUINAL INCISION FOR RECURRENT OVARIAN CANCER: THE RUTHERFORD MORRISON APPROACH

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Introduction: We present a case of a 75-year-old woman with oligo-metastatic recurrence of high-grade serous ovarian cancer (HGSOC) involving the left external iliac lymph node, managed via retroperitoneal pelvic lymphadenectomy using a supra-inguinal (Rutherford Morrison) incision. Adapted from renal transplant surgery, this approach provides retroperitoneal access without entering the peritoneal cavity—beneficial for obese or heavily pre-treated patients with likely dense adhesions.

Description: Initially diagnosed with Stage IIIC HGSOC in 2020, the patient underwent primary debulking followed by chemotherapy. A second recurrence in 2024 revealed a solitary glucose-avid lymph node above the inguinal ligament. Surgical resection via a retroperitoneal approach was favored.

With the patient in modified lithotomy, a 10 cm incision was made 2 cm above the inguinal ligament. Dissection proceeded through the following - skin, camper's fascia, scarpa's fascia, external oblique aponeurosis, external oblique muscle, internal oblique/ transversalis abdominus muscle layers and transversalis fascia to access the retroperitoneal space. The psoas muscle, genitofemoral nerve, sigmoid colon, ureter, and iliac vessels were identified. The enlarged lymph node was excised using Liga clips and Ligasure. Hemostasis was confirmed, a drain placed, and layered closure completed.

Conclusion/Implications: This approach avoids re-entry into the peritoneal cavity, reducing surgical morbidity and risk of bowel injury in re-operative fields. The Rutherford Morrison incision offers safe, direct retroperitoneal access and may be especially valuable in selected cases of isolated distal pelvic nodal recurrence. As a novel application in gynecological oncology, it highlights the importance of cross-disciplinary surgical innovation and warrants broader evaluation in complex ovarian cancer cases.

OF010 / #235

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

ILEAL CONDUIT DIVERSION DURING TOTAL PELVIC EXENTERATION

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Introduction: Pelvic exenteration is a challenging procedure mainly performed in cases of persistent or recurrent locally advanced gynecological malignancies after radiotherapy. It was first described in 1948 by Alexander Brunschwig as a palliative procedure in a patient diagnosed with recurrent cervical cancer, and it was later applied to other types of pelvic tumors, such as colorectal cancer or lower urinary tract malignancies. In 1950, Eugene Bricker first reported the ileal conduit diversion, which to date remains the most commonly performed urinary reconstruction. To perform the ileal conduit, a 20cm segment of ileum in isoperistaltic orientation is harvested at least 15cm away from the ileocecal valve. The ureters are anastomosed to the proximal end of the conduit while the distal end is used for the stoma. The ureters are spatulate, before end-to-side separate anastomosis to the anti-mesenteric aspect of the loop.

Description: Here, we demonstrate a case of creating an ileal conduit diversion during a total pelvic exenteration.

Conclusion/Implications: This case illustrates the technical execution and clinical role of ileal conduit diversion during a total pelvic exenteration for recurrent gynecologic malignancy. As one of the most radical procedures in gynecologic oncology, pelvic exenteration remains a potentially curative option for select patients with central pelvic recurrence after radiotherapy. Demonstrating the reconstruction of the urinary tract using an ileal conduit in this context reinforces the importance of surgical precision and multidisciplinary expertise in achieving optimal outcomes.

OF011 / #234

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

WHIPPLE PANCREATICODUODENECTOMY DURING CYTOREDUCTIVE SURGERY

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Introduction: Ovarian cancer remains the deadliest gynecologic cancer and the fifth leading cause of cancer-related deaths among women. The reduction in mortality from ovarian cancer over the past 40 years has been notably modest compared to other malignancies. Ovarian cancer typically presents with non-specific symptoms, including abdominal distention, urinary symptoms, early satiety, and pelvic or abdominal discomfort which can be attributed to various gastrointestinal, urological, or other medical conditions. Since ovarian cancer spreads mainly intraperitoneally or via lymphatics, obstruction of the retroperitoneal duodenum is rarely encountered.

Description: Here, we demonstrate a high-grade serous ovarian cancer case that required a Whipple procedure as part of the interval debulking surgery to achieve complete cytoreduction.

Conclusion/Implications: This case highlights the atypical presentation and rare anatomic spread of high-grade serous ovarian cancer requiring a pancreaticoduodenectomy (Whipple procedure) during interval debulking surgery to achieve complete cytoreduction. The significance of this work lies in its illustration of the surgical complexity sometimes required to optimally manage advanced ovarian cancer. It underscores the need for individualized, multidisciplinary surgical planning and the importance of complete cytoreduction in improving survival outcomes.

OF012 / #1077

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

ENDOSCOPIC MANAGEMENT OF ANASTOMOTIC LEAK AFTER LOW ANTERIOR RECTUM RESECTION

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Introduction: Anastomotic leakage is a serious complication following bowel resection and is associated with increased morbidity and mortality. Endoluminal vacuum therapy (EVT) has been reported as an effective treatment in colorectal surgery, but has not yet been adopted in gynecologic oncology.

Description: An anastomotic leak was diagnosed on day three after low anterior rectum resection performed during cytoreductive surgery in a 55-year-old patient with FIGO stage IIIC high-grade serous ovarian cancer. Imaging revealed early abscess formation in the pelvis. A protective ileostomy was created and EVT was initiated to drain the abscess and support leak closure. Endoscopy revealed an 8mm defect located 4cm ab ano, communicating with a 5cm pelvic abscess cavity extending into the peritoneal cavity. The endoscopic video sequences show the string-of-pearls-like configuration of sponge material being used to fill the abscess cavity, while continuous negative pressure of -125mmHg was applied via endoluminal drainage. After four sponge exchanges within a 24-day period, the abscess resolved and the remaining leak was successfully closed using an over-the-scope clip. The patient received first systemic treatment two months later.

Conclusion/Implications: In this case, EVT contributed significantly to the closure of an anastomotic leak. EVT should be considered as standalone or adjunctive treatment option for anastomotic leakages following bowel resection in gynecological oncology, in particular in stable patients with high perioperative risks.

OF012A / #1077

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

COMPLETE RESECTION OF A MASSIVE PELVIC AGGRESSIVE ANGIOMYXOMA BY LAPAROSCOPY COMBINED WITH PERINEAL SURGERY

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Introduction: Aggressive angiomyxoma (AAM) is an uncommon hormone-dependent mesenchymal neoplasm, recognized as a low-grade malignant tumor due to its locally infiltrative growth and high recurrence rate. It predominantly originates from soft tissues in the pelvic region such as perineum and vaginal wall, usually affecting the lower genital tract of reproductive-aged women. The most common symptom is gradually enlarging mass. However, preoperative diagnosis of AAM is difficult due to the absence of specific clinical features, frequently misdiagnosed as Bartholin duct cyst, lipoma, and vulva abscess. Surgery is the preferred treatment with hormonal therapy as an adjuvant option. The reported postoperative recurrence rate is relatively high (28%-72%) with complete resection as the essential prerequisite for minimizing the risk of recurrence.

Description: A rare case of AAM manifesting as a large mass extending from the left pelvis to vulvar was presented. The tumor was completely resected by gynecologic oncologists without assistance from other surgeons, using laparoscopy combined with perineal approach. The surgical procedures consist of the following steps: exposure of the mass, sequential excision of the pelvic and perineal part of the mass, pelvic floor reconstruction and episiotomy. No recurrence was observed as of April 2025 (46 months after diagnosis).

Conclusion/Implications: In this video (<https://vimeo.com/1081098699?share=copy>), we demonstrate how we combined the minimally invasive technology and perineal approach for complete resection of a massive tumor invading from pelvis to vulvar. This technique is feasible and safe, enabling en bloc resection of tumors involving multiple sites via a small incision.

OF013 / #701

Topic: AS06. Tumor Types / AS06b. Cervical Cancer

LAPAROSCOPIC MANAGEMENT OF CHYLOPERITONEUM FOLLOWING SIMPLE TRACHELECTOMY AND PELVIC SENTINEL LYMPH NODE DISSECTION – A CASE REPORT

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Introduction: Pelvic and/or paraortic lymphadenectomy are essential parts of staging and therapy in patients with gynecologic malignancies. The more extensive and closer to Cysterna chyli the higher the risk for lymphatic fistula. Chyloperitoneum has not been described following pelvic sentinel lymphadenectomy.

Description: In a 28-old nulliparous women adenocarcinoma of the cervix with FIGO IB1 L0 V0 G2 R1 was diagnosed by conization and one month later completely removed by re-conization. Due to high need for safety, she decided for simple trachelectomy with sentinel concept as fertility sparing therapy. Surgery was without adverse intraoperative event with removal of 14 tumor-free lymph nodes. Postoperatively patients developed chyloscos, that could not be managed by repeated puncture and conservative treatment. During second laparoscopy lymphatic fistula in right-sided lumbosacral fossa was identified, clipped and covered by fibrin-glue. 18 months later patients is disease-free and without any complaints.

Conclusion/Implications: Incidence of chyloscos following gynecologic oncologic surgery is very low (0.1-1%). This complication is not described following sentinel lymph node dissection. If conservative treatment fails, surgery with closure of fistula using clips, fibrin glue and/or sutures is mandatory.

OF014 / #782**Topic:** AS06. *Tumor Types* / AS06d. *Ovarian Cancer***MANAGEMENT OF HIGH-GRADE OVARIAN ADENOCARCINOMA IN AN INTRAPERITONEAL PELVIC RENAL TRANSPLANT RECIPIENT**Hadi Erfani¹, Farr Nezhat²¹University of Southern California, Los Angeles, United States of America, ²Nezhat Surgery for Gynecology/ Oncology, New York, United States of America

Introduction: The increasing number of organ transplant recipients has led to a rise in cancer diagnoses in this population. Kidney transplant recipients, in particular, have a two-to-four-fold higher risk of developing cancer due to immunosuppressive therapy. The management of gynecologic cancers in this subset of patients presents unique challenges due to anatomical considerations, immunosuppression, and the nephrotoxicity of oncologic treatments.

Description: A 44-year-old woman with a history of polycystic kidney disease underwent a bilateral nephrectomy followed by a living-related intraperitoneal renal transplant. She presented with pelvic pain and was found to have high-grade ovarian adenocarcinoma, possibly arising from endometriosis. Surgical staging included total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, omentectomy, and right pelvic lymph node dissection. The patient underwent six cycles of carboplatin and paclitaxel chemotherapy while maintaining stable renal function with close monitoring of immunosuppressive drug levels. Surveillance imaging detected recurrence in the right pelvic lymph nodes, leading to secondary tumor debulking and whole pelvic radiation therapy. Despite a slight increase in creatinine, kidney function remained stable, and the patient has remained disease-free on subsequent follow-ups.

Conclusion/Implications: The management of ovarian cancer in kidney transplant recipients requires a multidisciplinary approach to balance oncologic control with graft preservation. Close monitoring of renal function, careful surgical planning, and tailored chemotherapy and radiation strategies are critical. More research is needed to establish standardized guidelines for managing gynecologic malignancies in transplant patients.

OF015 / #1076

Topic: AS06. *Tumor Types* / AS06d. *Ovarian Cancer*

PERIHEPATIC AND PERIPANCREATIC LYMPH NODE DISSECTION AND ANATOMY OF HEPATODUODENAL REGION IN OVARIAN CANCER CASE

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Introduction: In ovarian cancer surgery, understanding the anatomy of the hepatoduodenal region is critically important for achieving complete cytoreduction. In this video, we demonstrate the anatomy of the hepatoduodenal region and the excision of perihepatic and peripancreatic lymph nodes in a patient with advanced-stage ovarian cancer.

Description: In a patient with perihepatic lymph nodes identified on preoperative imaging, perihepatic and peripancreatic lymph node excisions were performed during cytoreductive surgery. During the dissection of the lymph nodes, the liver, pancreas, and the associated critical anatomical structures were exposed.

Conclusion/Implications: This video aims to demonstrate the hepatoduodenal ligament and the associated critical structures.

OF016 / #935**Topic:** *AS06. Tumor Types / AS06d. Ovarian Cancer***INDOCYANINE GREEN FLUORESCENCE-GUIDED MINIMALLY INVASIVE INTERVAL DEBULKING SURGERY WITH HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY FOR ADVANCED-STAGE EPITHELIAL OVARIAN CANCER: OUR FIRST LOCAL EXPERIENCE**Almaira Pagayao, Romelyn Imperio-Onglao

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Introduction: Epithelial ovarian cancer is often diagnosed in advanced stages, commonly characterized by peritoneal carcinomatosis. Treatment is cytoreduction, either as primary or interval debulking surgery after neoadjuvant chemotherapy. Open surgery is traditionally the preferred approach but there is growing interest in minimally invasive surgery, with comparable oncologic outcomes and lower perioperative morbidity. Limited visualization in certain anatomic locations may limit detection of small/occult peritoneal metastasis. A novel approach to enhance detection of carcinomatosis is the use of indocyanine green fluorescence-guided imaging. Studies on this technique in ovarian cancer are limited, with most case series reporting its use in laparotomy.

Description: A 58-year-old woman presented with ascites. Diagnostic laparoscopy showed carcinomatosis, and biopsy showed high-grade adenocarcinoma. Three cycles of NACT with Carboplatin/Paclitaxel were administered. Minimally invasive IDS with HIPEC was planned. Preoperative intraureteral instillation of ICG was done and 5mg ICG was administered intravenously after abdominal survey. Tumor debulking was performed via conventional laparoscopy. Under near-infrared (NIR)-fluorescence imaging, subcentimeter tumor implants were identified over the peritoneum and bowel mesentery, which were less apparent under standard white-light imaging. Complete cytoreduction was achieved, and HIPEC was administered. Patient tolerated the procedure well.

Conclusion/Implications: This report demonstrates the feasibility and safety of MIS for IDS with HIPEC for advanced-stage EOC, and the use of ICG-FI for intraoperative detection of peritoneal metastases. Challenges of this technique include variability in ICG uptake, limited ability to discriminate between active metastasis and residual tumoral scars, lack of standardized dosing and timing of administration, and limited availability of NIR imaging in resource-limited settings.

OF017 / #1006

Topic: AS06. *Tumor Types* / AS06d. *Ovarian Cancer*

TRANSDIAPHRAGMATIC VATS

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Introduction: In advanced-stage ovarian cancer, complete cytoreduction is a crucial goal due to its positive impact on overall survival. In this video, we demonstrate the use of transdiaphragmatic VATS in a patient with stage IVB ovarian cancer.

Description: In a 59-year-old patient diagnosed with ovarian cancer, preoperative imaging revealed pleural effusion in the left hemithorax. During the operation, the left hemithorax was accessed using a 10 mm camera trocar. Thoracoscopy revealed tumoral implants on the pleural surface of the diaphragm. The pleural effusion was drained, followed by partial diaphragmatic resection to excise the tumor. The resulting defect was then repaired with primary closure.

Conclusion/Implications: Transdiaphragmatic VATS is a feasible and effective surgical approach for the management of pleural metastases in patients with advanced-stage ovarian cancer. It allows for direct visualization and resection of diaphragmatic and pleural implants, contributing to complete cytoreduction a key factor in improving overall survival. When performed by experienced teams in selected patients, this technique can be safely integrated into the multimodal treatment of advanced ovarian cancer.

OF018 / #969

Topic: AS06. *Tumor Types* / AS06e. *Trophoblastic Disease & Rare Tumors*

LIVER WEDGE RESECTION IN A CASE OF METASTATIC CHORIOCARCINOMA

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Introduction: Choriocarcinomas are an aggressive form of gestational trophoblastic neoplasia. Approximately 50% of cases occur following a molar pregnancy. The most common sites of metastasis are the lungs and the vagina. Also can metastasize to liver and brain. In this video, we aimed to present the surgical management of a choriocarcinoma case with liver metastasis.

Description: In a 29-year-old patient under follow-up for choriocarcinoma, routine imaging revealed a newly developed metastatic lesion located at the junction of liver segments 5 and 8. The patient was diagnosed two years ago, with a calculated WHO score of 14. She had previously received multi-agent chemotherapy regimens and cranial radiotherapy. Due to the presence of an isolated metastatic lesion in the liver, a wedge resection was planned. During the operation, liver mobilization was performed. After delineation of the metastatic lesion margins, parenchymal dissection was carried out using a Cavitron Ultrasonic Surgical Aspirator (CUSA).

Conclusion/Implications: Although chemotherapy is generally the preferred treatment for high-risk and ultra high-risk choriocarcinoma cases, surgical intervention can also be beneficial in selected patients.

OF019 / #1106

Topic: *AS06. Tumor Types / AS06f. Vulvar & Vaginal Cancer*

LATERAL VEIL - THE WAY FORWARD ??(CONTEXT OF IFLND IN CA VULVA)

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Introduction: Videoendoscopic inguinal lymphadenectomy, or VEIL, is a minimally invasive alternative to traditional open groin node dissection. Originally described for penile cancer, it has been increasingly adopted in vulvar cancer surgery. VEIL aims to reduce wound complications such as infection and flap necrosis offering faster recovery and improved cosmetic outcomes.

Description: In conventional VEIL, access is gained via a medial approach beneath the inguinal ligament (apex of femoral triangle), offering limited workspace and visibility. In contrast, lateral VEIL approaches the femoral triangle from the side, along the sartorius muscle, providing broader exposure and better ergonomics.

Conclusion/Implications: Implications of Lateral VEIL Reduced wound complications Faster recovery Shorter learning curve (robotic) Interestingly, this video demonstrates the **author's first robotic VEIL (second groin)** and only the **fifth robotic surgery** using the **da Vinci system**.