

SC001 / #967

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

ROBOTIC-ASSISTED PRIMARY REPAIR OF AN IATROGENIC OBTURATOR NERVE TRANSECTION DURING PELVIC LYMPHADENECTOMY

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Introduction: The aim of this video is to demonstrate a robotic-assisted repair of an iatrogenic obturator nerve injury (ONI) sustained during complex pelvic surgery.

Description: This video presents a real patient case of robotic-assisted obturator nerve repair, beginning with a comprehensive review of the nerve's pelvic anatomy, its motor and sensory functions, and the clinical signs of neurological deficit. Following a demonstration of the iatrogenic damage sustained during a pelvic lymphadenectomy, the content focuses on the surgical technique of immediate intraoperative recognition and the meticulous removal of devitalized tissue to address crush or thermal injury. Utilizing the robotic platform's precision, a tension-free epineural repair is performed using multiple 5-0 Prolene sutures to ensure fascicular alignment. The video concludes by showcasing the patient's clinical outcomes and functional recovery, providing guidance for managing this intraoperative complication.

Conclusion/Implications: In conclusion, immediate intraoperative recognition and robotic microsurgical repair are essential for preventing permanent neurological morbidity following obturator nerve injury. This case demonstrates that by utilizing the robotic platform's precision, surgeons can successfully restore functional mobility and improve long-term patient outcomes after complex pelvic dissections.

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

ROBOTIC RESECTION OF THE INTERNAL ILIAC VASCULAR SYSTEM FOR RECURRENT LOW-GRADE ENDOMETRIAL STROMAL SARCOMA

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Introduction: The aim of this video presentation is to demonstrate the diagnostic challenges and complex surgical management of a late recurrence of low-grade endometrial stromal sarcoma (ESS), highlighting deep pelvic dissection, neurolysis, and Laterally Extended Endopelvic Resection (LEER) involving the internal iliac vasculature in a previously operated pelvis.

Description: This video presentation details the management of a late recurrence of low-grade endometrial stromal sarcoma (ESS), highlighting the diagnostic challenges and surgical complexities inherent in secondary cytoreduction. We first review the preoperative imaging findings, emphasizing the difficulty of differentiating recurrent tumor from postoperative fibrosis in a previously operated pelvis. The surgical footage demonstrates a high-complexity deep pelvic dissection and Laterally Extended Endopelvic Resection (LEER), featuring extensive neurolysis and the technical management of tumor invasion into the internal iliac vasculature. By detailing the mobilization of major pelvic structures in a scarred field, the video provides a framework for achieving oncological clearance while preserving critical neurological and vascular function. The presentation concludes with a summary of the patient's postoperative course, showcasing the feasibility of aggressive surgical intervention for late ESS recurrences.

Conclusion/Implications: The significance of this case lies in demonstrating that complete oncological resection of late ESS recurrences is achievable through advanced surgical techniques like LEER and meticulous neurolysis, even when faced with the technical challenges of a previously operated pelvis and major vascular invasion.

SC003 / #766

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

ROBOTIC VASCULAR DISSECTION AND RESECTION OF ISOLATED EXTERNAL ILIAC NODE RECURRENCE AFTER CHEMOTHERAPY IN STAGE 2B CERVICAL CANCER

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Introduction: Isolated nodal recurrence after chemoradiation for locally advanced cervical cancer represents a therapeutic challenge. Surgical resection may offer local disease control in certain patients. This video demonstrated robotic vascular dissection and resection of an isolated external iliac lymph node recurrence following treatment for stage IIB cervical cancer.

Description: A 47 year old patient previously treated with definitive chemoradiation and brachytherapy remained disease free for 18 months before PET/CT identified an isolated external iliac nodal recurrence. Surgical resection was performed using a robotic approach, beginning with the development of paravesical and pararectal spaces to allow ureteral identification and exposure of the external iliac vessels. Dissection was performed cautiously due to radiation induced fibrosis and elevated fistula risk. Following medial mobilization of the ureter, vascular dissection was performed, where an inadvertent arterial injury occurred. Hemostasis was achieved through proximal and distal vascular control, and the defect was managed via transverse repair using a 4-0 Prolene suture to prevent luminal narrowing. Despite suspected vascular adherence, circumferential dissection of the external iliac vein enabled safe en bloc tumour removal. The 2.5 cm specimen, later confirmed by pathology as a metastatic lymph node with extracapsular extension, was extracted in an endobag. Estimated blood loss was 20 mL, and the patient was discharged on postoperative day one without any complications.

Conclusion/Implications: Robotic resection of isolated pelvic nodal recurrence following prior chemoradiation is feasible and can be performed safely in carefully selected patients. This approach enables precise vascular repair when necessary.

SC004 / #707

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

MINIMALLY INVASIVE APPROACH TO AN EXTRAORDINARY CERVICAL CANCER CASE WITH GASTROINTESTINAL STROMAL TUMOR AND LOW GRADE APPENDICEAL NEOPLASIA MIMICKING METASTATIC DISEASE

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Introduction: After LACC trial minimally invasive approach has lost its applicability in the arena of cervical cancer surgical therapy. To decrease morbidity of open surgery hybrid concepts, laparoscopic approach to lymph nodes with radical hysterectomy by low transverse incision is reasonable and feasible. Here we present an unusual cervical cancer patient both in presentation and as a case.

Description: A patient with diagnosis of cervical squamous cancer with right adnexial mass and left morphologically malignant appearing implant on small bowel wall on MRI was discussed on tumor board. To make picture clearer and as a part of hybrid approach to lessen morbidity exploratory laparoscopy (+/- sentinel lymph node dissection) was planned. An appendiceal mucocoele and small bowel GIST tumor were observed in exploration and had explained atypical imaging findings and presentation. Laparoscopically appendectomy segmental small bowel resection, sentinel node mapping and pelvic paraaortic lymphadenectomy then by Pfannenstiel incision type C1 hysterectomy were performed. Specimen pathologies stage IB2 for cervical squamous cancer, gastrointestinal stromal tumor for small bowel mass and low grade mucinous neoplasia were reported. Approach by laparoscopy first and performing parts of the procedures endoscopically then carrying out radical hysterectomy by Pfannenstiel incision have made possible to complete surgical therapy in minimally invasive approach and had advantage in respect of morbidity.

Conclusion/Implications: Even though, minimal invasive surgery was significantly abandoned after the LACC trial, performing sentinel node biopsy, lymphadenectomies and various procedures endoscopically, and sequentially, carrying out the radical hysterectomy by Pfannenstiel incision, can be adopted as advantageous approach for cervical cancer patients.

SC005 / #715

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

LAPAROSCOPIC NERVE-SPARING PARAAORTIC LYMPH NODE DISSECTION WITH THREE GAUZE TENTED TECHNIC

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Introduction: Accurate nodal assessment is crucial in gynecologic cancers. Paraaortic lymph node dissection (PALND) provides essential staging information and guides adjuvant treatment. Minimally invasive techniques offer improved visualization and may reduce morbidity. This video demonstrates a standardized laparoscopic PALND focusing on key anatomical landmarks.

Description: A patient with cervical cancer underwent laparoscopic sentinel lymph node dissection followed by paraaortic lymphadenectomy and subsequent open radical hysterectomy. The laparoscopic approach included retroperitoneal access, identification of the ureter, and exposure of the inferior vena cava and abdominal aorta. Systematic lymph node dissection was performed from the aortic bifurcation up to the level of the renal vessels. Emphasis is placed on anatomical orientation, meticulous dissection, and strategies to prevent vascular and ureteral injury. In this case, the three-gauze tented technique facilitated better visualization of the surgical field and more effective removal of nearby tissues and organs in the surgical field. It can be used as a facilitating method in such risky field surgeries to provide a clearer field of vision and comfortable working conditions.

Conclusion/Implications: Laparoscopic PALND is a feasible and effective technique for surgical staging in cervical, endometrial and ovarian cancers. A standardized, anatomy-based approach enhances safety and reproducibility. This video provides practical guidance for gynecologic oncologists aiming to refine minimally invasive surgical skills.

SC006 / #220

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

MINIMALLY INVASIVE, MAXIMUM PRECISION: SINGLE-PORT LAPAROSCOPIC HYSTERECTOMY AND SLN MAPPING WITH MICROMETASTASIS DETECTION IN ENDOMETRIAL CANCER

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Introduction: Surgical staging via minimally invasive surgery (MIS) is the standard for endometrial cancer. Sentinel lymph node (SLN) mapping improves diagnostic accuracy and reduces lymphadenectomy risk such as lymphedema and prolong operative time. FIGO 2023 emphasizes nodal ultrastaging, where micrometastasis upstages patients to Stage IIIC1mi. This video demonstrates the precision of the single-port platform in achieving these standards.

Description: We present a 62-year-old G0 virgin female with endometrial cancer. Pre-operative imaging showed a 2.3 cm endometrial lesion. After cervical ICG injection, single-port umbilical entry was performed. Following adhesiolysis of the sigmoid colon, SLN mapping was conducted. The right and left retroperitoneal approach were used to successfully identify and retrieve sentinel nodes under near-infrared fluorescence. Subsequent TLH was performed. The vaginal vault was closed with a two-layer barbed suture.

Conclusion/Implications: The procedure was successfully performed with no intraoperative complications or conversion to multi-port laparoscopy. Final pathology revealed a micrometastasis (< 2 mm) in the left sentinel node, resulting in an upstage to **FIGO 2023 Stage IIIC1mi**. This case demonstrates that the technical challenges of single-port surgery can be overcome to deliver high-quality oncologic care, specifically the precise detection of microscopic nodal disease essential for tailored adjuvant therapy.

SC007 / #483

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

ABDOMINAL RADICAL TRACHELECTOMY IN NTRK FUSION POSITIVE SARCOMA OF THE CERVIX

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Introduction: Cervical sarcomas are rare malignancies with limited evidence to guide management, especially in young patients desiring fertility preservation. Tumors with neurotrophic tyrosine receptor kinase (NTRK) gene fusions leading to constitutive activation of TRK signaling pathways, demonstrate high response rates to targeted TRK inhibitors such as Larotrectinib. We present a surgical film of a 23-year-old patient with NTRK fusion-positive cervical sarcoma undergoing a fertility preserving approach of neoadjuvant Larotrectinib with partial response on imaging, followed by abdominal radical trachelectomy.

Description: The video illustrates the key steps of the surgical treatment of cervical sarcoma by abdominal radical trachelectomy, including resection of the cervix, upper vagina and parametria, while preserving the uterine corpus and thus fertility. Staging procedures included bilateral indocyanine green (ICG)-guided sentinel lymph node biopsy, followed by pelvic lymphadenectomy, and omental biopsy. After confirmation of negative margins, a permanent internal cerclage was placed and reconstruction was performed via isthmo-vaginal anastomosis.

Conclusion/Implications: Final pathology confirmed a pathological complete response, and the patient remains disease-free on follow-up. This case highlights the relevance of molecular diagnostics and the potential of neoadjuvant TRK inhibition in downstaging NTRK fusion-positive cervical sarcomas, enabling fertility-preserving approaches in highly selected patients, after thorough (multidisciplinary) counseling and with close surveillance.

SC008 / #545

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

FLUORESCENCE-GUIDED SURGERY USING INDOCYANINE GREEN FOR OVARIAN CARCINOID TUMOR

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Introduction: Neuroendocrine tumors are uncommon among gynecologic malignancies as ovarian carcinoids represent less than 0.5% of all ovarian cancers. Most of them are metastatic lesions from the gastrointestinal tract and tend to present as bilateral multinodular disease. Primary ovarian carcinoids are usually unilateral, confined to the ovary and frequently associated with mature cystic teratomas.

Description: This is the case of a 41-year-old nulligravid woman, without reproductive desire, asymptomatic. Patient had previously undergone a right oophorectomy for a presumed ovarian teratoma. Pathology review found a primary ovarian carcinoid tumor arising within a mature cystic teratoma. Gallium-68 DOTATATE PET/CT identified mesenteric and para-aortic lymph nodes with intense radiotracer uptake with no other suspicious metastatic sites. Multidisciplinary tumor board discussion favored the diagnosis of metastatic ovarian carcinoid and recommended surgical management. In order to facilitate intraoperative localization, Interventional Radiology team performed a preoperative injection of indocyanine green (ICG) directly into target nodes the day before surgery. Since ICG rapidly disperses after injection, a homogeneous 1:1 lipiodol–ICG formulation was used to increase tracer retention. Near-infrared fluorescence imaging during minimally invasive surgery enabled accurate identification and precise resection. Patient recovered uneventfully and was discharged on postoperative day 2. Unexpectedly, final histopathology revealed follicular lymphoma in the resected lymph nodes, with no evidence of metastatic carcinoid tumor.

Conclusion/Implications: This surgical film shows how fluorescence-guided surgery using ICG can enable identification of suspicious lesions during minimally invasive surgery. This approach may enhance surgical precision and guide resection of marked targets while preserving uninvolved structures.

SC009 / #874

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

ROBOTIC POSTERIOR PELVIC EXENTERATION WITH PROFUNDA ARTERY PERFORATOR (PAP) FLAP RECONSTRUCTION FOR RECURRENT VULVAL CANCER

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Introduction: Management of locally recurrent vulval squamous cell carcinoma after radiotherapy is challenging. In selected patients, palliative pelvic exenteration may be performed to improve symptoms and quality of life. Surgery in a previously irradiated field however carries high risks of infection, and reconstructive failure, making multidisciplinary operative planning critical. This video demonstrates a robotic posterior pelvic exenteration with uterine preservation, permanent stoma formation and profunda artery perforator (PAP) flap reconstruction.

Description: We present a 56-year-old with recurrent HPV-independent vulval squamous cell carcinoma. Initially she had Stage IB disease, managed with wide local excision and sentinel lymph node biopsy. She had two further recurrences, managed with chemoradiotherapy and excision with V-Y flap reconstruction. Her third recurrence presented as a PET-avid ulcerated lesion associated with significant pain and reduced quality of life. Following multidisciplinary consensus, a palliative robotic posterior pelvic exenteration was performed. The robotic abdominal phase involved pelvic dissection, rectal mobilisation, distal rectal resection and stoma formation. Bilateral salpingo-oophorectomy was performed with uterine preservation given no oncologic involvement and to prevent empty pelvis. Perineal reconstruction involved a PAP flap. This was complicated by infection and flap necrosis requiring revision. Histopathology confirmed recurrent poorly differentiated HPV-independent squamous cell carcinoma with clear margins.

Conclusion/Implications: Palliative robotic posterior pelvic exenteration can provide symptom relief in select patients. This video highlights key technical principles, including multidisciplinary planning, dissection in an irradiated field, rectal mobilisation, and PAP flap reconstruction. Despite advanced reconstruction, irradiated tissue is associated with poor healing. Appropriate selection, pre-operative counselling, and individualised reconstructive planning are essential for patient-centred outcomes.

SC010 / #952

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

SENTINEL LYMPH NODE IN ENDOMETRIAL CANCER

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Introduction: Endometrial carcinoma is the second most common gynecologic malignancy worldwide, according to GLOBOCAN 2025. Standard treatment consists of total hysterectomy with bilateral salpingo-oophorectomy and lymph node assessment. In uterine-confined disease, sentinel lymph node mapping is considered a safe and preferred approach, offering high sensitivity and a low false-negative rate. Indocyanine green has demonstrated the highest detection rates.

Description: We demonstrate the surgical technique of sentinel lymph node mapping. We begin with ICG injection into the cervix at the 3 and 9 o'clock positions, both superficial and deep. A uterine manipulator and trocars are then placed, and pneumoperitoneum is established.

Under white light, the abdominal cavity is inspected, and the retroperitoneum is opened between the round ligament and the infundibulopelvic ligament. Paravesical and pararectal spaces are developed. We identify anatomic structures such as the ureter, external iliac vessels, internal iliac artery, obliterated umbilical ligament, and uterine artery. Using near-infrared light, we identify lymphatic channels. The most proximal lymph nodes to the uterus are identified and excised.

The sentinel lymph node is retrieved in a bag, and ex vivo fluorescence is confirmed. We then continue the procedure, completing hysterectomy and bilateral salpingo-oophorectomy.

Conclusion/Implications: ICG-guided sentinel lymph node mapping is safe and effective. Its success depends on surgical technique and surgeon expertise.

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

ROBOTIC-ASSISTED MODIFIED LATERAL EXTENDED ENDOPELVIC RESECTION

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Introduction: Laterally extended endopelvic resection (LEER), first described by Dr. Hoeckel in 1999, involves en bloc resection of pelvic tumors extending beyond the endopelvic cavity — including pelvic sidewall muscles, bones, and neurovascular structures — to achieve negative margins. Advances in surgical technique, imaging, and multidisciplinary care have expanded eligibility to previously inoperable patients.

Description: This surgical video is of a 68-year-old woman with FIGO stage IB mesonephric-like adenocarcinoma who developed bilateral pelvic lymph node recurrence five months after robotic hysterectomy and adjuvant vaginal brachytherapy. Imaging revealed bulky bilateral adenopathy encasing obturator nerves, adherent to iliac vessels, and invading the right obturator internus muscle. She underwent robotic-assisted bilateral modified LEER. Using four robotic ports and one assist port, retroperitoneal dissection bilaterally identified and preserved ureters, iliac vessels, and obturator nerves. The tumors were resected from the obturator fossae and pelvic sidewalls. Estimated blood loss was 100 mL; operative time was 3 hours and 56 minutes. She was discharged on postoperative day 1. Final pathology confirmed recurrence of a mesonephric-like carcinoma: the right tumor measured 5.8×5.5×3.9 cm, and the left tumor measured 4.2×2.5×2.5 cm.

Conclusion/Implications: This case demonstrates the feasibility and safety of robotic-assisted bilateral modified LEER for recurrent gynecologic malignancy with pelvic sidewall involvement. The minimally invasive approach achieved oncologic resection with minimal morbidity and rapid recovery. The patient is currently enrolled in a phase II trial of avutometinib and defactinib, highlighting the importance of integrating surgical and systemic strategies in rare, aggressive histologies.

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

ROBOTIC MANAGEMENT OF BOWEL PERFORATION AND PELVIC ABSCESS IN ADVANCED ENDOMETRIAL CANCER

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Introduction: Bowel perforation with associated pelvic abscess is a rare but serious complication in patients with advanced endometrial cancer and is traditionally managed via laparotomy. This video aims to demonstrate the feasibility and safety of a robotic approach for the management of a contained bowel perforation, emphasizing meticulous dissection, preservation of critical structures, and reliable reconstruction in a high-risk oncologic setting.

Description: This surgical video demonstrates a stepwise robotic approach to the management of a contained bowel perforation with associated pelvic abscess in the setting of advanced endometrial cancer. The technique highlights safe entry into a hostile pelvis, careful adhesiolysis, identification and protection of the ureters and major vascular structures, and systematic exposure of the abscess cavity. En-bloc resection of the uterus, adnexa, and pelvic abscess is performed, followed by resection of the involved sigmoid colon using a robotic stapler. Primary colorectal anastomosis and two-layer bladder repair are demonstrated, emphasizing meticulous reconstruction and hemostasis. The video underscores key principles for managing complex infectious and reconstructive challenges robotically while avoiding laparotomy in a high-risk oncologic patient.

Conclusion/Implications: This case demonstrates that robotic surgery can be a safe and effective approach for the management of contained bowel perforation and pelvic abscess in selected patients with advanced endometrial cancer. The robotic platform facilitates precise dissection and complex reconstruction in a hostile pelvis, potentially allowing avoidance of laparotomy in high-risk patients. These findings support the broader application of minimally invasive robotic techniques for select surgical complications in gynecologic oncology and warrant further evaluation in larger series.

SC013 / #422

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

SALVAGE PROCEDURES FOR RESIDUAL CERVICAL CANCER FOLLOWING NEOADJUVANT CHEMOTHERAPY

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Introduction: Salvage procedures for residual cervical cancer following neoadjuvant chemotherapy can be offered to patients with motivation and willingness to undergo massive operative procedures. It needs the skill of a multidisciplinary team who can contribute to various aspects of this complicated procedure.

Description: The video illustrates a sequential narrative of operative steps of radical hysterectomy and Pelvic and Para-aortic lymph node dissections in a 51-year-old female with residual disease of cervical cancer who after neoadjuvant chemotherapy for a stage IIIB squamous cell carcinoma of the cervix. She was offered surgery after 3 cycles of chemotherapy with Paclitaxel and Carboplatinum and immunotherapy after ruling out metastatic disease with a PETCT. She underwent a standard surgical procedure for cervical cancer. Post operatively her wound healed well and she was discharged on 7th post-operative day. Surgical margins were free of tumour on histopathology. She is alive and well on follow up after 18 months.

Conclusion/Implications: Salvage procedures for residual cervical cancers can result in good survival and quality of life in motivated and surgically fit patients.

SC014 / #709

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

CERVICAL CANCER IN PREGNANCY MANAGED WITH FERTILITY PRESERVATION

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Introduction: We describe a case of early-stage cervical adenocarcinoma diagnosed at 19 weeks of pregnancy and managed with fertility sparing surgical approach. We discuss the options for fertility preservation, and surgical technique for sentinel lymph node assessment in the late second trimester.

Description: The patient underwent diagnostic laparoscopy and bilateral sentinel node mapping with indocyanine green at 21 weeks gestation. We review optimal timing of surgery in pregnancy, trocar placement and patient positioning for access to the pelvic retroperitoneum while avoiding manipulation of the gravid uterus. The technique for sentinel node procedure is shown. The safety of indocyanine green (ICG) in pregnancy is reviewed.

Conclusion/Implications: Cancer is diagnosed in 1 in 1000 pregnancies. Patients must be counseled thoroughly about their options; a fertility sparing approach should not be offered at the expense of oncologic outcomes. While the optimal time to perform laparoscopic pelvic surgery in pregnancy is during the early second trimester (typically 14–16 weeks gestation), laparoscopy can be safely performed during any trimester when medically indicated, rather than delaying treatment. A supraumbilical, epigastric or Palmer's point entry should be used to avoid the gravid uterus. Patient positioning, including lateral tilt, can be used to optimize access to the pelvic retroperitoneum. Indocyanine green is generally considered safe for use in pregnancy when indicated, with minimal to no transplacental transfer to the fetus. Patients presenting with invasive cervical cancer in pregnancy require a multidisciplinary approach including Maternal Fetal Medicine consultation.

SC015 / #357

Topic: *AS04. Patient-Centered Care / AS04a. Fertility & Pregnancy*

ROBOTIC-ASSISTED HYSTEROSCOPIC CERVICAL RECANALIZATION AFTER RADICAL TRACHELECTOMY: A NOVEL SURGICAL APPROACH FOR CERVICAL STENOSIS-RELATED HEMATOMETRA

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Introduction: Cervical stenosis is an uncommon but clinically significant complication following radical trachelectomy, potentially leading to hematometra, pelvic pain, infertility, and impaired access to the uterine cavity. Management is particularly challenging in cases of complete obstruction, where conventional hysteroscopic access is not feasible. In this setting, combined surgical approaches may be required to restore uterine cavity patency. Minimally invasive techniques, in combination with hysteroscopy, may offer improved visualization, precision, and surgical control in anatomically altered fields.

Description: his video demonstrates a combined robot-assisted laparoscopic and hysteroscopic approach for cervical canal recanalization in a 35-year-old patient with complete cervical stenosis following radical trachelectomy. The patient presented with hematometra and failed prior hysteroscopic access. Following diagnostic laparoscopy confirming the absence of macroscopic disease, a stepwise dissection is performed to identify the expected location of the cervical canal and create a neocervical channel using monopolar scissors. Vaginal access provides traction and facilitates proper alignment of the canal. Hysteroscopy under laparoscopic guidance confirms successful entry into the endometrial cavity, with clear visualization of the tubal ostia. An endocervical catheter is placed to maintain patency. The procedure is completed with uterovaginal anastomosis and meticulous hemostatic suturing.

Conclusion/Implications: The combined robot-assisted laparoscopic and hysteroscopic approach is a feasible and safe option for selected patients with complete cervical stenosis, allowing effective recanalization and restoration of cervical canal.

Topic: AS06. *Tumor Types* / AS06a. *Cervical Cancer*

ROBOTIC RADICAL COLPECTOMY WITH C1 PARAMETRECTOMY AND PELVIC LYMPHADENECTOMY FOR EARLY-STAGE CERVICAL CANCER FOLLOWING PREVIOUS NON-ONCOLOGIC SURGICAL INTERVENTION

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Introduction: Cancer treatment in patients who have previously undergone non-oncologic surgery is always challenging. This applies both to treatment selection and to the technical complexity of a new surgical approach, particularly due to adhesions and anatomical distortion. According to the National Comprehensive Cancer Network (NCCN, 2025), concurrent chemoradiotherapy or completion surgery—including radical parametrectomy, upper vaginectomy, and pelvic lymphadenectomy—may be considered for patients with early-stage cervical cancer who have undergone an inadvertent hysterectomy. Clear surgical margins, absence of Sedlis criteria, and no suspicious findings on imaging are required. Both treatment options carry potential complications and long-term sequelae that should be discussed with the patient. This video demonstrates a robotic completion surgery performed as the primary oncologic treatment in a 29-year-old patient with stage IB2 squamous cervical cancer who had previously undergone non-oncologic surgery (open total hysterectomy).

Description: A radical parametrectomy, colpectomy, and pelvic lymphadenectomy were performed robotically.

Conclusion/Implications: The patient had an uneventful postoperative recovery and was discharged two days after surgery with a post-void residual volume of 50 mL. Final pathology revealed no residual disease. She remains under follow-up and has experienced no postoperative complications to date. A surgical re-approach as complementary treatment can be technically demanding due to adhesions and distorted anatomy. However, experienced surgical teams may successfully avoid the need for radiotherapy and its associated morbidity in selected cases. Additionally, greater awareness among surgeons and gynecologists is essential regarding the importance of thoroughly investigating abnormal uterine bleeding before performing a hysterectomy.

SC017 / #1036

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

**CLOSING THE DOOR ON TUMOR SPILLAGE:
DIFFERENT VAGINAL CLOSURE TECHNIQUES IN LAPAROSCOPIC
HYSTERECTOMY FOR EARLY-STAGE CERVICAL CANCER**

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Introduction: The LACC trial demonstrated significantly lower disease-free and overall survival with minimally invasive radical hysterectomy compared to the open approach. Two mechanisms have been implicated: uterine manipulator use and unprotected intracorporeal colpotomy with tumor exposure to the pneumoperitoneum. The SUCCOR study provided a critical insight: patients who underwent minimally invasive surgery with a protective vaginal closure had recurrence rates comparable to open surgery, identifying colpotomy technique as a modifiable risk factor. For low-risk patients (FIGO IA2–IB1, tumor ≤ 2 cm, stromal invasion < 10 mm), the SHAPE trial confirmed that simple hysterectomy is non-inferior to radical hysterectomy. A subsequent subanalysis suggested comparable recurrence rates between laparoscopic and open approaches; however, since surgical approach was not a randomization variable, these findings require cautious interpretation and prospective validation.

Description: Based on this evidence, our group at Hospital Italiano de Buenos Aires developed three vaginal closure techniques for laparoscopic hysterectomy in SHAPE-eligible patients, all performed without a uterine manipulator. The three techniques are: (1) an articulating laparoscopic stapler placed across the vaginal cuff prior to colpotomy; (2) transvaginal mucosal closure with interrupted Vicryl sutures following hydrodissection and circumferential cervical dissection; and (3) bilateral laparoscopic bulldog vascular clamps occluding the vaginal lumen before colpotomy with the harmonic scalpel. The guiding oncologic principle is identical across all three: close the vagina first, then perform the colpotomy.

Conclusion/Implications: These techniques offer reproducible, adaptable solutions to prevent tumor spillage during laparoscopic hysterectomy in low-risk cervical cancer, selectable based on surgeon experience and available instrumentation.

SC018 / #1088

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

SENTINEL LYMPH NODE MAPPING IN PREGNANCY: DEMONSTRATION OF THE LAPAROSCOPIC TECHNIQUE IN A SECOND-TRIMESTER PATIENT WITH CERVICAL ADENOCARCINOMA

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Introduction: Sentinel lymph node (SLN) mapping is widely adopted in the management of early-stage cervical cancer, reducing the need for full lymphadenectomy and its associated morbidity. However, its application during pregnancy is still limited, given anatomical changes and concerns regarding fetal safety. This report demonstrates the feasibility of laparoscopic SLN mapping using indocyanine green (ICG) in a second-trimester pregnant patient.

Description: A 30-year-old pregnant patient, with no comorbidities, was diagnosed with endocervical adenocarcinoma at 8 weeks of gestation after routine screening. Pelvic image revealed a cervical lesion smaller than 1 cm, with no evidence of parametrial, vaginal, or nodal involvement. A conservative, pregnancy-preserving approach was proposed. At 14 weeks and 3 days of gestation, the patient underwent laparoscopic cervical conization, cerclage, and bilateral SLN mapping with ICG. Due to the enlarged uterus, trocar placement was performed higher than usual. Careful retroperitoneal dissection allowed identification of key anatomical structures, including the ureter, pelvic vessels, and genitofemoral nerve. Fluorescence imaging enabled detection of SLNs in the interiliac regions bilaterally, which were successfully resected despite technical challenges related to uterine size. The intraoperative course was uneventful, with fetal monitoring throughout. Final pathology showed negative bilateral SLNs. The conization specimen revealed a 19 mm adenocarcinoma with negative margins, consistent with stage IB1 disease.

Conclusion/Implications: Laparoscopic SLN mapping with ICG during pregnancy is feasible and safe in selected cases. This approach allows accurate staging while preserving pregnancy, highlighting the importance of multidisciplinary management to optimize maternal and fetal outcomes.

SC019 / #693

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

ROBOT-ASSISTED SINGLE-PORT RADICAL HYSTERECTOMY FOR STAGE IIIC1 CERVICAL CANCER FOLLOWING NEOADJUVANT CHEMOIMMUNOTHERAPY

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Introduction: The optimal management for FIGO 2018 stage IIIC1 cervical cancer with pelvic lymph node metastasis remains controversial. A multimodal approach, integrating neoadjuvant immunochemotherapy followed by conversion radical surgery, represents a promising exploratory strategy. Following the NACI study protocol as a reference, this video demonstrates a robot-assisted single-port radical hysterectomy emphasizing strict tumor-free principles for a stage IIIC1 patient achieving complete clinical response (CR), conducted under our multicenter LUCK study (MOSZGO1).

Description: A patient with stage IIIC1 squamous cell carcinoma (pretreatment tumor: 4.5×3.2×4 cm; suspected parailiac lymph node metastasis) received three cycles of neoadjuvant therapy (one chemotherapy; two incorporating a PD-1 inhibitor). Upon achieving CR, and based on multidisciplinary consensus, she underwent robot-assisted single-port radical hysterectomy, bilateral salpingo-oophorectomy, and pelvic/para-aortic lymphadenectomy. Key technical highlights ensuring maximum oncological safety included: (1) Uterine manipulator-free technique utilizing transabdominal suture suspension for retraction; (2) Early ligation of bilateral uterine arteries; (3) Targeted excision of radiologically suspicious lymph nodes; (4) Transvaginal suture closure prior to uterine resection to completely isolate the tumor bed and prevent dissemination; and (5) Extensive intraoperative pelvic and abdominal irrigation. The robotic 3D visualization facilitated complex dissection in constrained anatomical spaces.

Conclusion/Implications: This video highlights the feasibility and safety of combining systemic immunochemotherapy with robot-assisted single-port surgery for stage IIIC1 cervical cancer. Strict adherence to tumor-free principles during minimally invasive procedures offers a personalized surgical strategy for locally advanced, node-positive cases. Ultimately, this individualized multidisciplinary treatment model may help achieve long-term remission and improve quality of life in carefully selected patients.

Topic: AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers

RESECTION OF RECURRENT ENDOMETRIAL STROMAL SARCOMA WITH INFERIOR VENA CAVA WALL INVOLVEMENT AND TUMOR THROMBUS WITH VASCULAR RECONSTRUCTION

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Introduction: A 43-year-old woman underwent hysterectomy with bilateral salpingectomy and left oophorectomy in September 2024 for presumed fibroids following abnormal uterine bleeding. Final pathology revealed stage IB low-grade endometrial stromal sarcoma (ESS). Subsequent imaging demonstrated retroperitoneal recurrence with extension into the inferior vena cava. Following multidisciplinary tumor board discussion in December 2025, she was referred for secondary cytoreductive surgery at a tertiary center (MUHC). The procedure was performed on February 12, 2026.

Description: A multidisciplinary en bloc resection was undertaken. Surgical exposure was achieved through hepatic mobilization, Kocher maneuver, and Cattell–Braasch maneuver, with additional liver mobilization to facilitate caval exposure. Early proximal and distal control of the inferior vena cava was obtained. The tumor thrombus was resected en bloc with partial excision of the caval wall, followed by reconstruction using a bovine pericardial graft. Additional procedures included para-aortic lymphadenectomy, ureterolysis, adhesiolysis, segmental small bowel resection, and rectal shaving. No major intraoperative or postoperative complications were observed. Grossly complete resection was achieved.

Conclusion/Implications: Surgical education for future cases.

SC021 / #328

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

ROBOTIC PELVIC NODAL DISSECTION POST CHEMOTHERAPY IN CARCINOMA ENDOMETRIUM STAGE IIIC1

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Introduction: Advanced-stage carcinoma endometrium frequently presents with nodal metastasis, posing significant surgical challenges. This video aims to demonstrate the role of robot-assisted surgery in achieving safe and effective dissection of complex pelvic lymph nodal disease following neoadjuvant chemotherapy.

Description: We present a robotic pelvic lymph node dissection as a part of cytoreductive surgery in a 67-year-old patient with stage IIIC1 disease post chemotherapy using the Da Vinci Xi system. The video highlights stepwise dissection of a bulky nodal mass densely adherent to major pelvic vessels, emphasizing precise tissue handling, vascular identification and safe nodal clearance using robotic technology.

Conclusion/Implications: Robotic surgery enhances precision and control in complex nodal dissections, potentially improving surgical outcomes in advanced gynecologic malignancies. This approach may expand the feasibility of complete cytoreduction in challenging cases and supports broader adoption of minimally invasive techniques in advanced-stage disease.

SC022 / #772

Topic: AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers

SURGICAL FILM (TECHNIQUE) ON "SENTINEL LYMPHNODE MAPPING IN ENDOMETRIAL CANCER - THE MIS APPROACH"

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Introduction: Sentinel lymph node (SLN) mapping in endometrial cancer is an effective alternative to systematic lymphadenectomy, reducing the morbidity associated with full nodal dissection without compromising oncologic outcomes. It facilitates ultra-staging and is increasingly applicable even in high-risk histologies. This video demonstrates a simple, reproducible, and effective SLN mapping technique using both robotic and laparoscopic platforms.

Description: The video demonstrates a systematic approach to indocyanine green (ICG) preparation and cervical injection, followed by clear visualization of lymphatic channels and sentinel lymph-node on the robotic platform when performed in a coordinated and stepwise manner. It highlights the prolonged tissue retention of ICG, enabling successful identification of sentinel nodes even when there is a delay in pelvic dissection for nodal identification. The final segment demonstrates laparoscopic para-aortic sentinel node mapping in the retroperitoneal region following exploration up to the renal veins.

Conclusion/Implications: SLN mapping on minimally invasive platforms, including robotic and laparoscopic approaches, is a valuable technique that minimizes the morbidity of routine lymphadenectomy while maintaining effective nodal assessment. The sustained fluorescence of ICG within retroperitoneal tissues further enhances sentinel node detection and surgical feasibility.

SC023 / #710

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

V-NOTES RIGHT SENTINEL LYMPH NODE EXCISION AND LEFT PELVIC LYMPHADENECTOMY

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Introduction: Vaginal natural orifice transluminal endoscopic surgery (V-NOTES) has increasingly been preferred in recent years due to its ability to reduce postoperative morbidity and provide favorable cosmetic outcomes. In this video, we aimed to demonstrate the feasibility and safety of performing right sentinel lymph node excision combined with left pelvic lymphadenectomy using V-NOTES approach in gynecologic oncology. This video presents the surgical steps of V-NOTES procedure performed in a patient requiring lymphatic assessment. Following transvaginal access, pelvic anatomy was systematically identified. Right-sided sentinel lymph node excision was performed, followed by left pelvic lymphadenectomy. Key anatomic landmarks, dissection planes, and technical tips facilitating adequate exposure and safe lymph node removal are highlighted.

Description: The procedure was successfully completed via the V-NOTES approach without intraoperative complications. Adequate exposure of the pelvic spaces allowed precise identification and excision of the sentinel lymph node on the right side. On the left side, there was no sentinel lymph node staining with indocyanine green. Therefore, systemic pelvic lymphadenectomy was performed on the left side. The technique provided effective lymphatic staging while preserving the benefits of minimally invasive surgery.

Conclusion/Implications: V-NOTES enables pelvic lymphadenectomy with efficacious exposure and surgical safety. This approach could be a valuable minimally invasive alternative for patients requiring lymph node assessment in gynecologic oncology.

RETROPERITONEAL CYST MIMICKING LYMPHADENOPATHY IN ENDOMETRIAL CANCER: STAGING LAPAROSCOPIC SURGICAL DEMONSTRATION

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Introduction: Endometrial cancer is the most common gynecologic malignancy in developed countries, and its management depends on accurate surgical staging. Lymph node assessment is essential for prognosis and adjuvant treatment planning, with minimally invasive approaches and sentinel lymph node mapping as the current standard. However, imaging findings suggestive of lymphadenopathy may not always represent malignancy. Rare benign conditions, such as retroperitoneal cysts, can mimic nodal disease, making intraoperative evaluation crucial to ensure accurate diagnosis and avoid overtreatment.

Description: We present a case of a retroperitoneal cyst mimicking lymphadenopathy during laparoscopic staging of endometrial cancer. A 67-year-old woman with grade 1 endometrioid carcinoma had imaging suggestive of less than 50% myometrial invasion and a suspicious left common iliac lymph node. She underwent laparoscopic staging with total hysterectomy, bilateral salpingo-oophorectomy, and sentinel lymph node mapping using indocyanine green. The suspicious node was identified, carefully dissected, and also resected via a retroperitoneal approach. Final pathology revealed FIGO stage IB disease with negative sentinel lymph nodes; the presumed metastatic node corresponded to a benign peritoneal cyst. Adjuvant brachytherapy was indicated according to the PORTEC-4a protocol.

Conclusion/Implications: This case highlights that benign retroperitoneal lesions may mimic nodal metastasis in endometrial cancer staging. Careful laparoscopic dissection combined with histopathological evaluation is essential for accurate diagnosis, helping to avoid overtreatment and improve patient management.

Topic: AS06. Tumor Types / AS06c. Ovarian Cancer

ROBOTIC RESECTION OF RENAL HILAR RECURRENCE OF GRANULOSA CELL TUMOR — A CASE VIDEO REPORT

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Introduction: Granulosa cell tumor (GCT) is a rare ovarian malignancy with a high rate of late recurrence. Recurrence in a high para-aortic lymph node at the renal hilum is exceptionally rare. Because GCT often recurs multiple times over decades, minimizing surgical morbidity is critical. Robotic surgery may offer advantages for complex para-aortic dissections.

Description: A 68-year-old woman with a history of stage IA GCT presented eight years post-primary staging with an elevated inhibin B (200 pg/mL). Imaging confirmed an isolated 1.2 cm left renal hilar recurrence. To minimize surgical morbidity, a robot-assisted laparoscopic approach was performed using the da Vinci Xi. The procedure was conducted in two phases. Initially docked toward the pelvis, the retroperitoneum was entered over the aorta for para-aortic dissection, resecting a prominent node above the inferior mesenteric artery. To access the upper retroperitoneum, the platform was rotated 180 degrees and re-docked toward the upper abdomen. Following duodenal mobilization, the left renal vessels were identified, and the hilar lymph node was excised intact. Complete gross resection was achieved with 50 mL blood loss and a 3-hour operative time. The patient was discharged the same day. Following six cycles of adjuvant carboplatin/paclitaxel, the patient remains disease-free at two-year follow-up.

Conclusion/Implications: Renal hilar lymph node recurrence in GCT is extremely uncommon and requires advanced surgical access. Robotic surgery may reduce cumulative morbidity in a disease characterized by multiple recurrences. Robotic para-aortic lymphadenectomy to the renal hilum is feasible for select patients with recurrent GCT and may reduce morbidity in tumors requiring repeated cytoreductions.

SC026 / #1012

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

EXTERNAL ILIAC ARTERY PSEUDOANEURYSM TREATED WITH STENT AND FEMORAL BYPASS

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Introduction: Pseudoaneurysm rupture represents an uncommon but potentially life-threatening complication after gynecologic surgery, requiring prompt diagnosis and management to prevent fatal outcomes.

Description: We present the case of a 45-year-old woman with recurrent ovarian cancer who had previously undergone multiple surgical procedures, including rectosigmoid resection, as well as several lines of chemotherapy with bevacizumab and radiotherapy for iliac lymph node metastases. Six years after initial diagnosis, she was admitted with severe pain impairing ambulation. CT revealed a complex collection involving the psoas muscle and rectosigmoid colon, in close proximity to the left external iliac vessels. Broad-spectrum antibiotics and opioid analgesia were initiated. The patient subsequently developed rectal bleeding with a 3 g/dL drop in hemoglobin. CT angiography demonstrated a pseudoaneurysm of the left external iliac artery with progression of the collection. Endovascular stent placement was attempted; however, intra-procedural rupture occurred. Due to persistent refractory pain and clinical deterioration, palliative surgery was indicated. Intraoperatively, a fecaloid collection with hematic remnants extending to the left psoas muscle was identified, with complete disruption of the external iliac artery and stent extrusion. Extensive adhesiolysis was performed, followed by rectosigmoid resection with creation of a terminal colostomy. Vascular control included ligation of the iliac vessels and removal of the endoprosthesis. An extra-anatomic femoro-femoral bypass using an 8 mm ringed graft was constructed, achieving adequate distal perfusion.

Conclusion/Implications: Palliative surgery is an option when quality of life is severely compromised. Pseudoaneurysms treatment require a multidisciplinary approach; in cases of infection or rupture, stent placement and bypass are effective options.

SC027 / #34

Topic: AS06. Tumor Types / AS06c. Ovarian Cancer

SECONDARY CYTOREDUCTION USING AN EXTRAPERITONEAL APPROACH

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Introduction: Around 70–80% of patients with high-grade serous ovarian cancer recur within three years after primary treatment. In selected cases, secondary cytoreductive surgery is a valid option when complete resection is feasible. Isolated or oligometastatic nodal recurrence, particularly in the para-aortic region, may represent an appropriate indication; however, surgical access can be challenging in patients with prior extensive abdominal surgery or adhesions. The extraperitoneal approach offers direct access to the retroperitoneum while minimizing intra-abdominal manipulation.

Description: This video demonstrates secondary cytoreductive surgery using an extraperitoneal laparoscopic approach for the resection of a lumbo-aortic lymph node recurrence in a 64-year-old patient with a three-year disease-free interval. Preoperative MRI identified a single para-aortic lymph node adjacent to the inferior mesenteric artery, and PET-CT excluded additional disease. Following diagnostic laparoscopy to rule out peritoneal carcinomatosis, an extraperitoneal approach was performed. The technique includes patient positioning, trocar placement, and development of the retroperitoneal working space. Key anatomical landmarks—ureter, psoas muscle, iliac vessels, and aorta—are identified. Step-by-step dissection highlights ureteral mobilization, vascular control, and en bloc lymph node resection, with specimen retrieval in a protective bag and careful hemostasis.

Conclusion/Implications: The extraperitoneal approach is a feasible and safe option for selected patients, providing direct retroperitoneal access and potentially reducing surgical morbidity

Topic: AS06. Tumor Types / AS06c. Ovarian Cancer

LIVE SURGICAL RETROPERITONEAL ANATOMY OF THE RIGHT UPPER QUADRANT AND SUPRARENAL-RETROCAVAL BULKY LYMPH NODE EXCISION

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Introduction: As ovarian cancer spreading is usually follow the peritoneal surfaces, its surgery commonly involves peritoneal stripping-type procedures and excisions of embryologically related structures. However, the retroperitoneal involvement due to the lymphatic spread is also common, especially in the paraaortic and pelvic lymph nodes. Some of ovarian cancer cases presents with uncommon patterns of retroperitoneal dissemination and involvement, such as in this presented case. Therefore, adequate retroperitoneal anatomical knowledge of the upper-middle-lower abdomen and particularly the right upper quadrant is critical for required surgical procedures in this region. In some cases, tumor resections mandate the surgeon to go deeper in the retroperitoneum and operate around suprarenal-retrohepatic vena cava, celiac truncus, peripancreatic, and celiac trunk area.

Description: In this video, by excising metastases located suprarenal and dorsal to right renal vessels and retrohepatic inferior vena cava, celiac truncus and peripancreatic area; above the pancreatic head and common hepatic artery course, we tried to demonstrate major critical anatomic structures and their relationships in the retroperitoneal right upper abdomen. Bulky retroperitoneal lymph nodes, including those in the right suprarenal and posterior to the retrohepatic vena cava, peripancreatic region and celiac area were excised and the retroperitoneal right upper abdominal anatomy was clearly demonstrated.

Conclusion/Implications: Right upper quadrant procedures are frequently performed ones for no macroscopic residual aim in cytoreductive surgery in advanced ovarian cancer. Although right upper quadrant intraperitoneal anatomical knowledge is essential for competency, retroperitoneal anatomical knowledge of this area, such as; retrohepatic vena cava, bare area, celiac truncus and right crux is not without exception.

SC029 / #236

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

3D IMAGING RECONSTRUCTION IN LATERALLY EXTENDED PELVIC RESECTION

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Introduction: Advances in surgical techniques have led to a paradigm shift in the management of pelvic sidewall (PSW) involvement, allowing surgery with curative intent in selected cases. However, these procedures remain highly complex and associated with significant morbidity, requiring careful patient selection and an experienced multidisciplinary team. Preoperative 3D imaging reconstruction showed an improvement in surgical outcomes in the urological field, reducing operative time, blood loss, and hospital stay. In complex pelvic surgery, this tool may help in the understanding of patient-specific anatomy and tumor relationships, and in anticipating intraoperative challenges. We describe the management of a complex case of PSW recurrence of a low-grade serous ovarian cancer treated at our Institute, using 3D imaging reconstruction in preoperative evaluation.

Description: A 49-year-old woman was referred to our Institute for low-grade serous ovarian cancer recurrence after multiple surgical and medical treatments. Preoperative evaluation with a 3D imaging reconstruction revealed a left pelvic lesion with involvement of left iliac vessels, pelvic ureter, blood supply of the residual colon, and compression of the L5 and S1 nerves. A femoral-femoral bypass was performed before surgery. Surgery required the resection of all left iliac vascular compartment, left ureteral resection with Psoas hitch and Boari bladder flap reconstruction, colon resection, and lumbo-sacral nerve dissection. Complete resection was achieved.

Conclusion/Implications: By presenting this case and its management, we want to show how 3D imaging reconstruction can help in such challenging situations, allowing careful evaluation of the disease, the involved structures, and patient-specific anatomy, with the possibility to anticipate and prevent surgical complications.

SC030 / #684

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DEBULKING SURGERY OF RETROPERITONEAL LYMPH NODE METASTASIS IN PRIMARY CYTOREDUCTIVE SURGERY FOR ADVANCED OVARIAN CANCER

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Introduction: This video demonstrated the debulking surgery of retroperitoneal Lymph Node (RLN) Metastasis in primary cytoreductive surgery for a 68-year-old woman with advanced ovarian cancer.

Description: The surgical difficulty lies in the dissection of the metastatic enlarged LNs located behind the inferior vena cava (IVC) and abdominal aorta (AA), involving the renal vessels, and around the celiac trunk and its branches. To achieve complete retroperitoneal exposure, the incision started at the foramen of Winslow, proceeding through the hepatic flexure, down to the ileocecal junction, then along the peritoneum of the small bowel mesentery, the duodenum to the ligament of Treitz. Ovarian vessels were firstly ligated at their origins. For metastatic nodes located behind major vessels and in front of the spine, carefully retract or suspend the AA and IVC to facilitate safe resection. For peri-renal and renal hilar LN dissection, the renal vessels should be exposed completely. To resect LNs of the celiac trunk and its branches, the lesser omental sac was opened and the vessels were exposed. Final pathology revealed extensive lymph node metastases of high-grade serous adenocarcinoma.

Conclusion/Implications: This video emphasized that extensive retroperitoneal lymph node metastasis poses a significant challenge to achieving complete (R0) resection. Gynecologic oncologists should be proficient in the anatomy of the AA and the branching of the IVC. During surgery, meticulous attention must be paid to prevent vascular injury and secure closure of lymphatic channels to avoid major hemorrhage, lymphatic fistula, and chylous leakage.

SC031 / #1105

Topic: AS06. Tumor Types / AS06e. Sarcomas

LATERAL EXTENDED ENDOPELVIC RESECTION FOR RECURRENT UTERINE LEIOMYOSARCOMA: STEP BY STEP

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Introduction: Recurrent uterine leiomyosarcoma represents a challenging clinical scenario, particularly in cases of oligoprogressive pelvic disease where therapeutic options remain limited and outcomes are generally poor. While systemic therapy remains the mainstay of treatment in advanced settings, selected patients may benefit from aggressive surgical management aimed at achieving local disease control. Laterally extended pelvic disease poses significant technical challenges due to the complex anatomy of the pelvic sidewall, including critical vascular structures and neural elements such as the internal iliac vessels, lumbosacral trunk, and sciatic nerve. In this context, lateral extended endopelvic resection (LEER) has emerged as a feasible, though highly demanding, surgical approach in carefully selected patients.

Description: This study aims to provide a detailed, step-by-step demonstration of the surgical anatomy and technical principles involved in LEER for recurrent uterine leiomyosarcoma. Through a video-based approach, we highlight key aspects of pelvic vascular control, nerve preservation, and en bloc tumor resection, emphasizing intraoperative decision-making and strategies to optimize surgical safety and oncologic outcomes.

Conclusion/Implications: Lateral extended endopelvic resection (LEER) is a feasible option for carefully selected patients with recurrent uterine leiomyosarcoma and oligoprogressive pelvic disease, offering potential for meaningful local control. Given its technical complexity and anatomical challenges, it should be performed in specialized centers with expertise in advanced pelvic surgery. This video provides a step-by-step demonstration emphasizing key surgical principles, including vascular control and nerve preservation. Further studies are needed to define optimal patient selection and long-term oncologic outcomes within multimodal treatment strategies.

SC032 / #382

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

IGNITE-V: INDOCYANINE GREEN–GUIDED SENTINEL LYMPH NODE MAPPING IN VULVAR CANCER – STUDY PROTOCOL AND SURGICAL TECHNIQUE

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Introduction: Sentinel lymph node biopsy (SLNB) is the standard of care for selected patients with early-stage vulvar cancer, reducing morbidity compared to inguinofemoral lymphadenectomy while maintaining oncologic safety. This approach has been validated using dual tracers, typically technetium-99m (Tc-99m) with blue dye. Indocyanine green (ICG) fluorescence imaging has emerged as a promising adjunct, offering real-time visualization and high detection rates. However, evidence supporting ICG as a **standalone tracer** remains limited, with no prospective confirmatory studies directly comparing it to the current standard.

Description: This surgical video presents the protocol and operative technique of the prospective IGNITE-V trial (ClinicalTrials.gov NCT06039111), designed to evaluate ICG as a standalone tracer for SLNB in vulvar cancer. It demonstrates peritumoral ICG injection, transdermal fluorescence assessment, and stepwise groin dissection using a handheld fluorescence imaging device. All fluorescent (“green”) nodes are identified and resected, with careful attention to depth of dissection to ensure complete sentinel node identification. Following ICG-guided mapping, standard Tc-99m–guided gamma probe assessment is performed to identify any additional “hot” nodes, allowing direct comparison between tracers. This sequential approach enables real-time assessment of the performance of ICG alone and allows for accurate estimation of sensitivity and false negative rates. To date, 40 patients (72 groins) have been recruited to the study. Ex vivo confirmation of tracer uptake is also demonstrated.

Conclusion/Implications: IGNITE-V study addresses a critical evidence gap by prospectively evaluating the diagnostic performance of ICG as standalone tracer for sentinel lymph node mapping in vulvar cancer using a standardized surgical protocol. This video highlights a reproducible technique and study design for direct comparison with current gold standard. Study outcomes will be reported separately.

Topic: AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer

RADICAL VULVECTOMY FOR ADVANCED VULVAR CANCER: COMPLETE VAGINAL MOBILIZATION AND URETHRAL NEOSTOMY AS KEY SURGICAL STEPS

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Introduction: Locally advanced vulvar cancer remains a major surgical challenge, requiring radical oncologic resection while preserving function and enabling satisfactory reconstruction. Radical vulvectomy combined with reconstructive techniques may optimize postoperative outcomes and quality of life. We present a surgical video demonstrating the management of advanced vulvar squamous cell carcinoma (VSCC) using vulvar field resection and bilateral gluteal V-Y advancement flap reconstruction with urethral neostomy.

Description: A 56-year-old paraplegic woman presented with a 4 cm VSCC involving the clitoris, distal urethra, and left labia minora, with ipsilateral inguinal lymph node involvement. The procedure began with a circumferential outer incision to ensure adequate margins and marking of bilateral gluteal V-Y flaps. Dissection was carried through subcutaneous tissue to the pubic periosteum anteriorly and to the perineal membrane posteriorly. Posterior dissection over the anal sphincter was performed under digital rectal guidance to reach the laterorectal avascular planes. Lateral dissection included sealing and cutting of internal pudendal artery branches, followed by rectovaginal, periurethral, paravaginal dissection, as well as division of the clitoral suspensory ligaments, allowing complete vaginal mobilization. After margin reassessment, an inner circumferential incision enabled en bloc resection. Reconstruction was performed using bilateral gluteal V-Y flaps with urethral neostomy. This procedure was followed by bilateral lymph node dissection.

Conclusion/Implications: Radical vulvectomy with bilateral gluteal V-Y flap reconstruction is an effective option for extensive vulvar malignancies. Complete vaginal mobilization and urethral neostomy represent key technical steps that facilitate adequate oncologic clearance while enabling functional reconstruction. Multidisciplinary planning remains essential to optimize perioperative and long-term outcomes.

ROBOTIC ASSISTED TOTAL VAGINECTOMY IN RECURRENT HIGH GRADE VAGINAL INTRAEPITHELIAL NEOPLASIA WITH SUSPECTED INVASIVE DISEASE FOLLOWING MULTIPLE PRIOR VAGINECTOMIES

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Introduction: Robotic-assisted total vaginectomy offers advantages over traditional open surgery including reduced postoperative pain, decreased analgesic requirements, shorter hospital stays, faster bowel function recovery, lower herniation and surgical site infection rates, and improved cosmesis. We present a 70-year-old woman with recurrent high-grade vaginal intraepithelial neoplasia with suspected papillary squamous cell carcinoma following multiple prior vaginectomies who underwent robotic-assisted total vaginectomy.

Description: Initial adhesiolysis was performed followed by bilateral pelvic sidewall dissection with identification and ligation of uterine vessels. Bilateral ureterolysis toward the bladder was completed to facilitate bladder identification. Rectal dissection from the posterior vagina was performed using a vaginal swab for countertraction. Bladder dissection from the anterior vagina proved technically challenging due to obliterated tissue planes but was completed following ureterolysis. Lateral connective tissue attachments were sealed and divided bilaterally. Following completion of the abdominal phase, the vagina was excised using a perineal approach.

Conclusion/Implications: Robotic-assisted total vaginectomy provides significant perioperative benefits over traditional abdominal approaches for patients requiring total vaginectomy for recurrent high-grade vaginal intraepithelial neoplasia. The enhanced visualization, instrument articulation, and three-dimensional optics facilitate precise dissection in anatomically distorted surgical fields, making it an effective minimally invasive option for carefully selected patients with complex pelvic anatomy.

SC035 / #128

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

**SURGICAL MANAGEMENT OF CLINICAL STAGE I VAGINAL CANCER WITH
CONCURRENT STAGE IV PELVIC ORGAN PROLAPSE**

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Introduction: Primary vaginal cancer is a rare gynecologic malignancy with surgery reserved for select early-stage patients. This video demonstrates the unique surgical challenges and considerations for a patient with clinical stage I vaginal cancer and stage IV pelvic organ prolapse with a prior total vaginal hysterectomy. Preoperative imaging confirmed absence of local invasion and metastatic disease. Surgery was performed with a palliative intent to alleviate significant tumor-related symptoms.

Description: Preoperative cystoscopy and bilateral ureteral stent placement were necessary to confirm anatomic locations in the setting of prolapse. Vaginal incisions were marked circumferentially around the 8-cm tumor, with approximately 1-2 cm gross margins, and Vasopressin was injected to facilitate hemostasis. Scalpel and Metzenbaum scissors were used to separate the tumor and involved vaginal epithelium from the underlying endopelvic fascia. Maintaining traction and countertraction with Allis clamps and blunt retraction was critical for avoiding injury to the prolapsed pelvic structures and surrounding bowel. Use of the ultrasonic surgical device helped to separate the tumor's hypervascular attachments, particularly around the urethral meatus. Following complete tumor resection, Vicryl sutures were placed for hemostasis and reinforcement of disrupted endopelvic fascia. After multidisciplinary consultation, vaginal suspension was performed to allow for postoperative radiation delivery. The vaginal cuff was closed using interrupted Vicryl sutures. Final pathology demonstrated negative margins.





Conclusion/Implications: This case demonstrates that surgical management of vaginal cancer with concurrent prolapse is feasible in carefully selected patients. Preoperative assessment to rule out widely invasive disease and discussion with a

multidisciplinary team regarding reconstructive options is essential to treatment planning.

SC036 / #378

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

VULVAR PAGET'S DISEASE WITH UNDERLYING ADENOSQUAMOUS PATHOLOGY

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Introduction: Adenosquamous carcinoma (ASC) of the vulva is an uncommon malignant cutaneous neoplasm that is more aggressive than conventional squamous cell carcinoma.

Description: Sentinel lymph node scintigraphy was started, dynamic imaging of the pelvis in the anterior projection was done for 20 minutes with a single-head detector gamma camera, low-energy, high-resolution resolution collimator. Dynamic and static images show the multiple foci of intense radiotracer uptake located at the left inguinal area which likely denotes the sentinel nodes. We then proceeded with the sentinel lymph node mapping biopsy with the use of a gamma probe and handheld imager. The sentinel lymph nodes were identified in the bilateral superficial and deep femoral lymph nodes. Final procedure done was sentinel lymph node mapping, bilateral inguinal lymph node dissection followed by radical vulvectomy with frozen section of surgical margins followed by primary closure of defect with split thickness skin graft and loop transverse colostomy.

Conclusion/Implications: Frozen section offers the advantage of performing synchronous complete lymphadenectomy to obtain negative margin because of concomitant paget's disease since local recurrence is common. Untreated differentiated VIN results in vulval cancer in most cases within 2–4 years, the patient had already itchiness for 2 years which might attribute to her present condition.

SC037 / #833

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

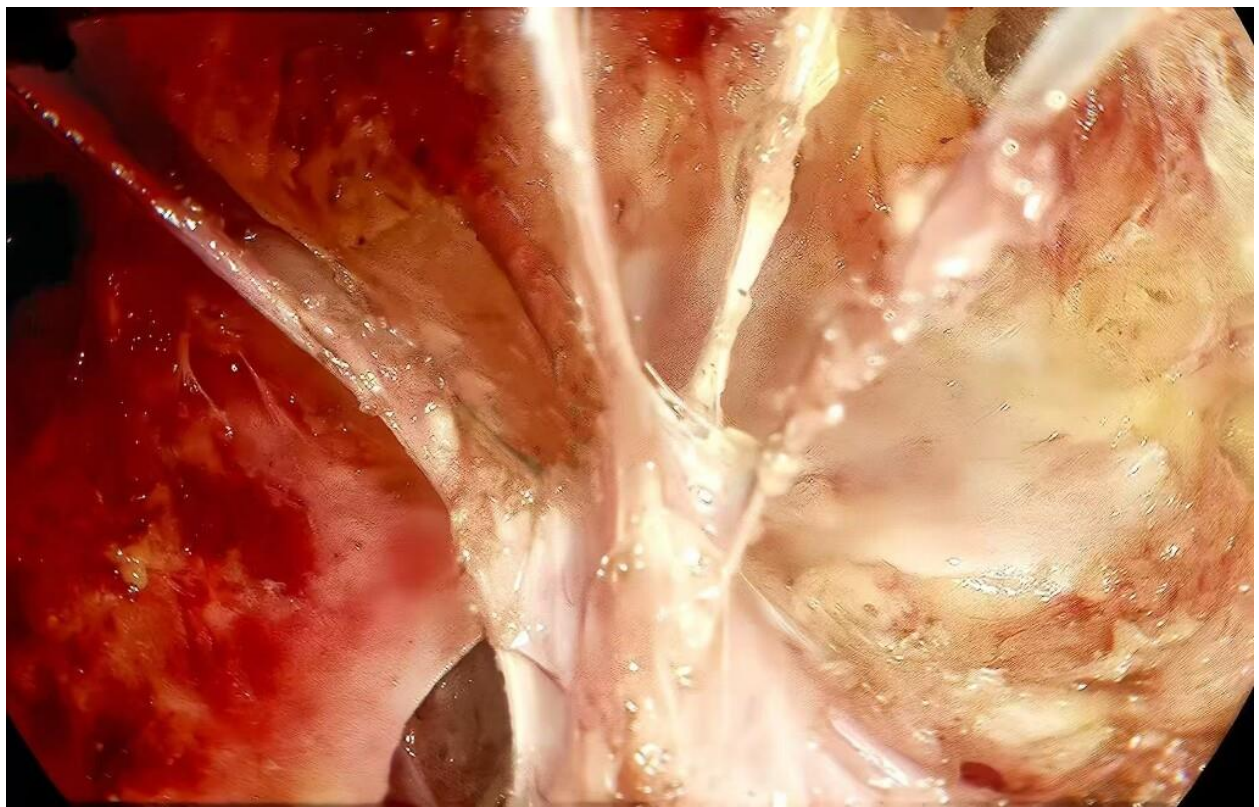
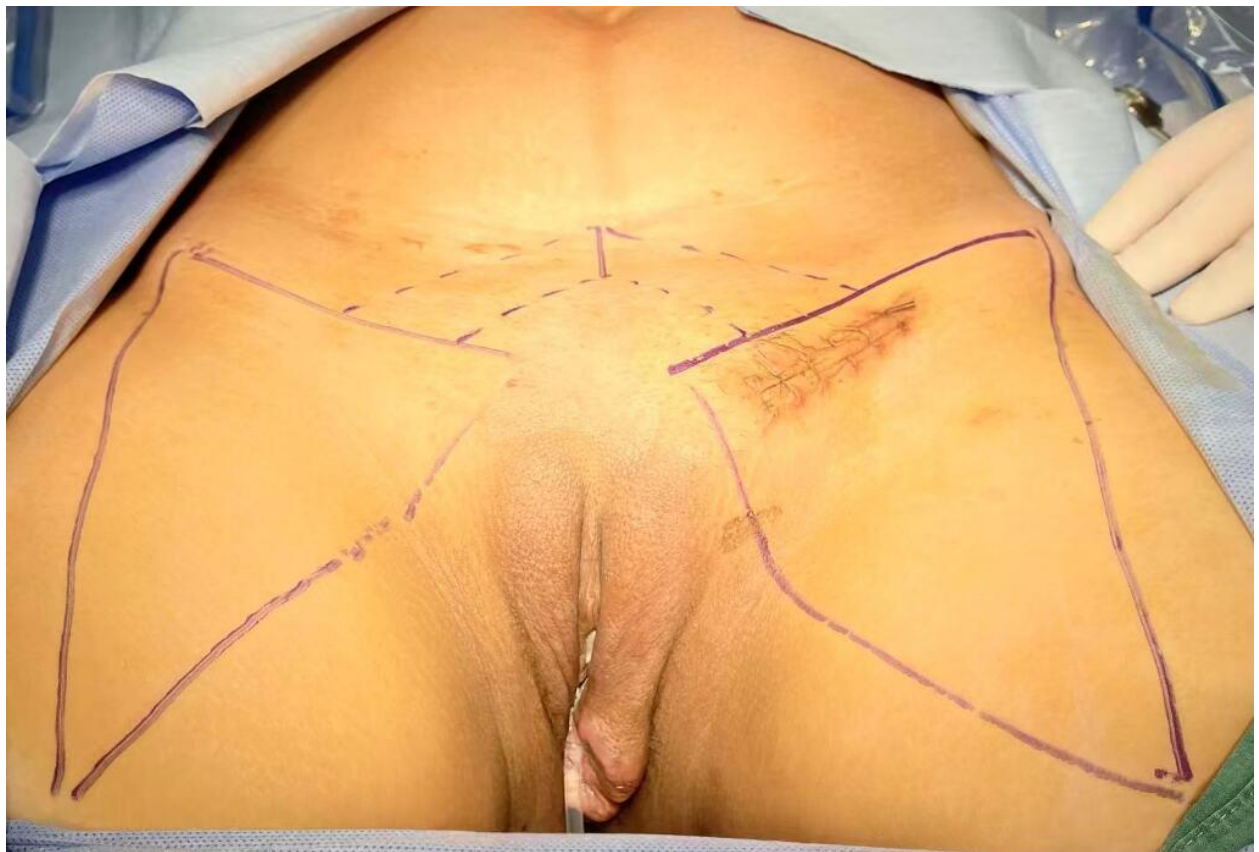
**TRANS-SUPRAPUBIC SINGLE-PORT LAPAROSCOPIC INGUINAL
LYMPHADENECTOMY WITH PRESERVATION OF TRIBUTARIES OF THE GREAT
SAPHENOUS VEIN**

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Introduction: Inguinal lymphadenectomy for vulvar cancer is associated with significant wound complications. Modifications including incision relocation, fascia lata preservation, and great saphenous vein (GSV) sparing have been attempted. We present a novel technique combining these: trans-suprapubic single-port laparoscopic anatomical inguinal lymphadenectomy with total preservation of the GSV and all five tributaries.

Description: A 34-year-old woman with vulvar squamous cell carcinoma and confirmed left inguinal metastasis underwent the procedure. The dissection targeted Scarpa's triangle (inguinal ligament, sartorius, adductor longus). Preoperatively, the dissection field was marked on the skin; based on these markings, the optimal single-port incision site was selected over the suprapubic region to align with the instrument channel, completely avoiding the groin crease. Laparoscopically, we dissected along the correct plane, stripping nodal tissue while preserving the GSV trunk and all five tributaries (superficial epigastric, superficial circumflex iliac, external pudendal, superficial medial femoral, superficial lateral femoral veins). The saphenofemoral junction and fossa ovalis were identified. The procedure was completed without conversion, no intraoperative complications occurred, and the patient had an uneventful recovery with only mild lower limb edema—no recurrence at 2 years.



Conclusion/Implications: This case demonstrates the technical feasibility of single-port laparoscopic radical inguinal lymphadenectomy with complete GSV tributary preservation via a suprapubic approach. This approach warrants further evaluation in larger cohorts to assess long-term oncological outcomes and impact on morbidity.

SC038 / #653

Topic: AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer

RADICAL HYSTERECTOMY, COMPLETE VAGINECTOMY, AND VULVECTOMY WITH DUAL-SITE ICG MAPPING FOR MULTIFOCAL GENITAL MELANOMA

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Introduction: Primary malignant melanoma (MM) of the female genital tract is a rare and highly aggressive malignancy. The purpose of this video is to demonstrate a surgical procedure including radical hysterectomy, complete vaginectomy, and radical vulvectomy for a women diagnosed with multifocal MM involving the cervix, vagina, and vulva.

Description: Indocyanine green (ICG) mapping and biopsy for inguinopelvic sentinel lymph nodes (SLNs) was firstly performed. ICG was injected around the vulvar lesions in four quadrants to accurately map and resect bilateral inguinal SLNs. Cervical ICG injection was performed to map and dissect the pelvic SLNs. Through an open abdominal approach, radical hysterectomy was performed as well as the en bloc resection of the upper two-thirds of the paravaginal tissue. A fusiform vulvar incision is made 2 cm beyond the vulvar lesions, and radical vulvectomy was done. The lower one-third vaginectomy was completed via circumferential dissection. Approximately 0.5 cm of the distal urethra was resected. The perineal defect was closed in layers, followed by a urethral-skin anastomosis. Grossly, the lesions exhibit a multifocal distribution in the vulva, vagina, and external cervical os, measuring 0.5 to 2.5 cm in maximum dimension. Postoperative pathology revealed the histological type as vulvar melanoma, predominantly in situ component with focal stromal invasion, breslow thickness approximately 0.3 mm, Clark level I.

Conclusion/Implications: This video highlights the use of dual-site ICG-guided SLN mapping and emphasis the feasibility and necessity of en bloc resection of the whole lower genital tract involved by melanoma.