

# **IGCS 2023**

## Annual Global Meeting

# **SEOUL**

### **IGCS 2023 Abstracts: Featured Surgical Films**

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

Featured Surgical Films  
Tuesday, November 7, 2023, 9:35 – 10:35 AM  
Grand Ballroom 103

FF001 / #556

**Topic: AS18. Surgical Techniques and Perioperative Management**

## **AN INNOVATIVE METHOD TO PREVENT LYMPHEDEMA AFTER GYNECOLOGICAL CANCER SURGERY: PROPHYLACTIC, CONCURRENT LYMPH NODE TO VEIN ANASTOMOSIS (LNVA)**

### **FEATURED SURGICAL FILMS**

Dasol Oh<sup>1</sup>, Ok-Ju Kang<sup>1</sup>, Sohyun Nam<sup>1</sup>, Ju-Hyun Kim<sup>1</sup>, Shin Wha Lee<sup>1</sup>, Jeong-Yeol Park<sup>1</sup>, Yong-Man Kim<sup>1</sup>, Joon Pio Hong<sup>2</sup>, Dae-Yeon Kim<sup>1</sup>

<sup>1</sup>Asan Medical Center, Department Of Obstetrics And Gynecology, Seoul, Korea, Republic of, <sup>2</sup>Asan Medical Center, Department Of Plastic And Reconstructive Surgery, Seoul, Korea, Republic of

**Introduction:** Lower limb lymphedema (LLL) is a chronic condition that requires long-term treatment and affects quality of life by causing symptoms such as pain, heaviness, discomfort, and restriction of movement. And it is one of the common complications in patients undergoing gynecological cancer surgery including pelvic lymph node dissection (PLND). Lymph node to vein anastomosis (LNVA) has been performed as one of the treatment techniques for LLL after gynecological cancer treatment. We performed prophylactic LNVA during gynecological cancer surgery to evaluate the preventive effect on LLL.

**Description:** Prophylactic LNVA was done in patients at high risk for LLL, such as those with extensive lymph node dissection or expected postoperative radiation therapy. LNVA was performed after conventional cancer surgery and lymph node dissection, regardless of the type of cancer (Ovarian, Endometrial, Cervical Cancer) or method of surgery (open, laparoscopic, robotic). After injecting Indocyanine green (ICG), ICG lymphangiography is used to locate a functioning inguinal lymph node. Functional lymph node is dissected and anastomosed to an adjacent vein of appropriate size.

**Conclusion/Implications:** From September 2022 to the time of abstract submission, 21 patients underwent the concurrent prophylactic LNVA surgery. Patients are scheduled for periodic follow-up through 24 months, and to date, there have been no lymphedema and complications from the surgery. We expect that this concurrent prophylactic LNVA will have a significant impact on the prevention of postoperative lymphedema in gynecological cancer patients.

FF002 / #801

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

## **SUCCESSFUL LAPAROSCOPIC PROCEDURE INVOLVING THE PRIMARY REPAIR OF A PERFORATION IN THE DUODENUM SUBSEQUENT TO A LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY**

### **FEATURED SURGICAL FILMS**

Seongsil Cho, Jeong Min Eom, Joong Sub Choi  
HANYANG COLLEGE OF MEDICINE, Obstetrics And Gynecology, Seongdong-gu, Korea, Republic of

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

**Description:** A 78-year-old Korean woman with postmenopausal bleeding and thickened endometrium presented to our department. The histopathology of biopsied endometrium revealed grade 1 endometrioid adenocarcinoma. The preoperative MRI shows an about 5cm sized tumor within the endometrial cavity suspicious myometrial invasion. We perform the laparoscopic staging surgery. No intraoperative complications were recognized. However, on postoperative day 1, the color of intra-abdominal drainage change from serosanguinous to dark green. We strongly suspected small bowel perforation and perform secondary laparoscopic surgery immediately. Peritoneum and prior operative site were tinged with bile. We scrutinized the small bowel and finally found the perforation site on duodenum. The perforation occurred at the horizontal part of duodenum ventrally vena cava. We carried out laparoscopic primary repair with 3-0 vicryl. Double layer closure was done by interrupted suture in first layer and Lambert suture for second layer. Then, we placed drainage into the duodenal repair site and traced the small bowel meticulously. We reviewed the video of primary surgery. But there was no definitive procedure related with duodenal perforation. We thought that the thermal injury was occurred by ultrasonic cutting and coagulating device during the lymphadenectomy in pre-caval area just below duodenum or mechanical micro-perforation is made during lifting the duodenum by dissecting forcep.

**Conclusion/Implications:** Immediate laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy is safe and feasible

FF003 / #250

**Topic:** AS04. Endometrial/Uterine Corpus Cancers

## **ROBOTIC RESECTION OF BULKY VAGINAL CUFF ENDOMETRIAL CANCER RECURRENCE WITH BLADDER INVOLVEMENT**

### **FEATURED SURGICAL FILMS**

Esra Demirel<sup>1</sup>, Farr Nezhat<sup>2</sup>, Anthony Corcoran<sup>3</sup>

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**Introduction:** In this surgical film, we present a robot-assisted upper vaginectomy and partial cystectomy for resection of endometrial cancer recurrence at the vaginal cuff involving the bladder. We highlight the use of indocyanine green dye guidance to avoid ureteral injury and review techniques to prevent fistula formation.

**Description:** The patient was taken to the operating room for robot-assisted resection of vaginal cuff tumor. Cystoscopy was performed and revealed no mucosal invasion of the bladder. Bilateral ureteral stents were placed without difficulty and injected with indocyanine green dye for identification of the ureters during dissection. Exploratory laparoscopy revealed no gross carcinomatosis or distant metastasis. The vaginal cuff tumor was noted to be invading into the bladder muscularis posteriorly and partial cystectomy was performed to resect the mass margins in this area. Once the tumor was completely mobilized off the bladder anteriorly and rectum posteriorly, upper vaginectomy was performed with adequate margins. The cystotomy was repaired with a running 3.0 absorbable barbed suture horizontally and the vagina was closed with a running absorbable barbed suture vertically to avoid parallel friction with the cystotomy repair for prevention of fistula formation. A piece of omentum was mobilized and sutured over the vaginal closure as an additional step to prevent future fistula formation.

**Conclusion/Implications:** Locally recurrent vaginal cuff tumors can be safely resected with adequate margins robotically under indocyanine green dye guidance to avoid ureteral injury. Techniques to prevent future fistula formation include avoiding parallel suture friction between bladder, vagina or rectum and using omentum as a friction barrier.

FF004 / #554

**Topic: AS18. Surgical Techniques and Perioperative Management**

## **VIDEO DEMONSTRATION OF ROBOTIC ASSISTED TYPE II RADICAL HYSTERECTOMY FOR EARLY CERVICAL CANCER WITH VAGINAL CUFF CLOSURE USING ENDOSCOPIC STAPLER BEFORE COLPOTOMY**

### **FEATURED SURGICAL FILMS**

Shree Bharathi, Rohit Ranade, Shruthi Dhevi, Abhirami G, Monica Saraswat  
Narayana Health City, Gynaecological Oncology, Bengaluru, India

**Introduction:** Minimally invasive surgery decreases postoperative morbidity after radical hysterectomy (RH) for early-stage cervical cancer. However, studies reported lower survival and higher recurrence rates as compared to open surgery, which maybe due to tumour spillage into the abdominal cavity during vaginal colpotomy or use of a uterine manipulator. This surgical film aims to present a methodical step-by-step approach for robotic radical hysterectomy with added steps for preventing tumour spillage.

**Description:** A 48-year-old multiparous lady underwent loop electrosurgical excision procedure (LEEP) for CIN III (Cervical Intraepithelial Neoplasia) which was reported as well differentiated squamous cell carcinoma. There was no visible lesion on clinical examination or imaging. Here is an account of the steps of surgery- Creation of retroperitoneal spaces Ureterolysis Transection of right uterine artery Transection of right infundibulopelvic and round ligaments Bladder mobilization Similar steps on opposite side Development of Rectovaginal space Dissection of ureters in ureteric tunnel Parametrectomy Vaginal cuff sealed using Endoscopic stapler Sealed distal edge opened and specimen delivered vaginally Pelvic lymph node dissection Vault closure Operative time was 180 minutes and blood loss was 50 ml. Post-operative course was uneventful and patient was discharged after three days

**Conclusion/Implications:** Robotic assisted radical surgery is a safe and precise technique in the treatment of cervical cancer, with clear definition of anatomical spaces. Vaginal closure using endoscopic stapler to seal the vagina before colpotomy is an effective and feasible way to prevent dissemination of tumor cells intra-peritoneally and can improve oncological outcomes like rates of recurrence and survival.

FF005 / #359

Topic: *AS22. Vulvar and Vaginal Cancer*

## **HIGH GRADE SARCOMA OF VAGINA RESECTED USING A TRANSVAGINAL NATURAL ORIFICE SPECIMEN EXTRACTION SURGERY (NOSES) TECHNIQUE FOR SPECIMEN RETRIEVAL. VIDEO CASE PRESENTATION.**

### **FEATURED SURGICAL FILMS**

Ganendra Raj Kader Ali, Ruben Rajan, [Megan Leitch](#)  
King Edward Memorial Hospital, Gynaecology Oncology, Subiaco, Australia

**Introduction:** Transvaginal NOSES technique offers reduced postoperative pain and analgesia use, reduced length of hospital stays, faster return of bowel function, less chance of herniation, reduced skin surgical site infections and improved cosmesis. This case video demonstrates a laparoscopic radical hysterectomy bilateral salpingo-oophorectomy, pelvic lymphadenectomy, radical vaginectomy, ultra-low anterior resection using the Transvaginal NOSES technique for retrieval of the en bloc specimen in a 57-year-old with a 4cm high grade vaginal sarcoma in the post vaginal wall.

**Description:** Adhesiolysis performed then splenic flexure mobilization. Inferior mesenteric vein and artery are ligated and divided. Dissection is started medially then laterally to mobilize colon adequately. Mesorectal resection performed, pelvic spaces are opened bilaterally, ureters identified before dividing uterine arteries. Pelvic lymphadenectomy performed. Bladder dissected before performing anterior colpotomy to visualize the tumor and stitch placed a centimeter below tumor. Posterior colpotomy is performed and recto vaginal space is developed. Once total mesorectal resection complete, rectum is divided using an ENDO GIA Stapler. The specimen is retrieved through the vagina, resected and the anvil is placed in preparation for anastomosis. The vagina is then sutured. Rectal anastomosis is performed with EEA stapler. Abdomen inspected, drain inserted and a covering loop ileostomy is formed. Patient made a good post-operative recovery.

**Conclusion/Implications:** Transvaginal NOSES technique is safe and feasible to perform and offers additional benefits over traditional abdominal specimen retrieval.

FF006 / #232

**Topic: AS18. Surgical Techniques and Perioperative Management**

## **HYPERTHERMIC INTRATHORACIC CHEMOTHERAPY (HITEC): TREATMENT OF RECURRENT METASTATIC OVARIAN CANCER**

### **FEATURED SURGICAL FILMS**

Gabriella Smith, Michelle Kuznicki, Danielle Chau, Johanna Kelley, Daniel Raymond, Robert Debernardo  
Cleveland Clinic Foundation, Gynecology Oncology, Cleveland, United States of America

**Introduction:** HITEC (hyperthermic intrathoracic chemotherapy) is a method of delivering chemotherapeutic agents directly to the chest cavity, often by way of video-assisted thoracoscopic surgery (VATS). This therapy has been reported in non-gynecologic malignancies including breast, mesothelioma, and pseudomyxoma peritonei. Its use in ovarian cancer has been reported in less than 10 cases to our knowledge. Here we present the Cleveland Clinic gynecologic oncology approach to HITEC therapy.

**Description:** We demonstrate the use of HITEC for a 72yo female with recurrent high-grade papillary serous fallopian tube adenocarcinoma with persistent bilateral malignant pleural effusions and no other evidence of disease. In coordination with our cardiothoracic team, she underwent a left VATS and placement of chemotherapy tubing. She was premedicated with fosaprepitant, ondansetron, dexamethasone, potassium, magnesium, mannitol, and furosemide. Adriamycin (15mg/m<sup>2</sup>) was then introduced into the ThermoChem system and infused intrathoracically and heated to 40-42 degrees Celsius for 45 min. This was followed by Cisplatin (100mg/m<sup>2</sup>) in the same manner. Subsequently at her 6-month follow-up, imaging demonstrated resolution of her left sided pleural effusion. She then underwent HITEC of her right lung.

**Conclusion/Implications:** Given the success of HIPEC (hyperthermic intraperitoneal chemotherapy) in certain randomized controlled trials for ovarian cancer treatment, HITEC is a promising therapy option for symptom control and disease management in select patients. Further exploration and research on its therapeutic benefit in gynecologic malignancies is warranted.