

# **IGCS 2024** **DUBLIN**

Annual Global Meeting

**OCTOBER 16-18, 2024**

## **IGCS 2024 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**

Friday, October 18, 11:30 AM – 12:30 PM | The Liffey B

**FF001 / #960**

**FEATURED SURGICAL FILMS**

**Topic:** *AS19. Surgical Techniques and Perioperative Management*

**NEAR-INFRARED FLUORESCENCE ASSESSMENT OF MYOCUTANEOUS FLAP MICROPERFUSION FOR GYNECOLOGIC RECONSTRUCTION: FINAL ANALYSIS OF A PROSPECTIVE NON-RANDOMIZED SURGICAL TRIAL**

Beryl Manning-Geist<sup>1</sup>, Alanna Jamner<sup>2</sup>, Elizabeth Burke<sup>1</sup>, Qin Zhou<sup>3</sup>, Alexia Iasonos<sup>3</sup>, Mario Leitao Jr.<sup>1</sup>, Anoushka Afonso<sup>4</sup>, Jennifer Mueller<sup>1</sup>, Farooq Shahzad<sup>1</sup>, Michelle Coriddi<sup>1</sup>, Joseph Dayan<sup>1</sup>, Iris Wei<sup>1</sup>, Colleen Mccarthy<sup>1</sup>, Ginger Gardner<sup>1</sup>, Evan Matros<sup>1</sup>, Vance Broach<sup>1</sup>, Jonas Nelson<sup>1</sup>, Yukio Sonoda<sup>1</sup>, Babak Mehrara<sup>1</sup>, Nadeem Abu-Rustum<sup>1</sup>

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**Introduction:** Flap-based reconstruction after pelvic exenteration is associated with high rates of wound complications, partly due to impaired perfusion.

**Description:** In this non-randomized phase II trial (NCT05071976), perfusion of pedicled flap-based reconstruction was evaluated using near-infrared (NIR) angiography following pelvic exenteration. The primary endpoint was percentage of patients in whom intraoperative NIR angiography led to a change in flap reconstruction management, calculated assuming binomial proportions, with a change in  $\geq 13.3\%$  of cases indicating the technology was worthy of additional investigation. Among 15 patients, 10 (66.7%) underwent total, 3 (20.0%) underwent posterior, and 2 (13.3%) underwent anterior pelvic exenteration. All patients underwent reconstruction with a vertical rectus abdominis myocutaneous flap. Changes in intraoperative flap reconstruction management based on NIR angiography findings occurred in 8 patients (53.3%), including trimming poorly perfused areas (n=7) and abandoning the flap (n=1). Surgeons were consistently able to discriminate between areas of maximal and least perfusion, as measured by NIH Image J calculated pixelation. Two patients (13.3%) experienced a 30-day postoperative wound complication—both grade 2 complications of necrosis. In this small sample size, the 2 patients who experienced necrosis had lower median global flap perfusion at 60 seconds (43.6, IQR: 26.2-61.1) compared to patients who did not experience postoperative necrosis (100.2, IQR: 92.9-111.3) ( $P=0.036$ ).

**Conclusion/Implications:** Introduction of NIR angiography after flap-based reconstruction led to altered intraoperative management in 53.3% of patients, meeting the study's primary endpoint. Our findings can inform future randomized controlled trials investigating if this technology improves postoperative outcomes.

**FF002 / #1080**

**FEATURED SURGICAL FILMS**

**Topic:** *AS19. Surgical Techniques and Perioperative Management*

**ROBOTIC-ASSISTED DOUBLE-BARREL WET COLOSTOMY FORMATION FOR CONCOMITANT URINARY AND BOWEL DIVERSION FOLLOWING ROBOTIC TOTAL PELVIC EXENTERATION**

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**Introduction:** Pelvic exenteration is a radical procedure used to treat locally advanced and/or recurrent pelvic malignancies. Different reconstruction options exist, the most popular being the end colostomy with ileal conduit or separate urinary and bowel diversions. An alternative approach, double barrel wet colostomy (DBWC) offers concomitant fecal and urinary diversion through a single stoma. The ureters are attached directly to the distal end of a loop colostomy, while the proximal end of same loop drains stool into one stoma. This avoids both bowel anastomosis and formation of a conduit in often-times previously radiated bowel. It leaves patients with one ostomy instead of two, and provides the option of extra space to utilize a VRAM flap for pelvic defect reconstruction. Initially there was some concern that proximity of the urinary draining system to fecal matter may increase risk of ascending urinary infections or complications, subsequent studies have consistently not demonstrated this.

**Description:** This video demonstrates a robotic-assisted double-barrel wet colostomy formation following robotic total pelvic exenteration. It demonstrates mobilization of the colon, bilateral ureteral dissection and mobilization, ureterocolic anastomoses, and stomal formation and maturation.

**Conclusion/Implications:** Double-barrel wet colostomy is an established concomitant fecal and urinary diversion approach during total pelvic exenteration which offers shorter operative time and similar short- and long-term complications when compared to separate urinary and bowel diversions. This video demonstrates the feasibility of performing this technique robotically at time of robotic-assisted total pelvic exenteration. This diversion method is a viable alternative to separate urinary and bowel diversions and the use of minimally invasive approach should be considered in appropriate patients.

**FF003 / #1127**

**FEATURED SURGICAL FILMS**

**Topic:** *AS19. Surgical Techniques and Perioperative Management*

**VULVAR RECONSTRUCTION USING BILATERAL SINGAPORE ISLAND PERFORATOR FLAP AFTER VULVECTOMY**

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Oncopole Claudius Regaud - IUCT Oncopole, Surgical Departement, Toulouse, France

**Introduction:** Surgical treatment of vulvar cancer can lead an important defect to consider a direct skin closure without flap reconstruction. The reconstruction is challenging, as one has to maintain the important excretory and sexual functions. There are several options for reconstruction for perineal defect with local, regional, or distant flaps.

**Description:** We present two cases of vulvar tumor needing a surgical approach with anterior or posterior vulvectomy. This surgery needs a multidisciplinary approach, first gynecological oncological surgeon proceeds to sentinel node excision and an en-bloc resection of the tumor with security margins of at least one centimeter medially and laterally and aponeurosis of perineal muscles for the deep margin. Then plastic surgeon harvest and conformed cutaneous flap after mapping perforator with a pencil doppler. Patient was placed in lithotomy position during all the procedure. Vulvar reconstruction was performed using a perforator-based island pedicle flap, the Singapore flap also called internal pudendal perforator flap, to recreate internal face of labia majora, vestibule and fill the space of the labia minora. At the same time, we performed clitoral reconstruction using Foldès technique, described to restore the clitoral anatomy in patients who undergone genital mutilation. This procedure enables elongation of the clitoris when the clitoral gland was sectioned. Post operative care was simple with bladder catheterization. Patients did not present major complication.

**Conclusion/Implications:** In conclusion, bilateral Singapore island perforator flap is an interesting flap to maintain vulvar cosmesis with minimal donor site-morbidity after vulvectomy.

**FF004 / #160**

**FEATURED SURGICAL FILMS**

**Topic:** AS03. *Cervical Cancer*

**INDOCYANINE GREEN SENTINEL LYMPH NODE MAPPING POST-HYSTERECTOMY FOR UTERINE OR CERVICAL CANCER. IS THIS POSSIBLE?**

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**Introduction:** Sentinel lymph node (SLN) dissection has been widely adopted in the management of endometrial cancer and has recently been described as a safe alternative to full pelvic lymph node dissections in early-stage cervical cancers. However, the use of SLN biopsy post-hysterectomy for any cancer has never been described. We know that the uterus, cervix, and upper vagina are derived embryologically from the caudal portions of the paramesonephric ducts. This novel technique uses this embryological concept that assumes that the upper vagina will have the same lymphatic drainage as the cervix and uterus.

**Description:** This video demonstrates this novel idea to see if SLN mapping is possible following a hysterectomy using ICG injection to the upper vagina and vault during a pelvic lymph node dissection for a patient with a cervical cancer diagnosis. Since most inadvertent hysterectomies for malignancies are performed by general gynaecologists, the pelvic side walls and retroperitoneum are not disturbed and should allow uninterrupted SLN mapping. Using the steps described in the surgical assessment tool by Moloney et al [1], sentinel lymph nodes were resected. References 1. Moloney K, Janda M, Frumovitz M, et al. Development of a surgical competency assessment tool for sentinel lymph node dissection by minimally invasive surgery for endometrial cancer. *Int J Gynecol Cancer* 2021;31:647–655.

**Conclusion/Implications:** The use of ICG for SLN dissection following a hysterectomy is possible. There are no current descriptions of this technique in the literature. The diagnostic accuracy of this procedure will need to be prospectively assessed.

**FF005 / #1043**

**FEATURED SURGICAL FILMS**

**Topic:** *AS10. Ovarian Cancer*

**ANTERIOR AND POSTERIOR SPLENECTOMY IN SURGERY OF CARCINOMATOSIS**

Elodie Gauroy

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**Introduction:** Complete cytoreductive surgery is an important factor for survival. Sometimes it needed a splenectomy and the approach may differ depending on the situation observed during the intervention. xe decide to show an anterior splenectomy and a posterior splenectomy

**Description:** these are 2 cases of cyto reduction surgery requiring splenectomy in the first case, in interval surgery, the spleen is adherent to the diaphragmatic dome and cannot be mobilized. We opted for an anterior approach with control of the splenic pedicle first, followed by resection of the spleen and dome.

In the second case, in primary surgery, it is necessary to remove the entire peritoneum of the dome and the parieto-colonic gutter, as well as the spleen, whose hilum is affected. It was decided to perform a posterior splenectomy, enabling the spleen to be completely mobilized, with the peritoneum removed, and the pedicle more easily controlled. the video describes the surgical steps as well as the gestures to be performed in order to optimize the gestures

**Conclusion/Implications:** when performing this type of surgery, it's important to be familiar with the different approaches available so as not to run into difficulties, and also to ensure the best prognosis for patients with complete cytoreduction. this type of video helps you to learn this type of technique.

**FF006 / #1216**

**FEATURED SURGICAL FILMS**

**Topic:** *AS19. Surgical Techniques and Perioperative Management*

**ROBOTIC RADICAL UPPER VAGINECTOMY**

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**Introduction:** The utilization of robotic surgery in the settings of Interval Debulking Surgery (IDS) for ovarian cancer is gaining momentum, particularly with the fast recovery and return to baseline for patients. We present Robotic Radical Upper Vaginectomy in the IDS settings

**Description:** 63-year-old patient diagnosed with stage IVB, grade 3 endometrioid adenocarcinoma. Underwent IDS following good response to chemotherapy. The patient had hysterectomy at the age of 40 for menorrhagia and the residual pelvic diseases was a vaginal vault mass. She had normal BMI, and no other medical comorbidities with a PS of 0. The procedure started by incising the peritoneum on the lateral pelvic sidewall, followed by development of the retroperitoneal space and identification of the ureters retroperitoneally. The infundibulopelvic ligament coagulated, clipped using HEM-O-LOK and cut. Ureterolysis from the point where the ureter crosses the common iliac artery to the ureteric tunnel performed. The pararectal and paravesical spaces were developed and the uterine artery and vein were identified at their origin from the anterior branch of the internal iliac artery and vein, coagulated, clipped using HEM-O-LOK, and cut. The ureter is further mobilized and separated from its attachment to its entrance into the bladder. The bladder is dissected and mobilized inferiorly. Posteriorly, the rectovaginal was developed, and circumferential vaginal incision was performed. The mass attached to the upper vagina was delivered vaginally, and the vault was closed using V-lock sutures.

**Conclusion/Implications:** Robotic IDS is a gaining acceptance and the surgical techniques are evolving, mandating well designed trials to emerge.