

IGCS 2024 **DUBLIN**

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IGCS 2024 Abstracts: On-Demand Surgical Film Cinema

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

SF001 / #818

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS03. Cervical Cancer

MASTERING DUPLEX URETERS: A GUIDED APPROACH FOR SAFER RADICAL HYSTERECTOMIES

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Introduction: Radical hysterectomy is a crucial procedure for treating cervical cancer, yet identifying and managing ureteral duplication during surgery poses challenges. This study presents a step-by-step approach for safely addressing this rare condition.

Description: We detail a case of cervical cancer where complete unilateral ureteral duplication was incidentally discovered during radical hysterectomy. Key points include identifying ureteral peristalsis, accurate dissection, and recognizing bilateral duplication risks. Surgical techniques are illustrated through narrated video footage, emphasizing the importance of meticulous exploration and surgeon awareness. The surgery's key points are as follows: 1) When encountering an abnormality, identify the ureter by its peristalsis and meticulously dissect it from its origin to the pelvis. 2) Handle duplicated ureters together, not separately, especially during the ureteral tunnel separation. 3) Unilateral duplication indicates potential contralateral malformation, necessitating suspicion and assessment for bilateral duplication. 4) In case of suspected ureteral injury during surgery, thorough examination via direct exploration and visual inspection is paramount for accurate diagnosis.

Conclusion/Implications: Early recognition and detailed exposure to the operative area are crucial for safe radical hysterectomy. This study underscores the significance of precision techniques in managing ureteral duplication, enhancing surgical outcomes and patient safety.

SF002 / #1195

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS03. *Cervical Cancer*

SALVAGE ROBOTIC ANTERIOR PELVIC EXENTERATION: TECHNIQUE & FEASIBILITY

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Introduction: The aim of this video is to explain the technique of salvage robotic anterior pelvic exenteration in residual/recurrent cervical cancer. Patient is a case of stage IIB ca cervix treated by definitive CCTRT and Brachytherapy with central pelvic recurrence at 6 months

Description: PROCEDURE: A total of six ports were placed A diagnostic laparoscopy was performed after placing camera port to rule out extra-pelvic metastasis and pelvic side wall disease Retroperitoneum was opened bilaterally and B/L ureters were identified B/L para-rectal and para-vesical spaces were developed B/L IP ligaments and Anterior division of B/L internal iliac arteries were clipped and cut Round ligaments were cut at lateral pelvic wall bilaterally B/L ureters were cut after preserving appropriate length for anastomosis later on Rectum was dissected off posteriorly from cervix and vagina and the uterosacral ligaments and cardinal ligaments were coagulated and cut at level of sacrum and lateral pelvic wall, respectively The dissection proceeded caudally till the levator ani muscles and the endopelvic fascia over it was incised Anteriorly the bladder was separated from the pubic symphysis entering the space of Retzius The dissection continued caudally where the dorsal venous plexus of clitoris was coagulated and the bladder neck and urethra were excised completely A colpotomy was performed circumferentially and the entire specimen was delivered out vaginally

Conclusion/Implications: Robotic anterior pelvic exenteration is a feasible option in selected patients with recurrent or residual cervical cancer post chemoradiation, without any adverse impact on the oncological parameters and with an acceptable morbidity and mortality.

SF003 / #32

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS03. Cervical Cancer

FERTILITY PRESERVING ROBOTIC RADICAL TRACHELECTOMY IN A 16YEAR-OLD PATIENT WITH CERVICAL EMBRYONAL RHABDOMYOSARCOMA

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Introduction: Background: Embryonal rhabdomyosarcoma (RMS) of the uterine cervix is a rare malignancy and mostly affects children and young adults. Radical trachelectomy is a reasonable option for select patients with early-stage cervical RMS.

Description: Key-Interventions: Bilateral retroperitoneal dissection with bilateral complete ureterolysis. Bilateral sentinel retroperitoneal lymph node dissection. Dissection of the pararectal and paravesical spaces Uterine vessels are taken at the origin and the parametrial tissues are mobilized Bladder is mobilized towards the mid vagina Pararectal space is developed and the rectum is mobilized towards the mid vagina Uterosacral ligaments are taken 2 cm from their insertion into the cervix Circumferential vaginotomy with a 2 cm margin from the cervix. The cervix is separated from the lower uterine segment at the level of the internal l os. The radical trachelectomy specimen is sent to frozen section to assess the uterine margin. The uterus is reapproximated to the upper 2/3 of the vagina in a circumferential fashion. Placement of abdominal cerclage using Mersiline tape suture which is placed at the level of the lower uterine segment and tied posteriorly.

Conclusion/Implications: Results: A 16-year-old patient successfully underwent fertility preserving robotic radical trachelectomy for the treatment of stage IB1 cervical RMS. All surgical resection margins were negative on final pathology. Sentinel lymph nodes showed no evidence of metastatic disease. She went on to complete systemic chemotherapy and did not require adjuvant radiation therapy. Post-treatment surveillance imaging showed no disease recurrence. **Conclusions:** Robotic Radical Trachelectomy is a reasonable surgical option for select patients with early-stage cervical RMS.

SF004 / #645

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS03. *Cervical Cancer*

ROBOTIC TOTAL PELVIC EXENTERATION FOR RECURRENT SQUAMOUS CELL CANCER OF THE CERVIX IN A YOUNG PATIENT TREATED PREVIOUSLY WITH CHEMORADIATION

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Introduction: Robotic total pelvic exenteration 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 infection and improved cosmesis. This case video demonstrates a Robotic total pelvic exenteration in a 39-year-old with recurrence of squamous cell cancer of the cervix treated previously with chemoradiation for a Stage 2B disease.

Description: Pelvic lymphadenectomy performed bilaterally. Internal Iliac vessels resected bilaterally using a vessel sealer. Ureterolysis performed bilaterally in preparation for ileal conduit formation. Inferior mesenteric artery dissected and sealed. Ascending colon resected using a robotic stapler. Total mesorectal resection (TME) performed and dissection is extended laterally towards the pelvic floor. Bladder dissection performed anteriorly towards the bladder neck. A second team performs perineal resection. Ligasure bipolar device is used to facilitate the dissection. When specimen is detached and removed, the perineal opening is closed primarily with sutures. A biological mesh is placed in the pelvis and sutured. Small bowel segment for ileal conduit formation is identified, resected and prepared. Small bowel anastomosis performed with robotic stapler. Indocyanine green used intraoperatively to ensure good vascularity of bowel and ureters. Ureteric anastomosis and insertion of stents performed bilaterally. An omental flap prepared and sutured below left ureteric anastomosis to reduce tension and prevent bowel herniation. Drains are placed and stoma's matured. Patient made a good post-operative recovery.

Conclusion/Implications: Robotic total pelvic exenteration offers additional benefits over the traditional abdominal surgical approach for patients with recurrent cervical cancer.

SF005 / #488

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS04. Endometrial/Uterine Corpus Cancers

TOTAL ABDOMINAL HYSTERECTOMY WITH BILATERAL SALPINGOOPHERECTOMY AND BILATERAL PELVIC LYMPH NODE DISSECTION IN ENDOMETRIAL CANCER

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Introduction: A 39 year old female presented with abnormal vaginal bleeding and vaginal discharge. She underwent endometrial biopsy that showed endometrioid adenocarcinoma. She had staging scans done that showed an enlarged supraclavicular lymph node that was evaluated by fine needle aspiration and was found to be negative for malignancy. She was discussed in an MDT meeting and predicted stage III disease was determined. Due to advanced disease she received four cycles of carboplatin/paclitaxel as neoadjuvant therapy.

Description: She underwent total laparoscopic hysterectomy with bilateral salpingoopherectomy and bilateral pelvic lymph node dissection. Final histopathology confirmed Endometrioid adenocarcinoma stage IIIC1. Left pelvic lymph nodes were positive for metastatic carcinoma with extranodal extension.

Conclusion/Implications: The surgical technique demonstrates adequate surgical management of advanced stage endometrial cancer with important anatomy and surgical technique lessons.

SF006 / #805

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS04. Endometrial/Uterine Corpus Cancers

SENTINEL LYMPH NODE SAMPLING: SEARCHING THE UNCOMMON LOCATIONS

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Introduction: Lymph node assessment by sentinel lymph node (SLN) sampling has important prognostic and therapeutic roles in endometrial cancer (EC). While the majority of SLNs are typically located in the obturator and external iliac regions, the absence of positive staining necessitates exploration of less common sites, such as the presacral and paraaortic areas. Hence, a methodical step-by-step approach is indispensable for effectively identifying SLNs, thereby guiding subsequent management decisions for these patients.

Description: This video presents our team's robotic technique for SLN in EC using a step-by-step approach, in a 44-year-old woman who presented to our center with a grade 1 endometrioid EC. At the beginning of the surgery, a 1mg/ml of ICG was used to infiltrate the cervix at the 3 and 9 o'clock positions. Following exposure of the ureter, and development of the pararectal and paravesical spaces, the SLN was not detected requiring us to follow the lymphatic vessels along their path to the presacral area. After several minutes, the sentinel lymph was located to the presacral area, extracted, and sent to pathology for evaluation by ultra-staging.

Conclusion/Implications: Employing systematic step-by-step protocol to locate SLN in patients with EC allows us to identify even those restricted to uncommon locations within a reasonable timeframe.

SF007 / #808

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS04. Endometrial/Uterine Corpus Cancers

ROBOTIC-ASSISTED PARA-AORTIC LYMPHADENECTOMY USING VESSEL SEALER, SCISSORS AND FENESTRATED BIPOLAR DIATHERMY ON DAVINCI XI

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Introduction: A short surgical film demonstrating technique for performing robotic assisted para-aortic lymph node dissection using fenestrated bipolar diathermy on the Davinci Xi robot.

Description: This video demonstrates a minimal access approach when performing para-aortic lymph node dissection in the context of definitive surgery for endometrial carcinoma of the uterine corpus. Classically, para-aortic lymph nodes are accessed through an open approach, however, with the rapidly evolving technological advances and in skilled hands it is becoming possible to complete this procedure safely laparoscopically. This can drastically reduce hospital stay and recovery for patients. In this video, the surgery is performed on Davinci Xi robot with fenestrated bipolar and the vessel sealer. The enlarged lymph node was resected and the anatomy of the para-aortic space can be visualized and appreciated.

Conclusion/Implications: This video demonstrates how minimal access robotic surgery can be successfully used in para-aortic lymph node dissection for the treatment of endometrial cancer.

SF008 / #1203

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS05. Fertility/Pregnancy

LAPAROSCOPIC ABDOMINAL CERCLAGE FOLLOWING TRACHELECTOMY FOR FERTILITY PRESERVATION

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Introduction: This video abstract discusses laparoscopic abdominal cerclage in a 40-year-old patient with stage IB1 villoglandular adenocarcinoma, following a fertility-preserving trachelectomy, aimed at maintaining reproductive potential.

Description: Case Description: In March 2023, cervical screening identified HPV 16 and imaging confirmed the tumor was 2 cm from the uterine isthmus. In June 2023, laparoscopic sentinel lymph node dissection and simple trachelectomy revealed stage IB1 cancer with involved endocervical margins (adenocarcinoma in situ). Further tests in October 2023, including conization and HPV typing, were negative for dysplasia and HPV. Examination and ultrasound confirmed a remaining cervical length of 18mm, lacking a vaginal cervix segment. **Surgical Technique Description:** The procedure began with the insertion of a vaginal cuff manipulator for better visualization. The bladder was retracted, and the anterior leaf of the broad ligament was opened to expose the uterine vessels. Windows were then made in the posterior leaf of the broad ligament on both sides for cerclage tape passage. The cerclage was placed at the uterine isthmus level and secured by passing the needle medially to the uterine vessels to preserve them. After positioning the tape and tightening it, a securing suture was placed anteriorly. The procedure concluded with a knot tied using Vicryl suture and the bladder peritoneum sutured over the cerclage for protection.

Conclusion/Implications: This case demonstrates the successful use of laparoscopic abdominal cerclage post-trachelectomy for preserving fertility in early-stage cervical cancer. It highlights the procedure as an option for patients aiming to maintain fertility despite significant cervical shortening after treatment.

SF009 / #1334

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS05. Fertility/Pregnancy

ROBOTIC DOUBLE CERCLAGE AS AN EFFECTIVE ALTERNATIVE TO PREVENT EXTREME PREMATURE DELIVERY AFTER TRACHELECTOMY: STEP-BY-STEP AND OBSTETRIC OUTCOMES

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Introduction: Fertility-sparing surgical treatment for cervical cancer shortens the cervix length and increases the risk of early pregnancy loss and highly premature birth. Recent data suggest the best obstetric outcomes with abdominal cerclage compared to the transvaginal approach. We aim to demonstrate the three cases of the modified abdominal robotic cerclage technique and its results, incorporating a new mechanical concept, including the double suture cerclage.

Description: This video demonstrates the step-by-step surgical technique and the outcomes. We describe three IB1 FIGO Stage cervical cancer patients who underwent fertility-sparing treatment. At 13 weeks of pregnancy, two polyester 0.5cm tape was used to double lace the cervix. Cerclage sutures are positioned at two distinct levels of the cervix, guided by intra-operative transvaginal ultrasound to rule out the limits between the residual uterine cervix and the amniotic membrane to place the double stitches accurately, guaranteeing the procedure's success and gestational safety. There are no surgical or obstetrics complications. The cesarean section was performed at 34.3 weeks of pregnancy and 2.3 Kg median weigh.

Conclusion/Implications: The double cerclage technique provided dual stabilization of the cervix, effectively preventing extreme premature births. The Da Vinci Xi Robotic platform enhances the precision and security of the procedure. The technique seems safe for needle passage and helps avoid accidental rupture of the amniotic membranes while simultaneously assessing fetal vitality. Moreover, it has shown to be a feasible and safe alternative for preventing extremely premature delivery following trachelectomy.

SF010 / #1156

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

LAPAROSCOPIC TERTIARY OPTIMAL CYTOREDUCTION IN RECURRENT OVARIAN CANCER: SAFETY AND FEASIBILITY OF A BRCA MUTATED PATIENT

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Introduction: The patient is a 60 years old woman with a history of advanced epithelial ovarian cancer (EOC) FIGO stage IIIC with BRCA1 mutation who underwent interval debulking surgery and platinum based chemotherapy followed by PARP inhibitor therapy. Further, the patient had a second recurrence treated with 2nd line chemotherapy with a complete response. During a routine follow-up, abdominal CT-scan showed a mass (20x10mm) arising along Glisson's capsule of VI hepatic segment suspicious for tertiary recurrence. PET-CT scan confirmed the liver metastasis.

Description: In January 2024, the patient underwent laparoscopic tertiary cytoreduction to achieve the goal of non-visible tumor at the end of surgery. This video is a step-by-step description of the laparoscopic approach for tertiary cytoreduction surgery. The patient was discharged on post operative day 3, no minor or major complications were observed. After tumor board the patient was addressed to adjuvant platinum-based chemotherapy (3 cycles). At this moment the patient is free of disease.

Conclusion/Implications: In carefully selected patients with recurrent EOC, laparoscopic approach (for secondary or tertiary cytoreduction) seems to be feasible and safe with several advantages comparing to the traditional technique in terms of reduced intraoperative blood loss, less post-operative pain, rapid post-surgery recovery and early access to adjuvant treatment. Future studies should focus on establishing precise selection criteria to further refine patient selection and evaluate long-term outcomes.

SF011 / #43

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

ROBOTIC ASSISTED CYTOREDUCTIVE SURGERY AND LAPAROSCOPIC HIPEC IN A PATIENT WITH ADVANCED EPITHELIAL OVARIAN CANCER

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Introduction: The standard approach for recurrent ovarian cancer is laparotomy. In this video, we demonstrate the feasibility, safety, and operative oncologic outcome of robotic interval cytoreductive surgery and laparoscopic hyperthermic intraperitoneal chemotherapy (HIPEC).

Description: We present a narrative video demonstration of robotic-assisted interval cytoreductive surgery and laparoscopic hyperthermic intraperitoneal chemotherapy (HIPEC). Our patient was an 81 year old female with stage IIIC ovarian carcinoma who received six cycles of neoadjuvant chemotherapy with Carboplatin and Paclitaxel. After chemotherapy her computed tomography (CT) scan showed a remarkable response, and her CA 125 decreased to normal limits. The patient underwent complete cytoreductive surgery(R0), robotic-assisted total laparoscopic hysterectomy with bilateral salpingo-oophorectomy, total omentectomy, diaphragmatic stripping, pelvic and abdominal peritonectomy and pelvic lymph node dissection, in conjunction with laparoscopic HIPEC. Total estimated blood loss for the case was 200 ml and there were no surgical complications. The patient was discharged on postoperative day 2.

Conclusion/Implications: There is limited data on the use of minimally invasive techniques for the surgical treatment of epithelial ovarian carcinoma. The National Cancer Network Guidelines suggest offering minimally invasive interval debulking surgery after neoadjuvant chemotherapy for well selected patients with advanced epithelial ovarian cancer. In our video, we demonstrate that robotic-assisted cytoreductive surgery with laparoscopic HIPEC is safe and feasible in select patients with recurrent disease.

SF012 / #452

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

VIDEO PRESENTATION: EN BLOC TOTAL ABDOMINAL HYSTERECTOMY, BILATERAL SALPINGO-OOPHORECTOMY, ANTERIOR RESECTION AND PELVIC PERITONECTOMY- HUDSON PROCEDURE

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Introduction: The ability to perform a Total Abdominal Hysterectomy, Bilateral salpingo-oophorectomy and recto-sigmoid resection is a vital skill for Gynaecological Oncologists undertaking cytoreductive surgery. The addition of a pelvic peritonectomy, ensures no residual disease in the pelvis. The retroperitoneal approach enables for an en bloc excision, but also exposes vital structures to allow for a safer, less morbid procedure with reduced blood loss.

Description: This video presentation describes the important steps to consider in order to perform a safe en bloc excision and achieve zero residual disease. Attention is paid to demonstrating and highlighting key structures and phases of the operation.

Conclusion/Implications: It is hoped that this instructive video could help Gynaecological Oncologists in training better understand this operation, as well as offer more experienced pelvic surgeons some suggestions that may improve their surgical technique.

SF013 / #1250

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS10. Ovarian Cancer

ROBOTIC RETROPERITONEAL SENTINEL LYMPH NODE DISSECTION IN OVARIAN CANCER RE-STAGING: A CASE REPORT

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Introduction: Pelvic and para-aortic lymphadenectomy is part of surgical staging in apparent early-stage epithelial ovarian cancer. Even if some studies are evaluating sentinel lymph node (SLN) mapping as alternative of standard procedure, reported data are still heterogenous and limited and forward studies are necessities. The aim of this video is to show our technique of retroperitoneal robotic-assisted SLN dissection in young patient with diagnosis of ovarian cancer.

Description: Our patient is a 42-year-old woman with diagnosis of a malignant transformation of a dermoid cyst into an “intestinal-type” mucinous adenocarcinoma, presumed FIGO stage IA (after right adnexectomy and complete peritoneal staging). Tumor board suggested surgical re-staging with pelvic and para-aortic lymphadenectomy that would allow, if negative, fertility-sparing surgery. We injected 2 mL of dilute indocyanine green solution into the right infundibulopelvic ligament. SLN were identified using fluorescence-guided dissection. Twenty minutes later, we identified an inter-aortocaval SLN, a pre-aortic SLN and a pre-inferior mesenteric artery SLN. SLN were extracted using endobag and sent to final pathology for ultra-staging. Complete pelvic and para-aortic lymphadenectomy was performed with standard robotic retroperitoneal approach. All lymph nodes were negative, included SLN, therefore surgical re-staging confirmed IA FIGO stage. There was no surgical complication.

Conclusion/Implications: Retroperitoneal robotic-assisted approach for lymphadenectomy in early-stage ovarian cancer seems to be feasible with several advantages, avoids intra-peritoneal adhesions due to previous surgery and allows rapid post-surgery recovery and early access to adjuvant treatment. SLN seems feasible using this surgical approach allowing a high-precision dissection. Therefore, further studies are needed to validate this technique.

SF014 / #1021

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

ROBOTIC INTERVAL CYTOREDUCTIVE SURGERY WITH HIPEC FOR ADVANCED OVARIAN MALIGNANCY

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Introduction: Cytoreductive surgery with hyperthermic intraperitoneal chemotherapy (CRS-HIPEC) is traditionally an open operation given the dissection required during cytoreduction. There are reports of minimally invasive HIPECs, but CRS to an accepted completeness of cytoreduction (CCR) has been described less frequently. We report our approach to robotic CRS-HIPEC for a patient with an advanced ovarian malignancy. Our dynamic video highlights the advantages of this approach.

Description: A 43 year old female presented to our center following 6 cycles of neoadjuvant chemotherapy with pathology showing epithelial ovarian carcinoma. She had a peritoneal cancer index (PCI) score of 7 determined by staging laparoscopy. Given the small amount of peritoneal disease, she was deemed a candidate for robotic interval CRS-HIPEC using the Intuitive daVinci Xi robotic surgical system through 4 robotic 8mm ports and one 12 mm laparoscopic assistant port for gauze placement, suctioning, irrigation and small specimens retrieval. Cytoreduction was completed robotically with a CCR score of 0. She then received HIPEC with cisplatin. The operative time was 416 min and the estimated blood loss was 40 ml. All specimens including the uterus, bilateral ovary with fallopian tube, bladder peritoneum, involved field peritonectomy, bilateral pelvic lymph node dissection, para aortic node dissection and omentectomy were sent for histopathology. The post-operative length of stay was 3 days, and the patient had regained bowel function by post-operative day 2.

Conclusion/Implications: When appropriately selected, we advocate for continued use of this robotic approach with HIPEC.

SF015 / #997

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

ROBOTIC SUBTOTAL GASTRECTOMY AT INTERVAL DEBULKING SURGERY FOR STAGE IVB OVARIAN CANCER: A VIDEO PRESENTATION

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Introduction: This surgical video demonstrates a subtotal gastrectomy performed jointly with interval debulking surgery for stage IVB ovarian cancer. The procedure was conducted jointly with the upper Gastro-oesophageal team on the Da Vinci XI Robot.

Description: The patient was a 76-year-old woman with stage 4b high grade serous ovarian cancer with a history of breast cancer and known BRCA2 gene mutation. Cross sectional imaging confirmed widespread peritoneal malignancy as well as a 4cm mass in the stomach wall. This lesion was confirmed by gastroscopy and directed biopsy as an adenocarcinoma consistent with gynaecological origin from its immune profile. She underwent five cycles of chemotherapy pre-operatively followed by a Da Vinci robot assisted interval debulking surgery with subtotal gastrectomy and Roux-En-Y reconstruction. Using the MIRRORS surgical protocol, the pelvis was operated on primarily and then the robot was re-targeted to perform the gastrectomy. The patient was resected to RO. Intraoperatively, blood loss was 200mls. The patient had no intra-operative or post-operative complications. Post-operatively, histology confirmed high grade serous ovarian cancer within the stomach and at other sites. Chemotherapy recommenced on day 28 with a further 3 cycles followed by Niraparib maintenance therapy. The patient remains alive and recurrence free at 2.5 years.

Conclusion/Implications: This case demonstrates the feasibility of performing complex upper abdominal surgery together with radical pelvic surgery for advanced stage ovarian cancer, achieving R0 resection. The dual console XI robot facilitates cross disciplinary team working. In our experience robotic surgery can offer enhanced recovery in highly selected cases of advanced gynaecological malignancy.

SF016 / #1322

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

ROBOT-ASSISTED UPPER-ABDOMINAL PERITONECTOMY IN A CYTOREDUCTIVE SURGERY ON HIGH CARCINOMATOSIS INDEX (PCI) OF BORDERLINE SEROUS TUMOR

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Introduction: Borderline serous ovarian tumors often present as a single adnexal mass. This video presents an unusual case of a 35-year-old patient with reproductive desire, previously diagnosed with bilateral borderline serous tumors, involving the uterine surface and peritoneal carcinomatosis. After imaging evaluation and prior laparoscopy, surgical treatment of peritoneal carcinomatosis was opted for using a robotic platform (Da Vinci Xi). Treatment of peritoneal carcinomatosis resulting from ovarian malignancy is primarily based on laparotomy; however, in selected cases, minimally invasive treatment can be feasible using laparoscopy and, more recently, robotic surgery.

Description: A cytoreductive surgery with uterine preservation is decided upon using a minimally invasive technique. Cytoreduction was performed after tumor load determination with Peritoneal Cancer Index (PCI) of 30. This video demonstrates trocar placement, initially planning an approach to the upper abdomen and redocking for pelvic approach. The robotic surgical technique and tactics used for peritonectomy are described for didactics to perform it safely and effectively. We performed peritonectomy of diaphragmatic domes, of the right hepatorenal space, of the mesentery of the terminal ileum, of the rectosigmoid meso, supracolic and infracolic omentectomy, appendectomy and anterior and posterior pelvic peritonectomy with uterine preservation.

Conclusion/Implications: Peritoneal stripping can be successfully achieved using robot- assisted minimally invasive approach even in high PCI diseases in selected cases. The robotic platform offers distinct advantages over laparoscopy with superior visualization and ergonomics, allowing pelvic and upper abdominal access with simple maneuvers. In selected cases the treatment of peritoneal surface malignancies with robotic surgery is feasible and can be associated with improved postoperative recovery.

SF017 / #1115

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

DEMONSTRATION OF THE OPEN AND CLOSED ADMINISTRATION TECHNIQUES FOR HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY (HIPEC) IN OVARIAN CANCER

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Introduction: Hyperthermic Intraperitoneal Chemotherapy (HIPEC) continues to be a subject of debate in ovarian cancer, but also of increasing interest. The OVIHIPEC-1 Study showed improvement in overall survival when utilised following complete interval cytoreductive surgery. There is currently no clear evidence regarding HIPEC following primary or secondary cytoreductive surgery. However, trials are ongoing in these areas. Establishing a service can be challenging including decisions regarding administration technique. Therefore in 2022, the Peritoneal Surface Oncology Group International (PSOGI) produced a consensus statement regarding HIPEC in epithelial ovarian cancer which addressed aspects including indications and technique.

Description: This video demonstrates both the Open and Closed administration techniques with HIPEC. The importance of clear standard operating procedures and teamwork is highlighted. Although each technique has advantages, the PSOGI group consensus could not identify that one technique was superior to the other, based on current evidence. Both therefore can be utilised for the administration of HIPEC in ovarian cancer. It is recommended that the chemotherapy agent used is Cisplatin with a minimum treatment time of 60mins at 41 degrees Celsius. Nephroprotection is achieved via the administration of Sodium Thiosulphate. Regardless of administration technique (Open vs Closed), it is important to establish good intrabdominal volume and flow, ensuring adequate exposure to all surfaces of the Cisplatin.

Conclusion/Implications: Currently both the Open and Closed techniques can be utilised for the administration of HIPEC in ovarian cancer. We hope this video provides useful information regarding the techniques, peri-operative considerations and the infrastructural requirements required in the establishment of a service.

SF018 / #1200

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS16. Rare Tumors*

ROBOTIC-ASSISTED LAPAROSCOPIC REMOVAL OF RETROPERITONEAL LEIOMYOSARCOMA

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Introduction: In this video, we present a case of robotic-assisted laparoscopic resection of a retroperitoneal nodule in a patient with a previous history of endometrial cancer. We also demonstrate the steps for utilizing a novel laparoscopic trocar-site closure device.

Description: 67 year old female with history of stage IA grade 1 endometrioid adenocarcinoma of the uterus s/p robotic-assisted hysterectomy, bilateral salpingo-oophorectomy, and sentinel lymph node dissection four years prior. Patient presented with left lower quadrant pain radiating to the back for a couple of months. Her preoperative imaging revealed a new 1.5 x 1.3 cm soft tissue nodule in the medial border of the left psoas muscle. Patient underwent a robotic assisted laparoscopic removal of 2.5 cm left retroperitoneal nodule and pelvic washings. There were no surgical complications. Patient was discharged on postoperative day 1. Final pathology of retroperitoneal mass was consistent with leiomyosarcoma arising from a vascular structure.

Conclusion/Implications: Primary retroperitoneal leiomyosarcoma tumors originating in the blood vessels are extremely rare and can present with nonspecific symptoms such as abdominal pain. Treatment of vascular leiomyosarcomas typically involves surgical resection of the involved vascular segment with negative margins. Performing minimally invasive resection of retroperitoneal nodules is feasible with adequate surgical planning including preoperative imaging and a solid understanding of retroperitoneal anatomy.

SF019 / #1062

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS16. *Rare Tumors*

ROBOTIC CYTOREDUCTIVE SURGERY FOR LOW GRADE EXTRA UTERINE STROMAL SARCOMA, A RARE DISEASE INNOVATIVE SURGICAL TECHNIQUE

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Introduction: Extra uterine Endometrial Stromal Sarcoma (EESS) is an extremely rare malignant neoplasm for which treatment closely follows that of uterine ESS. Here, presenting this case because of its rarity and performing it in robotic platform is the first one in this modern era.

Description: A 40-year-old obese female initially diagnosed to have cholelithiasis underwent diagnostic laparoscopy + cholecystectomy + incidental right para ovarian mesenteric biopsy. Biopsy showed low grade extra uterine stromal sarcoma, started on hormonal therapy. On follow-up, CT abdomen suggestive of carcinoma ovary with peritoneal metastases. Tumor markers were within normal range. Endometrial biopsy negative for malignancy. PET CT showed low FDG avid soft tissue mass lesion probably arising from anterior wall of uterus closely abutting the right ovary with low FDG avid multiple omental thickening and soft tissue nodules – deposits. Patient underwent robotic cytoreductive surgery as a day care procedure. Histopathology revealed extra uterine endometrial stromal sarcoma and metastatic foci of adenosarcoma with sarcomatous growth in the omentum and peritoneal deposits and nodes free of tumor. Post operatively, patient was started on hormonal therapy.

Conclusion/Implications: Approach of extra uterine endometrial stromal tumor in a obese patient with previous surgery was challenging and performing it in a robotic davinci xi is an optimal approach.

SF020 / #140

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS17. Screening/Early Detection*

RISK REDUCING SALPINGO–OOPHORECTOMY (RRSO) FOR HBOC CASES WITH VAGINAL NATURAL ORIFICE TRANSLUMINAL ENDOSCOPIC SURGERY (VNOTES)

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Introduction: In Japan, risk-reducing surgery (RRSO) is performed for patients with BRCA-positive hereditary breast-ovarian cancer syndrome (HBOC), and RRSO is also performed for the other genetic mutations in other countries. In the future, when the Multi Genome Project and Whole Genome Sequence are covered by insurance, the number of RRSO procedures is expected to increase due to the expansion of indications. Although often performed laparoscopically, transvaginal RRSO using vNOTES may be useful as a minimally invasive procedure.

Description: The Douglas fossa is released transvaginally, and a transvaginal instrument is attached to observe the insufflation and intraperitoneal cavity. At this point, a single trocar is added to the umbilicus for intraperitoneal observation, and ascites is collected. After collection, the colon is mobilized, the perineum is incised, and the ovarian vessels are isolated. The resection is completed by taking 2-3 cm from the ovary and finally suturing the Douglas fossa. To date, half of the RRSOs have been performed with vNOTES. The average operative time is about 30 minutes with minimal blood loss.

Conclusion/Implications: The results of vNOTES are better than those of laparoscopy in terms of operative time. The vNOTES-RRSO is a less invasive and more useful technique than laparoscopy as long as the protocol is followed, including intraperitoneal observation.

SF021 / #1253

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ROBOTIC HYSTERECTOMY WITH PROTECTIVE VAGINAL CLOSURE FOR EARLY-STAGE CERVICAL CANCER

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Introduction: With the publication of the LACC study in 2018, it is known that the minimally invasive surgery (MIS) has worse oncologic outcomes in the treatment of cervical cancer compared to the laparotomic approach. However, MIS is associated with less intraoperative blood loss, a lower risk of postoperative complications and a shorter hospital stay. In this context, recent studies have tried to show that by adopting techniques to avoid tumor spread during colpotomy, MIS can show similar results to traditional open surgery. This method includes using protective vaginal closure and not using a uterine manipulator.

Description: The procedure shown is a robotic radical hysterectomy with bilateral salpingectomy and sentinel lymph node mapping in a patient with stage IB1 squamous cell carcinoma, without the use of a uterine manipulator, with a protective vaginal closure. Initially, the cervix was identified by speculum examination and indocyanine green was injected at 3am and 9am. The vaginal mucosa was then opened 1.5 cm from the cervix, the vaginal flap was dissected, and the edges of the flap were sutured anteriorly to the cervix to form the vaginal cuff. After surgery, the colpotomy was guided with vaginal gauze. The patient was discharged 24 hours after surgery with no complications.

Conclusion/Implications: Given the benefits of MIS, it is necessary to look for advances in the technique that also provide good oncologic outcomes. Therefore, as possible techniques to prevent tumor spread, the procedures presented in this video stand out.

SF022 / #561

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

UTERINE CERVIX EXCISION BY VAGINAL ROUTE FOLLOWED BY VNOTES APPROACH TO ABDOMINAL CAVITY: AN EASIER AND FASTER ALTERNATIVE TO PATIENTS WITH PREVIOUS SUBTOTAL HYSTERECTOMY.

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Introduction: Occasionally, the gynecologic oncologist is faced with a patient who was previously submitted to subtotal hysterectomy which requires new surgical intervention and uterine cervix removal. Usually, this procedure is performed from cranial to caudal way laparoscopically, robotically, or open. Since we started our vNOTES (vaginal Natural Orifices Transluminal Endoscopic Surgery) program, we improved our vaginal surgical skills and we started to perform such cases vaginally.

Description: The uterine cervix removal follows the same steps as vaginal hysterectomy: 1) Infiltration of diluted adrenaline plus ropivacaïne. 2) Circular incision around uterine cervix. 3) Sealing and sectioning with the advanced bipolar device of the uterosacral ligaments. 4) Sealing and sectioning bladder pillars. 5) Sealing and sectioning parametria. 6) Blunt dissection from bladder and peritoneum and reachment of the abdominal cavity. 7) Insertion of the vNOTES port (gloveport self-constructed or gelpoint mini) and performing the remaining of the surgery according to each case (salpingectomy, oophorectomy, omentectomy, etc).

Conclusion/Implications: Uterine cervix removal by vaginal route seems to be much faster and easier to perform when compared to our previous experience with other routes. Furthermore, it allows proceeding into the abdominal cavity through vNOTES technique.

SF023 / #573

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

BEYOND THE BASICS : TIPS AND TRICKS FOR BOARI FLAP RECONSTRUCTION BY GYNECOLOGIC ONCOLOGIST

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Introduction: The Boari bladder flap is a vital tool in the armamentarium of gynecologic oncologist. We present step by step video demonstration of distal ureteroneocystostomy with a Boari flap and stabilizing psoas fixation , for accidental ureteric resection in a case of cervical leiomyosarcoma .

Description: 10 key surgical steps : Step 1 : Bladder mobilization : developing retzius and bilateral paravesical spaces Step 2: Mobilisation of proximal ureter and tying the distal cut end of ureter Step 3 : Ureteral spatulation Step 4 : Raising the boari flap, ensuring distal aspect of the flap is not less than 2 to 3 cm in width. Step 5 : Tunneling the ureter (antireflux mechanism) through submucosal tunnel using the stay sutures Step 6 : Flap is raised and extended to spatulated ureter and sewn into a tube . Step 7 : Spatulated ureter fixed end to end to the bladder tube with pds 4-0. Step 8 : Ureteral stent placed along anastomosis, intravesically Step 9 : Cystostomy closure Step 10 : Psoas hitch.

Conclusion/Implications: This technique is pivotal in correcting distal ureteric defects . It has been described in literature with excellent success rates . It is a valuable troubleshooting skill to be inculcated among the budding gynaecologic oncologists .

SF024 / #416

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

USE OF INTRAVASCULAR ULTRASOUND FOR BALLOON INSERTION FOR ABDOMINAL AORTIC OCCLUSION

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Introduction: Intravascular ultrasound (IVUS) is a minimally invasive technique used to insert balloons for abdominal aortic occlusion. Such interventions are useful when massive haemorrhage or vascular injury are anticipated, for example for aggressive pelvic tumours or placenta accreta. Occlusion of the abdominal aorta provides particularly effective control for complex pelvic surgery as collateral pelvic vessels are occluded. In this video, we demonstrate a technique for aortic balloon insertion using IVUS. This involves balloon insertion via a single, small caliber (5mm) common femoral arterial site. Using IVUS allows both accurate balloon sizing, by measuring the abdominal aortic diameter, and ensures correct placement by identifying the renal arteries and aortic bifurcation before securing the balloon in place. Additional benefits include no radiation exposure to patients or staff, no iodinated contrast, and as these can be placed in a standard operating room, transfer to an interventional radiology suite is not required.

Description: This video demonstrates insertion of an aortic balloon using IVUS for a patient with placenta accreta spectrum. Here we show IVUS being used to measure the diameter of the aorta and correctly place the balloon below the renal arteries and above the aortic bifurcation. In this case, the balloon was inflated at 10 minute intervals on two occasions during the surgery, with successful uterine conservation performed by myometrial resection.

Conclusion/Implications: Use of IVUS to place an aortic balloon is a safe and effective technique with several advantages which can be used for cases where there is a high risk of haemorrhage or vascular injury, such as for complex pelvic tumours.

SF025 / #1065

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

UTILIZING INDOCYANINE GREEN (ICG) FOR URETER IDENTIFICATION IN GYNAECOLOGICAL ONCOLOGY SURGERY

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Introduction: The ureters, due to their close proximity to vital structures and pelvic organs, are prone to intra-operative injury. The risk varies between 0.5% and 5%, with the distal ureter being particularly vulnerable. This risk escalates with surgical complexity, distorted anatomy, and surgical technique. This video demonstrates the use of Indocyanine Green (ICG) to mitigate ureteric injury, a technique previously employed in urological, colorectal, and complex minimally invasive gynaecological surgeries. Our aim is to showcase novel approaches and highlight their advantages in real-time gynaecologic oncology surgery.

Description: The video illustrates four methods of ureter identification using ICG: 1) Open approach with Spy-Phi camera, 2) Laparoscopic pinpoint camera 3) Laparoscopic 1788 camera, and 4) Laparoscopic with IRIS stents. The first three methods involve the intra-operative injection of ICG into the ureter via Pollock catheters, which are placed through cystoscopy and retrograde ureteric injection of ICG. The latter method demonstrates a similar approach using IRIS stents.

Conclusion/Implications: The retrograde injection of ICG for ureteric illumination is a feasible and safe method for intra-operative ureter identification. This technique could prove invaluable in preventing intra-operative ureteric injury during complex surgeries, such as severe endometriosis resection, large uterus removal, and radical hysterectomy, or in cases of distorted or fibrosed retroperitoneum, like post-radiation patients. Further research is warranted to explore its potential applications.

SF026 / #1211

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

HEPATIC MOBILIZATION AND LIVER ANATOMY FOR CYTOREDUCTIVE SURGERY

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Introduction: involvement of the right diaphragmatic dome is very frequent in ovarian carcinosis

to ensure complete resection, hepatic mobilization is necessary, and this mobilization also provides essential exposure in the event of hepatic vessel hemorrhage. we have decided to show the stages of liver mobilization

Description: we present the case of a patient undergoing interval surgery for high-grade serous carcinoma of the ovary, in whom a BRCA1 mutation was discovered, partly explaining the very good response to chemotherapy.

Involvement of the right cupola was noted, with fine, diffuse lesions and no infiltration of the diaphragm.

We divided the liver mobilization steps according to the order of ligament section

We have also detailed the solutions that allow better exposure or optimization of surgical gestures.

During this operation, the supra-hepatic veins were particularly well dissected and visualized.

Conclusion/Implications: the impact of complete cytoreduction surgery is a major factor in patient survival, which is why we felt it was important to detail the stages of liver exposure and mobilization during cytoreduction surgery for ovarian carcinoma.

SF027 / #487

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

MANAGEMENT OF A CYSTIC LEIOMYOMA MIMICKING AN OVARIAN CYST: A VIDEO PRESENTATION

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Introduction: Objective: To demonstrate laparoscopic management of a large pelvic cyst

Description: A huge ovarian cyst was planned for debulking surgery after appropriate work up and multidisciplinary team meeting discussion. Unique port sites were employed to manage a large pelvic cyst occupying almost the entire pelvic cavity. After the introduction of the optical port higher than its usual supra-umbilical location, a lateral working port was inserted under vision and pelvic cyst dissected away from the anterior abdominal wall. We successfully excised the pelvic cyst that was seen originating from the uterine fundus, with virtually no spillage of the cystic fluid.

Conclusion/Implications: The pelvic cyst was reported to be a benign uterine fibroid and the patient is well on follow up.

SF028 / #338

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ROBOTIC-ASSISTED HYSTERECTOMY IN A CASE OF UTERINE INVERSION

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Introduction: Uterine inversion is a rare condition which involves the sinking of the uterine fundus into the endometrial cavity, either partially or completely inside out. While puerperal cases are more common, non-puerperal instances often result from benign uterine tumors, with 5-15% attributed to uterine malignancy. Here, we outline the surgical management of a robotic-assisted hysterectomy and staging in the case of an inverted uterus due to a suspected uterine malignancy.

Description: The patient was taken to the operating room and positioned in dorsal lithotomy position. Exam revealed a 7 cm mass filling the vagina and an inverted uterus. The mass was removed and frozen section analysis revealed a high-grade endometrial malignancy. Attempts at uterine replacement were not successful, and the decision was made to proceed with robotic surgery in the inverted position. Physiologic adhesions were lysed, and careful exploration of perirectal spaces ensued, with particular attention to identifying the course of the ureter, which was medialized due to the uterine inversion. An EEA sizer was used to delineate the boundary of the colpotomy. A lymph node dissection and omental biopsy were performed. The patient underwent successful robotic-assisted surgery for uterine inversion and suspected malignancy, resulting in a positive outcome with no immediate complications. Pathological analysis confirmed the presence of a FIGO 2023 Stage IICmp53abn uterine carcinosarcoma.

Conclusion/Implications: This case highlights the importance of prompt diagnosis and feasibility of a robotic-assisted approach in managing uterine inversion, especially in cases with suspected malignancy, ensuring optimal patient outcomes and postoperative recovery.

SF029 / #28

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ROBOTIC PRIMARY DEBULKING SURGERY IN STAGE IIIC OVARIAN CANCER

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Introduction: Primary cytoreductive surgery for advanced ovarian cancer is typically performed via exploratory laparotomy, with the goal of achieving R0. Robotic surgical technology extends the benefit of MIS to patients with advanced ovarian cancer without compromising the cytoreductive effort. This video illustrates optimal cytoreduction of patient with stage IIIC ovarian cancer, including diaphragmatic stripping, complete omentectomy, enbloc resection of pelvic mass with pelvic peritonectomy.

Description: Our patient is 46-year-old who presented with abdominal discomfort. CT revealed moderate ascites, omental caking and 2.6cm left adnexal mass with 2.5cm right anterior pelvic mass abutting uterus. Initial laparoscopic assessment was performed to determine resectability. Lower pelvic port placement was utilised to allow multi-quadrant surgery for optimal cytoreductive effort. Starting with upper abdominal surgery, abdominal docking was done. Arm 2 (camera) is docked to the second right pelvic port. Omental resection began by dividing the left phrenicocolic ligament. The lesser sac is explored. The surgeon then proceeded on to right diaphragmatic stripping. After completion of upper abdominal surgery, the robot is undocked and rotated for pelvic surgery. Arm 2 (camera) is docked to the umbilical port. The surgeon then performed pelvic peritonectomy with enbloc resection of anterior pelvic tumour deposit with uterus, tubes, ovaries and appendix. There was no gross disease at the end of surgery.

Conclusion/Implications: Lower pelvic robotic port placement allows for multi-quadrant abdominal surgery, and is a feasible approach in select patients with advanced ovarian cancer.

SF030 / #1148

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

TRANSPERITONEAL LAPAROSCOPIC PELVIC LYMPH NODE DEBULKING FOR STAGE IIC1 CERVICAL CANCER

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Introduction: Patients with advanced cervical cancer with lymph node enlargement are classified as FIGO 2018 staging IIC1 or IIC2, when positive pelvic or paraaortic lymph nodes are detected, respectively. These patients are candidates for combined treatment with chemotherapy and radiotherapy, with or without inductive chemotherapy. However, some studies suggest a role of lymph node debulking, with acceptable morbidity and higher rates of tumor sterilization.

Description: The patient was placed in a low lithotomy position, with arms along the body and lower limbs in Allen stirrups. One 11mm trocar was inserted in the umbilical site, and three other 5mm trocars in the lower quadrants. An incision was performed in the right pelvic peritoneum. The ureter was medialized, with adequate enlarged lymph node exposure. A dissection of the right external iliac artery was performed to improve access to the tumor laterally and medially. The dissection was performed with a suction device to identify the right internal iliac artery. This was the anatomical landmark to approach the tumor and its dissection from the right common iliac artery bifurcation. Then is access to the obturator fossa allowed the identification of the obturator nerve. Confirmation of the anatomical landmarks, the final removal of the enlarged lymph node was performed.

Conclusion/Implications: Locally advanced cervical cancer should be managed with chemoradiation, with or without neoadjuvant chemotherapy. In selected cases, lymph nodes conglomerate with more than 2 cm may benefit from minimally invasive debulking. This video demonstrates a safe pelvic nodal debulking with a transperitoneal laparoscopic approach using permanent instruments.

SF031 / #365

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

URINARY RECONSTRUCTION USING ENTEROCYSTOPLASTY AFTER PARTIAL CYSTECTOMY IN SURGICAL RECURRENCE OF CERVICAL CANCER

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Introduction: Nowadays, in cases of recurrent or persistent gynecological malignancies involving the bladder after prior radiotherapy, the gold standard procedure is anterior pelvic exenteration. In this case, urinary reconstruction is crucial. Many techniques have been described, such as ileal orthotopic neobladder in cases of bladder neck preservation. In the absence of fistula and limited bladder invasion, partial cystectomy could be an option. Bladder augmentation using enterocystoplasty is a common procedure in urological surgery in cases of reduced bladder capacity and compliance.

Description: We present the case of a 40-year-old woman treated with chemoradiotherapy for locally advanced cervical cancer stage IB3 in 2022. Two years later, she presented with cervical local recurrence with minor vaginal extension. The MRI shows cervical tumor in contact with the bladder without signs of infiltration. Anterior pelvic exenteration was evocated. In the absence of signs of bladder infiltration, a conservative treatment with radical hysterectomy and partial cystectomy was suggested. To avoid reduced bladder capacity, especially after radiotherapy, an enterocystoplasty was performed. This video explains the surgical procedure in ten steps. The final anatomopathological analysis reported a 30x13 mm ulcerated squamous cell cervical carcinoma, with complete excision. There were no postoperative complications.

Conclusion/Implications: Partial cystectomy with enterocystoplasty could be an option in cases of local cervical recurrence without major invasion of the bladder. However, this technique should be offered only in selected cases. This interesting procedure is easily reproducible and useful in this case.

SF032 / #1088

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ROBOTIC RETROPERITONEAL LYMPHADENECTOMY USING ICG DYE FOR INTRAOPERATIVE URETER IDENTIFICATION

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Introduction: We introduce a novel technique for intra-operative identification of the ureters during surgery for gynecologic malignancies. Retroperitoneal dissection and ureterolysis are often required for identification of sentinel lymph nodes or radical dissection for advanced stage disease. Minimally invasive and robotic surgery are increasingly the surgical approach of choice to increase visualization, reduce blood loss, hospital stay, and patient morbidity. Pre-procedure cystoscopic-guided retrograde instillation of ICG dye into ureters stains the ureters with indocyanine green (ICG) dye and facilitates transperitoneal and retroperitoneal identification of the ureter.

Description: Using a 30-degree cystoscope, ureters are cannulated with a 5-French angled Whistle Tip Ureteral Catheter to a depth of 10 cm, followed by retrograde injection of 10 mL, ICG dye 2.5 mg/dL, over 30 seconds with a 30-second pause to stain the ureteral epithelium. Abdominal access is obtained, and the robot is “docked.” Near-infrared (NIR) imaging using Firefly® technique enables visualization of the ureters by using the hand-controlled toggle switch, enabling quick identification of ureters transperitoneally and without dissection. In a retrospective pilot study of 40 matched cases comparing matched before and after technique implementation, there was no statistical difference in OR time or Procedure Duration resulting from addition of this technique. 96.5% of ureters were identified.

Conclusion/Implications: Retrograde instillation of indocyanine green dye using near-infrared imaging on the robotic platform facilitates identification of the ureters without increasing surgical time, enabling real-time identification of ureters, reducing risk of ureteral injury and increasing patient safety.

SF033 / #1181

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

INSTILLATION OF ICG DYE INTO URETERS FOR INTRA-OPERATIVE IDENTIFICATION DURING ROBOTIC SURGERY FOR GYNECOLOGIC MALIGNANCIES

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Introduction: We present a step-by-step approach to cystoscopy with retrograde instillation of indocyanine green dye (ICG) into bilateral ureters before robotic surgery to improve visualization and reduce risk of ureteral injury.

Description: Preoperative cystoscopy is performed using a 30-degree cystoscope. Ureters serially are cannulated with a Bard 5Fr Whistle Tip[®] angled ureteral catheter, advanced 10 cm into the distal ureter. Ten mL of ICG dye 2.5 mg/dL is injected into each ureter over 30-45 seconds. After a 30 second wait for ICG to stain urothelial proteins, the catheter is removed and advanced into the contralateral ureter. Intraoperative visualization is performed with NIR-Infrared imaging, using the Firefly[®] finger switch on the DaVinci[®] Robotic Platform. In a pilot study of 120 complex-benign and gynecologic cancer cases, we identified 96.5% of instilled ureters intraoperatively. Total time for the cystoscopy and retrograde instillation ranged from 7 to 12 minutes. We assessed the effect on surgical time and total operating room time using a paired T-Test. Sixty cases prior to the intervention were matched to 60 comparable cases after the intervention. There was no statistically significant increase in surgical or operating room time. There were no complications related to the cystoscopy procedure. The technique is illustrated during sentinel lymphadenectomy and aortic lymphadenectomy.

Conclusion/Implications: Pre-operative cystoscopy with retrograde instillation ICG into the ureters facilitates ureter identification, is safe, effective and does not increase operating time. Ongoing data validation will determine the effect on reducing OR times.

SF034 / #954

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ICG: HAS IT BECOME A STANDARD OF CARE IN GYNECOLOGICAL SURGERY?

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Introduction: Indocyanine green (ICG) has established its role in gynecological surgery as the standard dye for sentinel lymph node mapping (SLNM), while also enabling complex surgical procedures by facilitating anatomical identification like ureter demarcation. This educational video showcases different applications of ICG in a single surgical setting.

Description: During a congress of the Argentine society of gynecological surgery, a live surgery was performed on a patient with gynecological cancer. The procedure begins with the injection of ICG into the ureters. Through cystoscopy, 4cm open-end catheter is inserted into each ureter, and 8ml of ICG is injected. After a 4-minute interval, the procedure is repeated on the opposite ureter. Upon laparoscopic visualization in the abdominal cavity, both ureters are identified using infrared light. The next step involves the cervical injection of ICG: 1.25mg of ICG is injected superficially at time 3 and 9 using a 21G spinal needle. Retroperitoneal dissection of both pelvic sides is then performed, allowing the identification of vascular structures and the visualization of the green ureters. An external iliac sentinel lymph node (SLN) is detected in the left pelvis, while no SLN is found in the right pelvis. further dissection reveals a primary iliac SLN. Both SLNs are extracted and placed in a pouch, identified extracorporeally, and sent for biopsy. Different key places to identify the ureter are shown on the video

Conclusion/Implications: ICG has become a standard tool in gynecologic oncology for SLNM, also proving beneficial in more intricate surgeries such as those involving deep endometriosis.

SF035 / #1129

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

ROBOT ASSISTED EXCISION OF ISOLATED LOCOREGIONAL RECURRENCE IN ENDOMETRIAL CANCER

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Introduction: The management of recurrent endometrial cancer necessitates careful consideration of various factors including the site of recurrence, duration of disease-free interval, patient's overall medical condition, and prior adjuvant treatments. While surgery has traditionally been the preferred option for vault recurrences in previously irradiated pelvis, radiotherapy has been the standard for single-site vault recurrence in patients without prior radiotherapy exposure. However, with advancements in surgical techniques, surgery is now emerging as a viable option even for single-site vault recurrence in radiotherapy-naïve patients. For locally recurrent disease limited to the central pelvis, curative treatment options such as surgery or radiotherapy are available. In patients with isolated vault recurrence and no prior radiotherapy exposure, external beam radiotherapy (EBRT) with or without brachytherapy, systemic therapy, or surgery with or without intraoperative radiotherapy and systemic therapy is recommended. Favourable surgical candidates typically exhibit good performance status, a prolonged disease-free interval, and resectable disease with potential for achieving tumour-free margins.

Description: This video demonstrates robotic excision of a single locoregional recurrent 3x2 cm vault mass in a 82-year-old woman with stage-IA endometrioid adenocarcinoma, who presented with P/V bleeding following a disease free interval of 4 years, after robotic hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymph node dissection. PET-CT scan showed only a single FDG avid - 3 x 2 cm mass in the vault. Biopsy from vault mass confirmed metastatic adenocarcinoma.

Conclusion/Implications: For locally recurrent disease limited to the central pelvis, curative treatment options include surgery besides radiotherapy. Surgery in recurrent setting requires good surgical skill and experience.

SF036 / #648

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

TOTAL VAGINECTOMY FOR RECCURENT GYNECOLOGICAL CANCER

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Introduction: The strategy for the treatment of vaginal recurrence of gynecological cancer remains a complex clinical problem. Surgery is an effective and relatively safe strategy for these cases. Vaginectomy is one of the methods of surgical treatment of local recurrence of gynecological cancer. Although vaginectomy is considered an effective treatment for vaginal recurrence of cervical, ovarian, and endometrial cancers, only a few published reports of vaginal resections have been found, and in most cases vaginal resections have been performed by vaginal and/or open access. Several reports of laparoscopic vaginal resection for recurrence in gynecological cancer have also been found.

Description: The age of the patients ranged from 42 to 62 years (median 53 years). The duration of the operation varied from 240 to 480 minutes (median 317 min), the volume of blood loss ranged from 90 to 220 ml (median 140 ml), resection margins were negative in all cases. In 2 patients, a ureteral catheter was placed. The Foley catheter was removed after a median of 10 days (range 1 to 11 days). The length of stay of patients in the hospital ranged from 7 to 14 days (median 7 days). There were no intraoperative complications. All patients after vaginectomy are alive.

Conclusion/Implications: Vaginal recurrence is the most common type of local recurrence in gynecological cancer, and there is no consensus on treatment tactics. This article is somewhat limited in terms of the number of patients, our results show the efficacy of vaginectomy in recurrent gynecological cancer.

SF037 / #431

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS19. *Surgical Techniques and Perioperative Management*

**FLUORESCENCE GUIDED TOTAL ROBOTIC PARIETAL PERITONECTOMY,
CYTOREDUCTIVE SURGERY AND CLOSED HIPEC**

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Introduction: Cytoreductive surgery with hyperthermic intraperitoneal chemotherapy has been increasingly utilized for peritoneal surface malignancies. Traditionally, CRS/HIPEC has been performed as an open, extensive surgery associated with prolonged hospitalization. However, when the peritoneal carcinomatosis index (PCI) is less and involves only few selected quadrants of abdomen without much visceral involvement, minimally invasive approaches can be considered. Such less invasive approaches may be associated with improved postoperative recovery, less complications while preserving oncologic outcomes. The robotic platform offers distinct advantages over laparoscopy with superior visualization and ergonomics which account for its increased utilization in oncologic surgery.

Description: Herein we show the steps of performing a robotic total parietal Peritonectomy with cytoreductive surgery and HIPEC in a 45 years old lady with stage IIIC ovarian cancer, post 3 cycles of NACT. We show the utilization of ICG for assessing the peritoneal deposits post chemotherapy and to guide the lymphadenectomy. PCI Index was 15, CC0 was achieved at the end of the procedure. Total docking time was 22 mins (lower and upper abdomen), total console time was 300 mins, HIPEC was given for 90 mins. Total operative time was 410 min. Total blood loss 100ml, no drains placed. Patient was shifted to ward after surgery and was discharged on POD 3.

Conclusion/Implications: Use of robotic technology in the form of ICG, vessel sealer allows for quicker and precise surgery. Patient selection is the key to success of Robotic CRS & HIPEC surgery The future of cytoreductive surgery and HIPEC is more minimally invasive, multimodal and promising.

SF038 / #700

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

LAPAROSCOPIC BILATERAL OVARIAN TRANSPOSITION

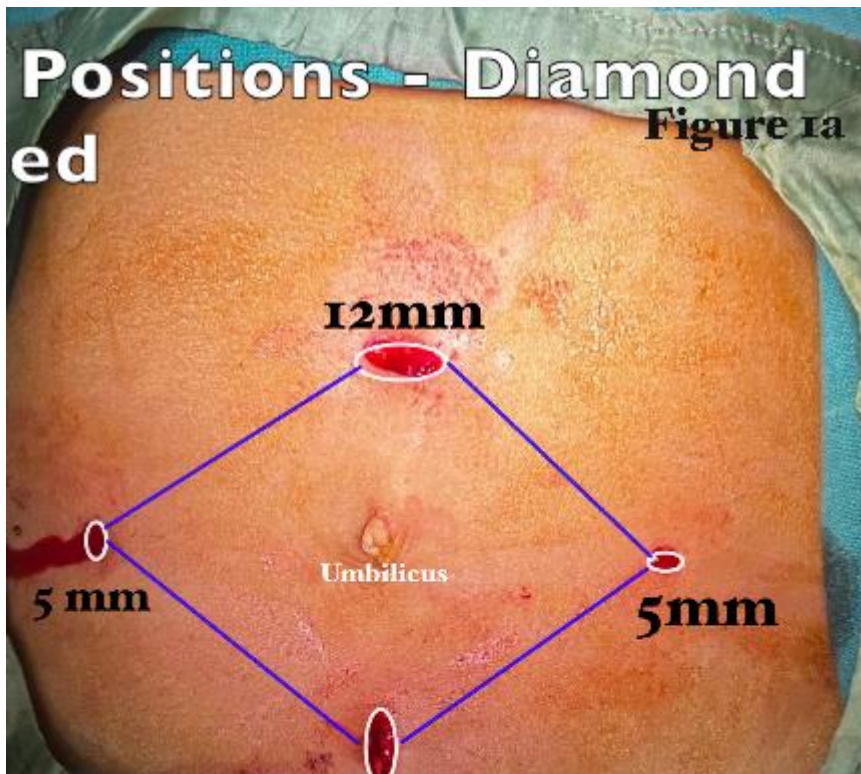
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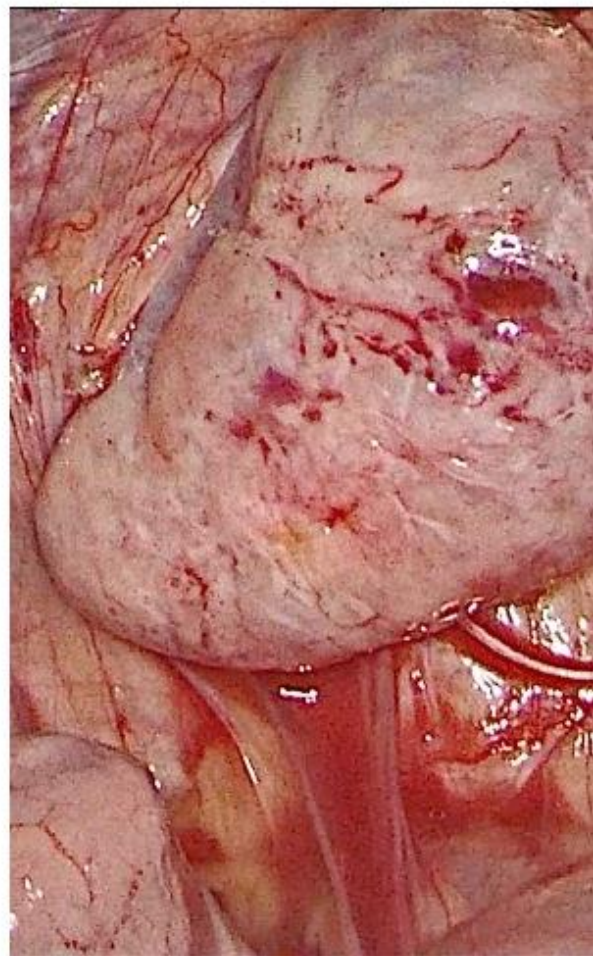
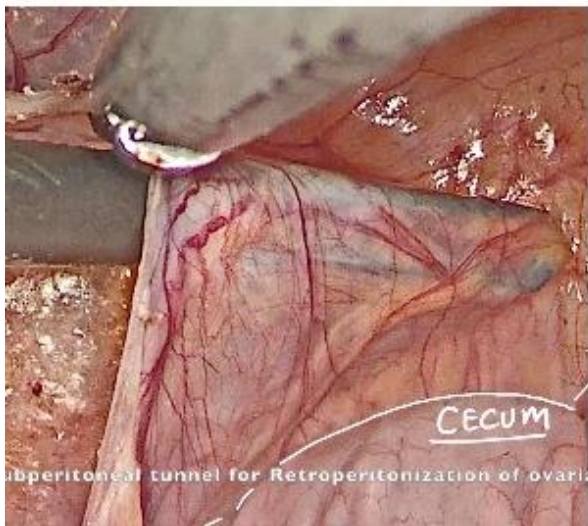
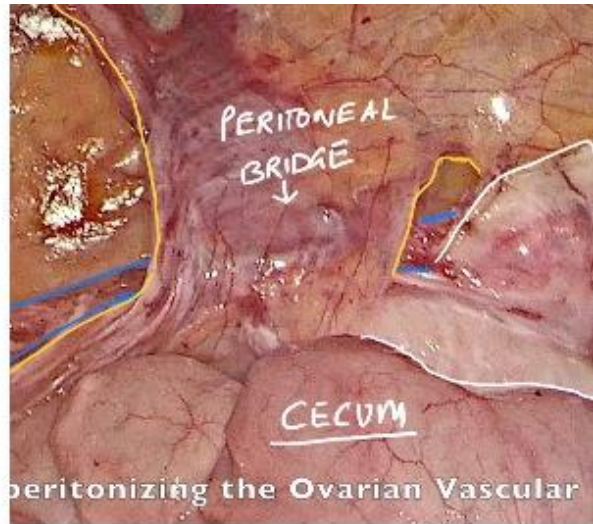
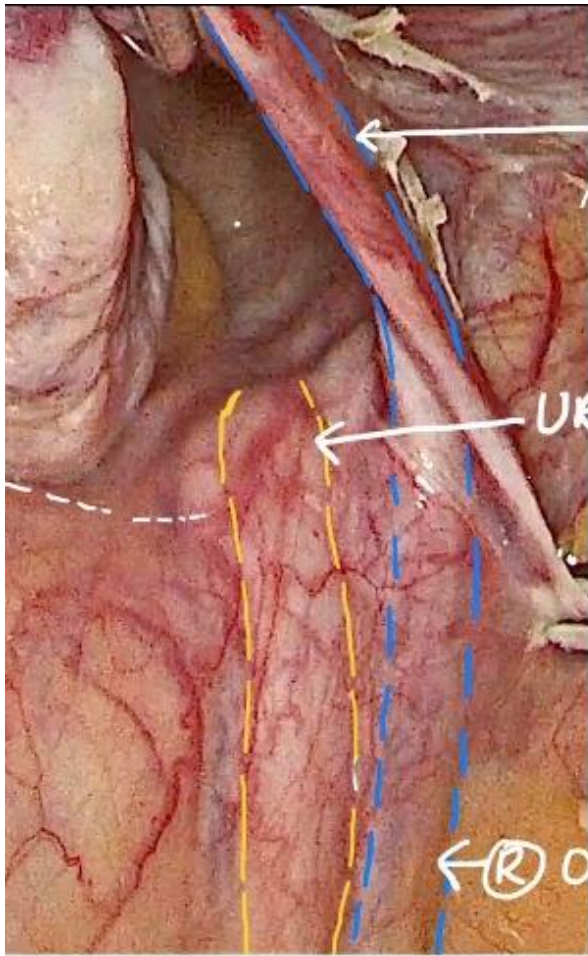
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Introduction: Ovarian transposition involves surgically relocating the ovaries from the pelvic area before undergoing pelvic radiation for either gynecologic or non-gynecologic cancers. Preserving the ovaries in younger patients is crucial to reduce the morbidity associated with premature menopause. Given that approximately half of cervical cancer patients are premenopausal at the time of diagnosis, undergoing ovarian transposition before radiation therapy can be advantageous for preserving ovarian function.

Description: 28 year old parous woman with stage IB3 squamous cell carcinoma of cervix underwent laparoscopic ovarian transposition before planned chemoradiation. Port positioning conformed to diamond shape configuration. 12mm primary trocar was put at a point midway between umbilicus and xiphisternum. Another 12 mm port was placed four finger breadth below umbilicus in midline. Two 5 mm port were used on either side of umbilicus (Figure 1A). Surgical technique involved bilateral salpingectomy followed by transection of ovarian ligament, retroperitoneal dissection to identify ureter and mobilizing ovarian vessels in entirety of infundibulopelvic ligament (2a-d). Rectosigmoid and cecum were both mobilized. Ovaries were fixed with three permanent sutures in the paracolic gutter and titanium clips were used to identify level of transposition later (figure 1B). Baseline FSH were measured.

Conclusion/Implications: Laparoscopic ovarian transposition, performed by experts well-versed in radiation field principles, dosage considerations (including scatter effects), and ovarian tolerance, can successfully preserve ovarian function using this approach. It's advisable to consider offering ovarian transposition to young female patients who need pelvic radiation as part of their cancer treatment.





SF039 / #1299

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

**ROBOTIC SPLENECTOMY WITH PARTIAL GASTRECTOMY FOR ISOLATED
RECURRENCE OF OVARIAN CANCER**

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Introduction: Splenectomy has been employed in the management of isolated recurrences of ovarian cancer. Robotic splenectomy can be used in such instances.

Description: A case of robotic splenectomy with partial gastrectomy is presented

Conclusion/Implications: Splenectomy associated surgical complications can be managed effectively with a minimally invasive approach.

SF040 / #744

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

**LAPAROSCOPIC TRANSPERITONEAL PARAAORTIC LYMPH NODE DEBULKING:
STANDARDIZATION OF THE TECHNIQUE.**

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Introduction: Surgical retroperitoneal lymph node staging or therapeutic is part of an integrated approach. Despite its importance, it is a challenging procedure, especially when performed minimally invasively. This video presents a standardized approach for the procedure by a transperitoneal laparoscopic route.

Description: A 58-year-old patient with incidental right adnexal mass finding by abdominal ultrasound. At diagnosis, CA125=1,280. The hypermetabolism was restricted to the right adnexa and paraaortic nodal conglomerate at the PET CT. The indication was a complete staging, including a laparoscopic paraaortic lymph node debulking, for a presumed diagnosis of an adnexal carcinoma with only nodal metastasis. This procedure started with the small bowel loops positioned in the right upper quadrant, and the transverse colon elevated towards the upper abdomen. A retroperitoneal incision was performed over the right common iliac/RCI vessels up to the Treitz's angle. The dissection follows parallel to the vena cava with the right ureter attached to the flap. The inferior mesenteric artery and the left ureter are identified. The lymph node retrieval is started after an adequate landmark identification. Lymph node dissection begins over the RCI in a cranial direction. The dissection and retrieval of the bulky lymph nodes ventral to the aorta, preserving the IMA. All the specimens were retrieved inside extraction bags. Blood loss was 120cc. The patient was discharged in 12 hours, and the final pathology confirmed the diagnosis. The patient started platinum-based therapy in POD14.

Conclusion/Implications: In this transperitoneal laparoscopic paraaortic debulking procedure, adequate nodal debulking was safe and feasible with a step-wise approach.

SF041 / #925

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

LAPAROSCOPIC MANAGEMENT OF A MASS CAUSING ELEVATED CREATININE LEVELS AFTER TOTAL PELVIC EXENTERATION

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Introduction: Pelvic exenteration is one of the most aggressive procedures in gynaecologic oncology practice. A later laparotomy may be highly morbid in these patients due to adhesions. Laparoscopy may be performed with its inherent advantages such as magnification and sharper dissection to avoid complications.

Description: A 74-year-old patient with a history of carcinoma of cervix presented with right-sided pain, and reduced urine output, with an increased serum creatinine. She had a total exenteration with sigmoidostomy and ileal conduit performed at our institution 4 months ago for her second recurrence. Her primary treatment was chemoradiation for a FIGO stage 2b cervical cancer 6 years ago followed by an open Type 1 hysterectomy for the first recurrence 4 years later. On examination a 5x5 cm semi-mobile mass was palpable in the right hypochondriac region close to ileal conduit. PET-CT revealed a cystic, necrotic mass suspicious for recurrence. Abscess, urinoma or a foreign body were also included in differential diagnosis. Laparoscopy was planned at multidisciplinary tumour board. At operation a 5 mm laparoscope was introduced at Palmer's point for possible extensive adhesions. Following ancillary trocar insertions and meticulous dissection of omental and intestinal adhesions using bipolar energy and cold scissors, the mass adhered to the ileal conduit and omentum was detected, carefully excised and extracted through a mini-laparotomy uneventfully for pathological analysis.

Conclusion/Implications: Laparoscopic approach using Palmer's point entry can be considered to avoid laparotomy for appropriate indications in selected patients with a history of complex surgery like exenteration and radiotherapy.

SF042 / #790

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

TRANSUMBILICAL SINGLE-SITE LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY TO THE LEFT RENAL VEIN: TECHNIQUES AND ANATOMIC CONCEPT

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Introduction: We developed a series of techniques with novel anatomic concept, which enables para-aortic lymphadenectomy to the left renal vein (LRV) via single-site laparoscopy.

Description: The challenge in laparoscopic para-aortic lymphadenectomy largely comes from the lack of stable exposure, which is further aggravated in single-site laparoscopy. The key point of our techniques is to create a stable operating space, which enables single-site laparoscopic para-aortic lymphadenectomy (SSLPAL) to the LRV. The bed was tilted 30 degrees to the right, and 15 degrees towards the head. A folded gauze pad was stuffed into the abdomen through the port, then unfolded to encase the bowels. With gravity, all small intestine were turned to the upper right abdomen. Then, the inferior mesenteric vein and ascending part of duodenum formed an angle, which we named as renal vein angle. The angle apex indicates the location of LRV. This anatomic relationship is very stable and can be utilized for locating LRV before para-aortic lymphadenectomy. Suspending peritoneum on two sides of the angle will create a space without intestine interference, just as it is beneath the embrace of angel wings. We successfully performed SSLPAL to the LRV in 28 patients with gynecological cancers (BMI between 18.1 and 37.3). There was no complication, conversion to laparotomy, or need for adding trocar. The median number of nodes removed was 25 (16 to 37). The details of techniques are still being refined.

Conclusion/Implications: Our techniques provide a safe and reliable approach for SSLPAL to the LRV, and may be reproducible for other surgeons.

SF043 / #1019

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

TRANSUMBILICAL SINGLE-SITE LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY TO THE LEFT RENAL VEIN: APPLICATION IN RETROPERITONEAL RELAPSE

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Introduction: With newly developed techniques, single-site laparoscopic para-aortic lymphadenectomy (SSLPAL) was performed in a selected ovarian cancer patient with retroperitoneal nodal relapse.

Description: The patient, a 43-year-old woman with stage IIIB ovarian cancer and BRAC1 mutation, underwent laparoscopic surgery 4 years ago. In the initial surgery, only pelvic lymphadenectomy was performed and nodal metastases were found. Para-aortic lymphadenectomy was not performed. A recent PET/CT examination indicated isolated nodal metastasis on the left side of aorta. After comprehensive evaluation, we planned SSLPAL for her. The bed was tilted 30 degrees to the right, and 15 degrees towards the head. This position allowed full exposure of retroperitoneal anatomical landmarks such as the left renal vein, ureter, psoas major muscle, and inferior mesenteric artery. The peritoneum was suspended through the abdominal wall to create a stable operating space. The metastatic lymph nodes were assessed to be resectable. We performed left para-aortic lymphadenectomy successfully to the renal vein level. On the right side of the aorta, closely adhered lymph nodes posed challenges in finding a safe dissection plane. Considering that this might be tissue fibrosis caused by previous surgery, we sought a safe plane from higher position and then processed the right para-aortic lymphadenectomy to the renal vein level. Finally we dissected the lower lymph nodes along the safe plane. A total of 20 lymph nodes were harvested and only those on the left side of the aorta were confirmed to be metastatic.

Conclusion/Implications: The feasibility of SSLPAL to the LRV persists in selected patients with recurrent disease.

SF044 / #566

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS19. Surgical Techniques and Perioperative Management*

**THORACOSCOPIC RESECTION OF LYMPH NODES METASTATIC TO THE
CARDIOPHRENIC ANGLE IN MESONEPHRIC DUCT CARCINOMA**

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Introduction: Gynecologic tumors, especially ovarian cancer, have a high incidence of metastasis to the lymph nodes of cardiophrenic angle. If R0 resection can be achieved in the abdominal and pelvic cavities, removal of the lymph nodes in the cardiophrenic angle can achieve true systemic R0 resection, which can improve the patient's prognosis. The video aims to showcase the technical advantages of this approach while also highlighting the challenges associated with mesonephric duct carcinoma, such as low incidence rate, difficult preoperative diagnosis, and insensitive to chemotherapy.

Description: The incision is made on the outer edge of the breast between the fourth and sixth ribs, with a 5mm trocar and a 2cm small incision. The cardiophrenic angle area is filled with adipose tissue, and the metastatic lymph nodes are surrounded by the adipose tissue. Therefore, to achieve R0 resection, the adipose tissue must be completely removed. Firstly, the entire fat tissue mass is dissected from the front of the diaphragm and towards the direction of the pericardium. When we see the muscle tissue of the diaphragm, it indicates that the fat has been stripped thoroughly. When the fat on the diaphragmatic and chest wall is completely loosened, the fat in the cardiophrenic angle can be completely removed along the pericardial side. When the dissection is completed, insert a No.22 closed thoracic drainage tube. Finally, close the incision.

Conclusion/Implications: Thoracoscopic cardiophrenic angle lymphadenectomy is feasible and safe. Compared to the abdominal approach, thoracoscopic cardiophrenic lymph node dissection provides a better view, easier operation, and more thorough cleaning.

SF045 / #575

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS23. Vulvar and Vaginal Cancer*

TYPE III INFRALEVATOR EXENTERATION WITH EXTENDED-VRAM FLAP NEO-VULVO-VAGINA RECONSTRUCTION FOR VULVAR LEIOMYOSARCOMA: STEPWISE ILLUSTRATION OF AN “OUT OF BOX “ APPROACH

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Introduction: In this video we illustrate complex surgical procedure for rare challenging case of vulvar leiomyosarcoma in 10 systematic steps. Primary sarcoma of the vulva is an extremely rare entity, representing only 1%–3% of all vulvar malignant neoplasms. Owing to its exceedingly rare diagnosis, management algorithms have been extrapolated from limited case reports and series . As surgical resection and achieving decent negative margins is the key determinant for prognosis in sarcomas, understanding of such ultra-radical surgeries is of paramount importance for a gynaecologic oncologist.

Description: Key surgical steps DEVELOPMENT OF PELVIC SPACES URETERAL MOBILIZATION PARAMETRIAL RESECTION WITH PRESERVATION OF OVARIES RESECTION OF RECTOSIGMOID, ENDOPELVIC FASCIA, AND LEVATOR ANI MUSCLE POSTERIOR VAGINECTOMY PERINEAL RESECTION SPECIMEN MOBILIZATION RAISING THE EXTENDED VRAM FLAP AND OMENTAL FLAP eVRAM FLAP BASED NEO-VULVOVAGINAL RECONSTRUCTION DONOR SITE CLOSURE AND CREATION OF PERMANENT COLOSTOMY

Conclusion/Implications: Unlike other surgical procedures in gynaecologic oncology such as pelvic lymphadenectomy or radical hysterectomy in which each step can be standardized in great detail, pelvic exenteration has an array of alternatives at each step. It must be tailored to the specific case. Likewise, we have systematically elucidated steps of a meticulous “out of the box “ approach. We emphasize that surgical skills must evolve along with decision-making for bizarre case scenarios and further expansion of understanding of such ultraradical procedures will provide an opportunity to customize care for patients dynamically.

SF046 / #427

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS23. *Vulvar and Vaginal Cancer*

INDOCYANINE GREEN INGUINAL SENTINEL LYMPH NODE MAPPING FOR MANAGEMENT OF VULVAR CANCERS- PRACTICAL TIPS AND TRICKS

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Introduction: The current recommendation to enhance sentinel lymph node (SLN) detection in the management of early-stage vulvar cancers is to utilise a combination of technetium-99m (Tc-99m) and a blue dye such as patent blue. There is now more published evidence to support the utility of indocyanine green (ICG) in inguinal SLN detection with some studies showing comparable detection rates to Tc-99m. [1] At this stage, the standard protocol for ICG use in SLN mapping for vulvar cancers is yet to be determined. Reference: Koual M, Benoit L, Nguyen-Xuan HT et al. Diagnostic value of indocyanine green fluorescence guided sentinel lymph node biopsy in vulvar cancer: a systematic review. *Gynecologic Oncology*. 2021 May 1;161(2):436-41.

Description: The utilization of ICG in inguinal SLN mapping appears to involve a learning curve. Here we present 10 surgical steps of inguinal SLN dissection using both ICG and Tc-99m including tips and tricks for mitigating pitfalls. These steps will also be useful in training fellows to develop their approach to this procedure. We collected video footage from unedited surgical recordings made at our institution. Here we present two cases of early-stage vulvar cancer with groin SLN dissection.

Conclusion/Implications: There needs to be a systematic approach to inguinal SLN mapping and resection which will allow navigation of pitfalls for ICG use and is a useful training tool for registrars and fellows. There is now increasing evidence that this technique allows improved localisation of SLND but requires ongoing research and validation.

SF047 / #1136

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS23. *Vulvar and Vaginal Cancer*

LAPAROSCOPIC VIDEO INGUINAL LYMPHADNECTOMY (L-VEIL) IN CARCINOMA VULVA

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Introduction: Vulvar cancer accounts for about 4% of gynecologic malignancies. Inguinal nodal metastasis is the essential independent prognostic factor. Inguinofemoral lymphadenectomy has a major role in surgical management of early vulvar cancer with prognostic and potentially therapeutic implications. Inguinofemoral lymphadenectomy is a challenging surgical procedure with a high complication rate owing to the devascularization of skin flaps, the disruption of lymphatic afferents, concomitant medical conditions predisposing to poor wound healing. Surgical morbidity is seen in 50%-76% cases. The mortality related to classical lymphadenectomy is as much as 3%.

Description: Endoscopic inguinofemoral lymphadenectomy was developed by Bishoff in 2003 by dissecting two cadaveric models and in one patient with stage T3N1M0 penile carcinoma. VEIL is an alternative to reduce the morbidity without compromising the oncologic outcomes. L-VEIL is a minimally invasive procedure duplicating the standard open procedure with less morbidity. A video presentation to describe the technique of L-VEIL in vulvar cancer and discuss the advantages and outcome.

Conclusion/Implications: L-VEIL is an attractive minimally invasive technique to do inguinal block dissection in a single sitting in patients with vulvar carcinoma. L-VEIL allows the removal of inguinal lymph nodes within the same limits as in open procedure and potentially reduces surgical morbidity. It is better accepted cosmetically and reduces hospital stay. Long term oncological results are not available. Randomized multi-institutional studies are required to prove its efficacy over open surgery.

SF048 / #804

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS23. Vulvar and Vaginal Cancer*

RECONSTRUCTION WITH TENSOR FASCIA LATA FLAP IN INGUINAL LYMPHADENOPATHY WITH ULCERATION IN RECURRENT VULVAR CARCINOMA

Ayesha Siddiqua¹, Nasrin Sultana²

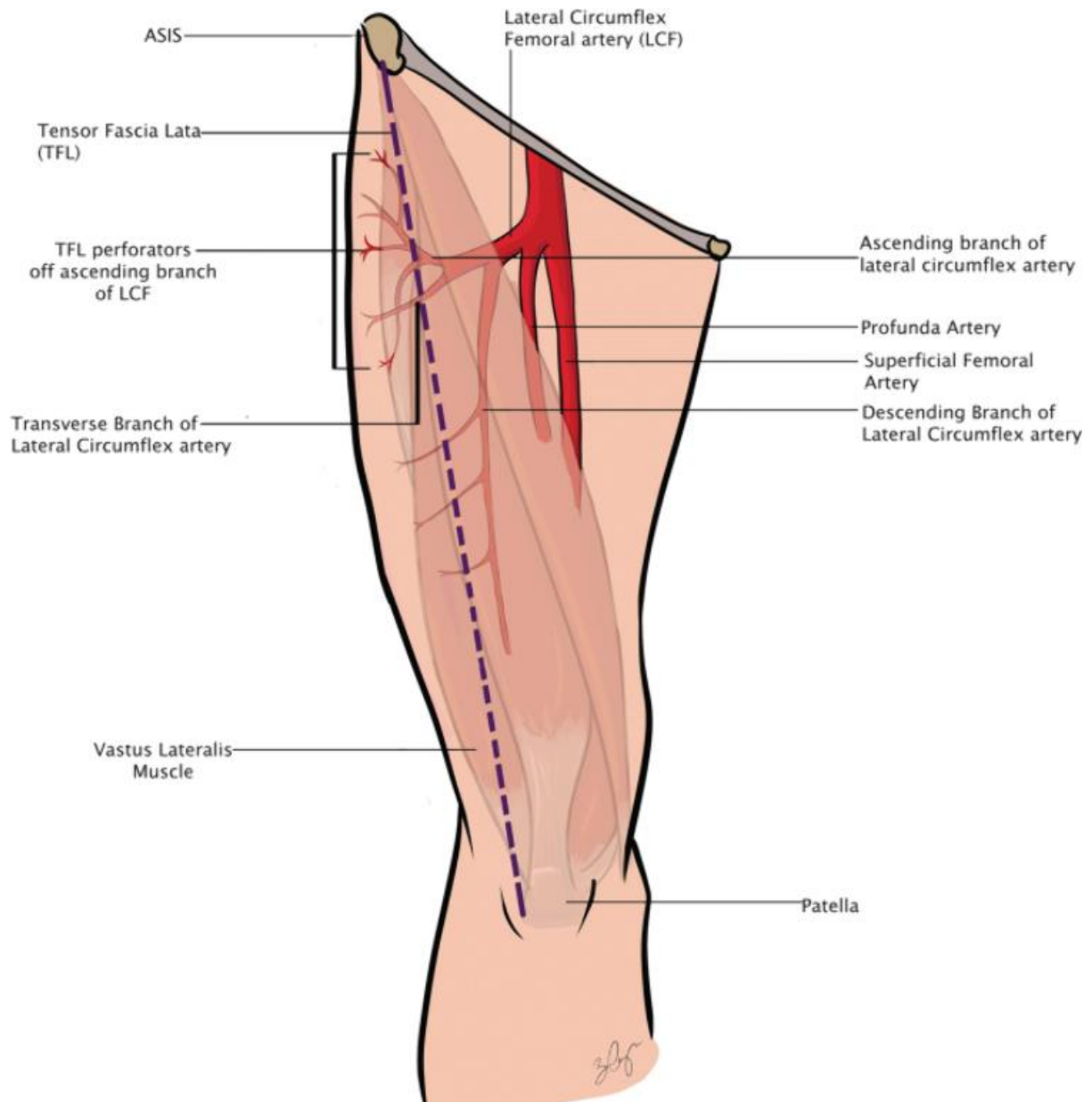
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Introduction: Vulvar cancer is the 4th most common gynaecologic tumors representing about 4% of all gynaecologic tumors. Management of vulvar carcinoma requires an experienced, multidisciplinary team approach. It includes management of -the primary lesion, groin nodes and reconstructive surgery.

Description: A 60 years old lady of vulvar squamous cell carcinoma had H/O WLE of primary lesion - 2years back with no evaluation of Inguinal LN. No adjuvant treatment and lost to follow-up. O/E: ECOG-0, Vulva-vagina- normal, P/S- cervix normal, P/V- Uterus atrophied, R/V- No lesion in the pelvis, No lesion at primary site. A (4x5cm) ulcerative lesion arising from left inguino-femoral area, fixed to underlying structure. MRI of pelvis including both inguinal area with MRA of left femoral vessels- enlarged left inguino-femoral LNs invading underlying soft tissue structures but not invading femoral vessels. CT chest and abdomen- Normal Patient was selected for wide local excision and reconstruction with tensor fascia lata flap.



The flap was harvested from the lateral thigh regions and based on ascending branch of lateral circumflex femoral artery. The donor area was closed primarily. Anterior border of the flap - a line from anterior superior iliac spine and lateral condyle of tibia. The posterior border - greater trochanter, superior border - iliac crest, and inferior border within 8 cm from joint line. Location of perforators - at the junction of proximal and middle third.



Conclusion/Implications: The versatility of tensor fascia lata flap makes it useful to cover - the defect, provide radiation, eradication of pain, achieve good palliation, improve quality of life.

SF049 / #1119

ON-DEMAND SURGICAL FILM CINEMA

Topic: AS23. *Vulvar and Vaginal Cancer*

SENTINEL LYMPH NODE MAPPING WITH INDOCYANINE GREEN (ICG) USING FLUORESCENT IMAGING DEVICE IN MALIGNANT TUMORS OF THE VULVA

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Introduction: Sentinel lymph node (SLN) mapping with indocyanine green (ICG) is a standard surgical procedure for early-stage cervical cancer and endometrial cancer. However, this technique has not been widely assessed in vulvar malignancies. This study aims to present the surgical process of SLN mapping with ICG in vulvar malignancies and evaluate its feasibility.

Description: Pinpoint, a fluorescent imaging device, was used for SLN mapping with ICG in 18 patients with vulvar malignancies, in which 12 were detected by fluorescent laparoscopy, and 6 by SPY Portable Handheld Imager (SPY-PHI). For each patient, 1ml ICG (1.25 mg/mL) was injected at four points along the longitudinal and transverse axes of the tumor. The 18 patients include 8 squamous cell carcinomas, 7 melanomas, and 3 Paget's diseases. The inguinofemoral SLN mapping was successful in all the 18 cases (15 bilateral and 3 unilateral). Real-time identification of lymphatic drainage was achieved on the screen by different modes of signals. With time, ICG could be detected along the lymph vessels from the primary tumor to inguinal regions, and the median time of the appearance of the inguinofemoral SLN was 10 minutes. The most common SLNs located beside the pubic tubercle. The median of SLNs was 3. In pathological ultra-staging, 5 cases were positive for SLN metastasis.

Conclusion/Implications: Sentinel lymph node (SLN) mapping with indocyanine green (ICG) was feasible for vulvar malignancies, and fluorescence imaging system is convenient for SLN localization.

SF050 / #686

ON-DEMAND SURGICAL FILM CINEMA

Topic: *AS10. Ovarian Cancer*

CONTAINED EXCISION TECHNIQUE IN A ROBOT-ASSISTED CYTOREDUCTION FOR RECURRENT OVARIAN CANCER

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Introduction: Traditional surgical techniques risk tumor spillage, which can disseminate cancerous cells and worsen patient outcomes. This abstract details the use of a novel robot-assisted contained excision technique in the cytoreductive surgery for a 74-year-old patient with recurrent ovarian carcinosarcoma, highlighting its efficacy in minimizing potential tumor spread.

Description: The procedure initiated with an intraperitoneal survey to locate any visible tumors. Upon identifying a recurrent tumor at the left pelvic sidewall, a meticulous approach was adopted to avoid direct tumor manipulation. Key to this technique was the extensive dissection of normal-appearing tissue to expose the tumor's base and the employment of a small x-ray detectable cotton sponge for indirect handling. The tumor was encapsulated and removed with the sponge in a specimen retrieval bag, ensuring a contained excision with no surface contact. The intervention recorded minimal blood loss and allowed for the patient's same-day discharge.

Conclusion/Implications: The contained excision technique for recurrent ovarian carcinosarcoma utilizing robotic assistance offers a promising avenue for surgical intervention. The approach aims to circumvent the risks associated with conventional surgery, specifically tumor dissemination. The success of this technique, demonstrated by the patient's outcome, suggests that such a method could be a standard consideration in the surgical management of similar oncologic recurrences, warranting further investigation and adoption in appropriate cases.