



## **IGCS 2021 Abstracts: Surgical Film Cinema**

**Registered Delegates will have access to these surgical films located within the Meeting Portal from August 30 – December 4, 2021.**

SF001 / #65

## LAPAROENDOSCOPIC RADICAL TRACHELECTOMY AND PELVIC LYMPHADENECTOMY WITHOUT UTERINE MANIPULATOR

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**Abstract Body:** Introduction: In face of the postponement in marital and reproductive age in the modern society, most of the patients with cervical cancer have not conceived yet or still bear fertility plans. We herein introduce the Laparoendoscopic radical trachelectomy (LRT) a surgery called radical trachelectomy through a minimally invasive approach for young patients with cervical cancer to preserve fertility without compromising the oncology outcomes. Description : A 29-year-old, nulliparous woman with stage IB1 cervical cancer received the LRT plus lymphadenectomy with enclosed colpotomy and without manipulator. Instead of using a uterine manipulator, uterine suspension was adopted. We suture bilateral round ligaments to form a coil with the anterior wall of the uterus which help remain the integrity of the uterus. After the branches of the uterine artery were separated, the uterine branch was retained. Reconstruction of the residual cervix and vagina was performed by the "cuff-sleeve" suture method. The anterior and posterior walls of the vagina were sutured with 2 "U" shapes respectively with special care given to the uterine branches of the uterine artery. At the end of the surgery, a stent was set trans-vaginally in case of cervical stenosis. The "neocervix" was restored to its original anatomy after 6 months. Till now, reproductive function and sexual health is satisfied for the patient. Conclusions: LRT with unique modifications is safe and feasible for patients with early stage cervical cancer to preserve fertility. Further study shall be in place to better evaluate the postoperative efficacy and pregnancy outcomes of such procedure.

SF002 / #332

**SENTINEL LYMPH NODE MAPPING FOR CERVICAL CANCER: A PRACTICAL ILLUSTRATION OF USING ICG DURING A LAPAROTOMY.**

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**Abstract Body:** We have created a surgical video to demonstrate the sentinel lymph node mapping in cervical cancer during a laprotomy. Sentinel lymph node (SLN) mapping is an emerging technique to be used in the surgical management of women with cervical cancer. Multiple studies including SENTICOL 2 has shows the accuracy of using SLN biopsy in cervical cancer treatment [1]. This approach has mainly been used with minimally invasive surgery. However, since the publication of the LACC trial in 2018, there has been a evidence based shift to open radical hysterectomy for early stage cervical cancer [2]. We aim to display how to perform SLN biopsy with indocyanine green (ICG) dye, using a laparoscopic camera even in open surgery. The video footahe were gleaned from an unedited surgical film recorded at our institute. We conclude that SLN mapping and biopsy with ICG during a laparotomy is feasible and achievable.

SF003 / #661

## TOTAL PELVIC EXENTERATION AND PERINEAL RECONSTRUCTION FOR RECURRENT CERVICAL CANCER

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**Abstract Body:** Background & Introduction: Salvage procedures for recurrent and residual cervical cancer following radical chemo radiation can be offered to patients with motivation and willingness to undergo massive operative procedures. It needs the skill of a multidisciplinary team who can contribute to various aspects of this complicated procedure. Description of the technique Here we describe Total Pelvic exenteration in a 49 year old lady with residual disease of cervical cancer who after chemo radiation for a bulky stage IIIB (8 cm) endocervical adenocarcinoma of the cervix was found to have central residual disease infiltrating bladder, vagina, anal canal and rectum. She was offered total exenteration after 3 cycles of chemotherapy with Paclitaxel and Carboplatinum after ruling out metastatic disease with a PET-CT. She was operated upon by a team comprising of urologist, colorectal surgeon, gynaecologic oncologists and plastic surgeon. She underwent Total Pelvic exenteration with enbloc removal of uterus with vagina, urinary bladder, urethra, rectum and anal canal. The ureters were diverted into an ileal conduit by Wallace technique and the colon was diverted into a Hartmans Pouch The vulval defect was reconstructed by gracilis myocutaneous flap repair over a vicryl mesh . Post operatively her wound healed well and she was discharged on 8<sup>th</sup> post-operative day. Surgical margins were free of tumour on histopathology. She is alive and well on follow up after 30 months. Conclusions: Salvage procedures for residual and recurrent cervical cancers can result in good survival and quality of life in motivated and surgically fit patients.

SF004 / #153

## THE USE OF LIGHTED URETERAL CATHETERS IN DIFFICULT MINIMALLY INVASIVE GYNECOLOGIC ONCOLOGIC SURGERY

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**Abstract Body:** Introduction Over the past decade, the utility of minimally invasive surgery (MIS), laparoscopy and robotics, has significantly increased in gynecologic oncology surgeries. MIS has many advantages Over open surgery including a significant reduction in the length of hospital stay, fewer post-operative complications, and increased patient satisfaction. Ureteral injuries are amongst the most common complication of gynecologic procedures. The presence of large pelvic masses, significant obesity, adhesions and previous radiation can increase the risk of ureteral injuries during gynecologic oncology procedures. Description Our objective is to demonstrate the technique of stent insertion and use. In addition we will demonstrate the use of lighted ureteral stents in difficult selective minimally invasive gynecologic oncology procedures such as surgery on morbidly obese patients, very large pelvic masses, management of adhesions and surgery for patients who were previously treated with pelvic radiation. We will demonstrate the use of lighted ureteral catheters in both laparoscopic and robotic procedures. Conclusion Lighted Urethral stents can assist the surgeon in identifying the ureter, reduce the needs for extensive retroperitoneal dissection and potentially reduce rates of ureteral injuries. The usage of lighted ureteral catheters/stents are supported in both standard laparoscopic and robotic surgery. Techniques that can support the surgeon to accurately identify the ureters are paramount.

## STRATEGY FOR MIS UTERINE MANIPULATION IN CERVICAL CARCINOSARCOMA

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**Abstract Body:** Introduction: Uterine manipulation could be associated with worst outcomes even in endometrial cancer, as suggested recently. In this video we demonstrated simple techniques to overcome the potential tumor spillage during uterine manipulation. Description: LAGOH 57 yo had a low differentiated adenocarcinoma involving uterine isthmus with 5,1 x 6,4cm with endometrial, cervical and right parametrial involvement. Pathologic report suggested an endometrial origin of the tumor. We proposed to do a radical hysterectomy and retroperitoneal lymph node dissection Our team offered to the patient minimally invasive surgical approach and regarding the big dimension of the tumor's cervical component we opted to avoid tumor spillage during uterine manipulation with the following measures: we used a big polypropylene graduated cylinder and fixed the device in the 4 cervical quadrants with stiches. For mobilizing uterine corpus, we used an hysterometer involved with bladder catheter placed in the uterus cavity. Radical hysterectomy, para-aortic lymph node dissection and pelvic lymph node debulking were performed uneventfully in 5h 10 min. Pathologic report accused carcinosarcoma with pelvic lymph nodes involvement, parametrial infiltration and free margins (FIGO IIIC). After 6 cycles of carboplatin/ paclitaxel and adjuvant radiotherapy, LAGOH maintains one year of outpatient follow-up without evidence of recurrence. Conclusion: While data related with the impact of uterine manipulation in endometrial/ uterine corpus cancer is still not available in multiple prospective trials, it is rational to develop strategies to optimize safety of the procedure.

**UPFRONT SURGICAL MANAGEMENT OF LARGE OR NECROTIC MALIGNANT MIXED MULLERIAN TUMORS OF THE ENDOMETRIUM BY A MINIMALLY INVASIVE APPROACH**

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**Abstract Body:** Introduction: Malignant Mixed Mullerian Tumors (MMMT) often present with very large, necrotic tumor burden in the uterus that leads to dilation and effacement of the cervix. In patients with this presentation, conventional hysterectomy poses a much greater challenge as the ureters are comprised by the mass of the tumor and are at an increased risk for injury. Given this surgical challenge, many of these patients may begin with neoadjuvant chemoradiation. However, these treatment modalities are associated with significant toxicity and negatively impact patient quality of life. Therefore, we present a minimally invasive robotic surgical approach that aims to optimize quality of life without sacrificing prognosis. Description. The patient had biopsy proven MMMT. Pre-operative CT scan showed an enlarged uterus with no evidence of extrauterine disease. On presentation, the cervix was dilated and effaced with extruding disease. Disease was initially reduced transvaginally. Robotic approach included 1) upfront vascular control of pedicles, 2) radical hysterectomy with complete dissection of the ureters secondary to the dilated and effaced cervix, 3) infracolic omentectomy, 4) lymph node dissection, and 5) appendectomy. Conclusion: The patient was debulked to zero residual disease. She was discharged the following day ad had no post-operative complications. A robotic approach for staging and complete cytoreduction of bulky Malignant Mixed Mullerian Tumors is feasible with good postoperative outcome.

SF007 / #206

## **A SYSTEMATIC APPROACH FOR ACHIEVING OPTIMAL CYTOREDUCTION OF LOCALLY ADVANCED ENDOMETRIAL CANCER BY A ROBOTIC APPROACH**

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**Abstract Body:** Introduction: This video demonstrates surgical techniques that can be utilized to optimally cytoreduced locally advanced endometrial cancer via a robotic approach. Description: The patient had biopsy proven endometrial adenocarcinoma. Pre-operative CT scan indicated omental caking with involvement of the pelvic peritoneum and uterosacral ligaments. The patient had diagnostic laparoscopy which showed disease limited to the pelvis. Robotic surgical techniques demonstrated include 1) upfront vascular control of pedicles, 2) lateral mobilization of ureters for management of uterosacral disease, 3) peritonectomy for excision of peritoneal lesions, and 4) infracolic omentectomy. Conclusions/Implication: The patient was debulked to zero residual disease. She was discharged the following day and had no post-operative complications. A robotic approach for staging and complete cytoreduction of locally advanced endometrial cancer is feasible with good postoperative and oncological outcome. This video presents a step by step approach for handling these challenging cases.

**EXTRAPERITONEAL SENTINEL LYMPH NODE BIOPSY BY VAGINAL NATURAL ORIFICE TRANSLUMINAL ENDOSCOPIC SURGERY (VNOTES) IN PATIENTS WITH NON-PROLAPSED UTERUS AND LOW-RISK ENDOMETRIAL CANCER**

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**Abstract Body:** Introduction: To evaluate the feasibility of extraperitoneal sentinel lymph node biopsy (SLNB) by vaginal natural orifice transluminal endoscopic surgery (vNOTES) in patients with a non-prolapsed uterus and low-risk endometrial cancer. Methods: A 54-year old woman visited because of vaginal bleeding that started three months ago. Endometrial biopsy revealed grade 1 endometrioid endometrial cancer, and imaging studies showed no abnormal finding. We tried vNOTES staging operation with extraperitoneal SLNB. First, each 1 ml of indocyanine green (ICG) diluted at 1.25 mg/ml was injected into the submucosa and stroma at 3 and 9 o'clock of the cervix. Second, we opened the mid-vagina between the cervix and vaginal orifice where the pelvic floor muscles were palpated. Third, a space was secured by placing a finger upward and outward after ensuring the opening space of the mid-vagina. Thereafter, we inserted single port trocar through the opening, and then we found the para-cervix including the pelvic autonomic nerves, and the obturator nerve. After peeling off the pelvic vessels and nerves and ureter, we found the sentinel lymph node near the external iliac vessel, and resected it. Then, we performed vNOTES hysterectomy, and she was discharged on the second day of surgery without any complications. Conclusions: vNOTES staging operation with extraperitoneal SLNB may be feasible, and the determination over the extraperitoneal opening may be important to ensure the adequate view to identify the pelvic structure for patients with a non-prolapsed uterus and low-risk endometrial cancer.

## MINIMALLY INVASIVE SECONDARY CYTOREDUCTIVE SURGERY FOR CELIAC AND CARDIOPHRENIC ISOLATED NODAL RECURRENCE OF OVARIAN CANCER

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**Abstract Body:** Introduction Despite the advances in cytoreductive efforts and frontline chemotherapy in advanced ovarian cancer (OC), recurrence is a common event, with >70% of women experiencing relapse within two years of from diagnosis. The standard treatment for recurrent ovarian cancer (ROC) patients has been traditionally represented by systemic chemotherapy; however, this concept has been recently recognized as presenting a greater level of complexity given the influence of histotype, status of BRCA genes, previous antiangiogenetic treatment and pattern of relapse presentation. Several retrospective studies, as well as randomized prospective trials suggested that secondary cytoreductive surgery (SCS) could provide better oncological outcomes in platinum-sensitive ROC patients, in case of complete cytoreduction, which has to be considered the goal to be achieved. Description As far as lymph node relapse is concerned, some biological and clinical lines of evidence suggest that lymph node recurrences from OC would be better managed with SCS than medical treatment alone, given a relatively more indolent clinical behaviour compared to parenchymal and peritoneal disease. However, the documentation of lymph nodes metastasis in the hepatoceliac and cardiophrenic region at the time of SCS might be considered as a challenging clinical and surgical scenario. Although surgical management by minimally invasive surgery (MIS) could be expected to represent a demanding task in SCS, this video provides a step-by-step description of the surgical technique adopted for hepatoceliac and cardiophrenic lymph nodes resection. Conclusion MIS is feasible and could be a viable option for selected cases of ROC, minimizing the intra- and post-operative complications.

SF010 / #77

## LAPAROSCOPIC SENTINEL LYMPH NODE BIOPSY FOR STAGE I ENDOMETRIAL CANCER: DUAL TRACER METHOD

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**Abstract Body:** Introduction: Sentinel lymph node (SLN) biopsy is a new trending option in the management of stage I endometrial cancer. The first results are showing non inferiority when compared to the classic pelvic lymphadenectomy dissection and also a decrease of morbidity especially lymphedema. Our Aim is to Share one of our cases with the IGCS community. Description: We report the case of a 50 year old women with a stage Ia Endometrial cancer. She was included into our institution Trial to see the feasibility of SLN biopsy in endometrial cancer. The patients have been treated laparoscopically and the Dual tracer method was used to detect the SLN. A four trocars approach was used. A 10 mm trocars in the umbilicus and one in the left iliac fossa, Two five mm in the hypogastric region and right iliac fossa. After careful abdominal exploration we detected the blue dye in the left iliac region. We started with opening the left pelvic wall peritoneum. Careful dissection of a blue enlarged lymph node. After the extraction the blue lymph node was also found to have a high radioactivity. The frozen section was negative. As a part of our protocol the women had a full lymph-node dissection and no metastatic lymph-node was found. Conclusion: SLN biopsy in stage one endometrial cancer seems to be technically feasible. We are waiting for the result of our trial to implemented in our current standards of care.

SF011 / #197

## TRANSVAGINAL ENDOSCOPIC RESECTION (TVER) OF INVASIVE VAGINAL LESION

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**Abstract Body:** OBJECTIVE: This video demonstrates a novel surgical technique for excision of an invasive vaginal lesion using a single port laparoscopic access device. STUDY METHODS: A 31 year old female with a history of SLE on azathioprine presented with recurrent HSIL of cervix. A LEEP showed microinvasion measuring 2 mm and a vaginal fornix biopsy showed HSIL, but was clinically suspicious for invasion. The patient underwent a transvaginal endoscopic resection (TVER) of the lesion for diagnostic purposes. A single port laparoscopic access device was used for colpo-pneumo-occlusion. The endoscope was inserted into the vagina, and the 1.5 cm lesion was resected with margins of 5 mm under direct visualization using monopolar cautery. The mucosa edges were reapproximated with V-lock suture. RESULTS: Pathology showed squamous mucosa with high-grade vaginal intraepithelial neoplasia and a focal area of invasion (with depth of invasion <1 mm). The patient tolerated the procedure well and was discharged from Day Surgery without any postoperative complications. CONCLUSION: Transvaginal endoscopic resection for superficially invasive vaginal lesions can be performed safely and provide accurate diagnosis with excellent visualization.

## 10 STEPS TO APPROACH LARGE OVARIAN MASSES THROUGH VNOTES (VAGINAL NATURAL TRANSLUMINAL ENDOSCOPIC SURGERY)

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**Abstract Body:** 10 steps to approach large ovarian masses through vNOTES Introduction

VNOTES (vaginal Natural Orifices Transluminal Endoscopic Surgery) is a novel technique that allows a laparoscopic approach to the pelvic and abdominal cavity through the vagina. It seems to facilitate large ovarian masses (with benign characteristics) removal when compared to conventional laparoscopy.

Description

We recommend 10 steps to approach large ovarian masses through vNOTES. Each step is explained in the surgical video.

Step 1. Select suitable case.

Step 2. Setting up the patient and the surgical team.

Step 3. Accessing the cavity.

Step 4. Inserting vaginal port.

Step 5. Cavity inspection.

Step 6. Sealing and division.

Step 7. Bag the cyst.

Step 8. Cavity revision.

Step 9. Revise the inner ring of the vaginal port.

Step 10. Closing the vaginal vault. Conclusion.

It is feasible to approach large ovarian masses through vNOTES

**ROBOTIC APPROACH FOR A TOTAL HYSTERECTOMY BILATERAL SALPINGO-OOPHORECTOMY AND SUCTION CURETTAGE OF A 20-WEEK SIZE UTERUS WITH GESTATIONAL TROPHOBLASTIC NEOPLASIA.**

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**Abstract Body:** Introduction: Gestational trophoblastic neoplasia (GTN) is a malignant trophoblastic disease following either molar or non-molar pregnancies. GTN is primarily treated through uterine evacuation using suction curettage followed by observation or adjuvant chemotherapy based on WHO risk scoring.<sup>1,2</sup> In patients who have completed child-bearing, hysterectomy is an acceptable option and may decrease time to remission and required chemotherapy cycles.<sup>2</sup> In patients presenting with large volume uterine disease, evidence of metastasis, and high-risk WHO scoring, patients are treated with multi-agent chemotherapy including Etoposide, Methotrexate, Actinomycin-D, Cyclophosphamide, and Vincristine (EMA-CA).<sup>1,2</sup> EMA-CO has significant risks of complications, including acute hemorrhage and trophoblastic emboli.<sup>2,3</sup> In patients with large uteri, surgical risks include uterine perforation and acute hemorrhage,<sup>4</sup> requiring a large laparotomic incision. Accordingly, there is a need for risk-reducing minimally invasive approaches in the surgical treatment of GTN. Description: The patient is a 53 year old G4P4 presenting with an enlarged uterus of 20 cm with snowstorm appearance, a beta-hCG >400 000IU, lung metastases and a WHO risk score of 8. Preoperatively her blood pressure was 168/105. She underwent a robotic total hysterectomy and bilateral salpingo-oophorectomy, and guided suction curettage. Blood loss was minimal. The patient was scored post-procedure as WHO low risk (3). She received methotrexate, and switched to Actinomycin-D after a plateau in beta-hCG. Her beta-hCG is normal 5 months later. Conclusion: We present a minimally invasive approach that ameliorates the surgical and chemotherapy risks of uterine rupture, acute hemorrhage, and trophoblastic emboli, with a normalization of beta-hCGs after treatment with single-agent chemotherapy.

SF014 / #370

## LAPAROSCOPIC REPAIR OF OBTURATOR NERVE INJURY AT THE TIME OF PELVIC LYMPHADENECTOMY

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**Abstract Body:** Introduction The obturator nerve is formed by the lumbar plexus, receiving its fibers from the anterior division of L2-4. Clinically, obturator nerve injury manifests with sensorial loss at the medial aspect of thigh, pain at medial portion of the groin and ipsilateral adductor weakness. The risk of obturator nerve injury is increased during pelvic lymphadenectomy and surgeries for gynecologic malignancies. Here, we present a video film of full-thickness transection of obturator nerve at the time of pelvic lymphadenectomy in a patient who underwent laparoscopic surgery for endometrial cancer. The transected nerve was primarily repaired through a laparoscopic approach at the time of surgery. The patient experienced a full recovery with no motor function deficiencies. Description In this surgical film we present an 83-year-old woman, G2P2, who was diagnosed with a grade 3 endometrioid endometrial adenocarcinoma. She underwent a laparoscopic hysterectomy and sentinel lymph-node biopsies as well as resection of enlarged external iliac node. During the procedure, we identified a complete transection of the obturator nerve. To enable an end to end repair, the external iliac artery and vein were mobilized. The proximal end of the nerve was identified lateral to these vessels. An end-to-end anastomosis of the nerve was performed using Prolene sutures. The patient experienced an uneventful post-operative recovery .She discharge home on post-operative day 2, able to ambulate independently with no assistance. Conclusion: Obturator nerve injuries are a well-recognized complication of pelvic lymphadenectomy. Immediate laparoscopic nerve repair, can facilitate earlier motor recovery and prevent the need for laparotomy.

SF015 / #465

## PELVIC LYMPHADENECTOMY MADE EASY – A STEPWISE TECHNIQUE FOR SYSTEMATIC PELVIC LYMPH NODE DISSECTION

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**Abstract Body:** Introduction Systematic pelvic lymph node dissection is a standard procedure conducted in the management of cervical and high-risk endometrial cancers. This requires a precise understanding of anatomical landmarks in addition to surgical approach, with present's confusion for trainees amidst multiple learning techniques. Trainees must develop economy of movement and maximise lymph node yield whilst avoiding potential complications including injury to nerves and vessels as well as post-operative morbidity. Description - Identify the boundaries - Lateral border - develop retroperitoneal space by division of round ligament laterally, divide peritoneum along the medial border of psoas muscle with identification of genitofemoral nerve toward paracolic gutter - Medial border – obliterated umbilical artery - dissect along lateral border to level of common iliac vessels bifurcation - Inferior border - obturator nerve – identify obturator foramen following pubic bone with nerve seen below - Caudal border – deep circumflex vessels - Cranial border – bifurcation of common iliac vessels - Lymph node en-bloc dissection technique - Orientation from lateral to medial and caudal to cranial - Initiate from lateral and caudal borders and dissect from external iliac vessels - Once below external iliac vein follow pubic bone to identify obturator nerve as it crosses the obturator foramen, acknowledging corona mortis vessel - Collect lymph nodes within anatomical boundaries - Ensure haemostasis Conclusion/Implications We present this case as an aide memoire of a basic gynaecological oncology technique. This is an essential surgical skill to develop with knowledge and practice for all subspecialists in training.  
<https://www.dropbox.com/s/b2k20eph9aomb5a/BPLND%20IGCS.mp4?dl=0>

SF016 / #501

## TECHNIQUE OF ROBOTIC ASSISTED RADICAL HYSTERECTOMY WITH BILATERAL PELVIC LYMPH NODE DISSECTION FOR EARLY CERVICAL CANCER

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**Abstract Body:** Introduction: Cervical cancer is the 2<sup>nd</sup> most common cancer in Indian women (as per globocan 2018). For many years, radical hysterectomy is the treatment of choice for early stage cervical cancer. This procedure has been traditionally performed via laparotomy but with the introduction of robotic assisted radical hysterectomy, blood loss during procedure, hospital stay, post-operative complications is relatively reduced. Description: The video illustrates a sequential narrative of operative steps of our robotic assisted radical hysterectomy and bilateral pelvic lymph node dissections in a 46-year-old female with squamous cell carcinoma of cervix. She presented with proliferative growth of 2x2 cm in the cervix, fornices free, bilateral parametrium and rectal mucosa free. The urinary bladder was dissected downward, the retroperitoneal space opened and visualized important structures like ureters and iliac vessels. Uterine arteries cauterized, clipped and cut at the level of its origin, ureters dissected from medial leaf of broad ligament peritoneum down to its entrance into the parametrium tunnel of Wertheim. Pararectal and paravesical space created. The infundibulopelvic ligament cauterized and cut laterally, pelvic wall peritoneum of broad ligament incised downward to base of uterosacral ligament, uterosacral ligament cauterized and cut closed to rectum. Colpotomy done specimen delivered vaginally without spillage. Bilateral pelvic lymph node dissection was done and specimen delivered vaginally. vault closure done with v- lock sutures. Conclusion: Certain studies demonstrate the safety and feasibility of Robotic assisted radical hysterectomy for early-stage cervical cancer. It provides benefits such as less bleeding, reduced in hospital stay and decrease in post-operative complication

SF017 / #513

## **PRESERVATION OF LEFT TRIPLE RENAL ARTERY DURING LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY**

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**Abstract Body:** Objective: To demonstrate of preservation of left triple renal artery during laparoscopic para-aortic lymphadenectomy Design: Case study. Settings: University hospital in Korea. Patients: A 54-year-old Korean woman with postmenopausal bleeding and thickened endometrium > 3cm presented to our department. The histopathology of biopsied endometrium revealed grade 2 endometrioid adenocarcinoma. The preoperative MRI shows an about 6cm sized large volume of tumor within the endometrial cavity. Interventions: We perform the laparoscopic staging surgery. Firstly we performed peritoneal washing cytology, LAVH, BSO, pelvic lymphadenectomy. We designated four area for para-aortic lymphadenectomy. During the procedure in area 4, it was confirmed that two left renal arteries were derived from the trunk of the aorta below the left renal vein. The left lower segmental artery was derived from the middle part of the inferior mesenteric artery and left renal vein. The middle segmental artery was derived just below left renal vein. The left main renal artery was located on the dorsal side of the left renal vein at its normal position. We carefully resected the para-aortic lymph nodes to prevent variant renal artery damage. Conclusions: Laparoscopy is a feasible and safe approach to diagnosis of vascular anomaly during para-aortic lymphadenectomy for gynecologic malignancies. It is very important for the gynecologic oncologist to have knowledge of retroperitoneal vascular anatomy, experience in laparoscopic surgery, and an accurate surgical technique to avoid vascular injury during laparoscopic para-aortic lymphadenectomy.

SF018 / #632

## MAYLARD INCISION: A TRANSVERSE INCISION FOR COMPLEX GYNECOLOGIC SURGERY

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**Abstract Body:** Introduction: Maylard incision is a transverse abdominal incision characterized by the ligation of inferior epigastric vessels and the transection of rectus abdominus muscles. It provides a good surgical exposure.

The aims of this video is to detail Maylard incision technique. Description: A transverse skin incision is made four cm above the symphysis pubis. After dissection of subcutaneous tissus, transversalis fascia is opened. Rectus abdominus muscles are separated from the fascia. Inferior epigastric vessels are located at the external edge of rectus abdominus muscles. They are dissected, ligated and cutted. The rectus abdominus muscles are sectionned using bipolar device. The parietal peritoneum can be opened. After the surgery, the parietal peritoneum is closed using a running suture. Rectus abdominus muscles can be autres but it is not mandatory. Conclusion: Maylard incision provides a good surgical exposure, a cosmetic, reproducible technique with less complications and pain comparing to midline incision. Hands on training are required to perform this technique.

SF019 / #636

## VASCULAR INJURY IN ROBOT-ASSISTED PARA-AORTIC LYMPHADENECTOMY

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**Abstract Body:** First robot-assisted para-aortic lymphadenectomy performed in gynecological oncology in our country for surgical staging of cervical cancer in a patient with radiological evidence of pelvic lymph node involvement. Description of the performance of docking for para-aortic lymphadenectomy by robot-assisted surgery and the presentation of a vascular lesion during dissection of the interaortocaval nodes and its management with vascular clip. Although unplanned conversion-to-open is a rare event occurring in less than 1% of robotic-assisted cases, it is associated with worse outcomes and carries significant morbidity and potentially life-threatening consequences. In the setting of massive hemorrhage, timely and effective emergency undocking followed by emergency laparotomy and obtaining vascular control may be lifesaving. In this case we used a vascular clip to control the bleeding and avoid converting to an open procedure. The presence of vascular lesions during robotic-assisted surgery can occur in up to 3%, depending on the series reviewed. Keep calm and recognize the bleeding site accurately to avoid collateral damage. The surgeon should have knowledge about the different techniques that can be used to control major bleeding. Vascular clips applied properly by trained surgeons provide a safe option for vascular control injury in robotic gynecology surgery. Future research should be aimed at finding the best bleeding control technique in robotic surgery.

SF020 / #652

## USE OF A VAGINALLY ADAPTED GAMMA PROBE IN THE VIDEOLAPAROSCOPIC SENTINEL LYMPH NODE RESEARCH

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**Abstract Body:** Introduction: The use of videolaparoscopy in the management of gynecological cancer has gained ground due to the possibility of offering quality treatment with benefits in relation to pain and postoperative recovery, mainly. Despite making it possible to conduct sentinel lymph node research, there is still a limitation regarding the use of the laparoscopic gamma probe, due to the high cost and low frequency of use in institutions that normally have the conventional gamma probe used in open surgery. The purpose of this video is to show the possibility of using the conventional gamma-probe vaginally in laparoscopic surgeries. Description: The video shows the challenge that the surgeon often faces when searching for sentinel lymph nodes using patent blue, when the lymphatic pathways and the sentinel are not stained on either or both sides. In this situation, the use of the Technetium-99m injection in the cervix and lymph node research using a gamma-probe protected by a sterile glove introduced vaginally may be an alternative, contributing to the sentinel meeting. Conclusion: The use of the adapted gamma-probe used vaginally can contribute to the investigation of the sentinel lymph node by a minimally invasive route when a laparoscopic probe is not available, especially in cases of early endometrial cancer, in which only the sentinel lymph node biopsy is sufficient for staging, and can be useful to find lymph nodes and avoid systematic lymphadenectomy and its consequences.

**MINIMALLY INVASIVE SECONDARY CYTOREDUCTIVE SURGERY FOR HEPATO-RENAL RECESS ISOLATED RECURRENCE OF SEROUS ENDOMETRIAL CANCER IN BRCA1 MUTATED PATIENT**

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**Abstract Body:** Introduction: This film shows the surgical management of a young BRCA1 mutated women affected by a recurrence of serous endometrial carcinoma (SEC). This aggressive subtype of endometrial cancer recurs in 30-80% of cases and shares most of its molecular features with serous ovarian cancer. The role of BRCA mutations in this setting is still not completely understood. The aim of this film was to show how a minimal invasive surgical approach is safe and feasible in selected patients. Description: In the video we present the case of a hepato-renal recess isolated recurrence of serous endometrial carcinoma. Patient positioning and port placement were critical to achieve an optimal exposure of the liver 6th segment and the Morison's pouch. An extensive removal of visceral adhesions was performed and the metastasis was then exposed. The tumor infiltrated the liver parenchyma for less than 2 cm. A superficial wedge resection was executed until complete removal of the lesion. The procedure has been performed in 90 minutes. Post-operative course was unremarkable and the patient was discharged on post-operative day 3. The patient was able to resume her oral PARP inhibitor after 10 days. Histopathology report confirmed the metastatic localization of a high-grade serous cancer.

Conclusions: Potential benefits of minimally invasive approach include reduced blood loss, less pain, faster recovery and a short interval to chemotherapy. The personalised treatment of recurrent endometrial serous cancer should be guided by the molecular pattern of the disease and by the surgical skills with a multidisciplinary approach. video:

<https://www.dropbox.com/s/glhzyjy7na5l0ls/MINIMALLY%20INVASIVE%20SECONDARY%20CYTOREDUCTIVE%20SURGERY%20FOR%20HEPATORENAL%20RECESS%20ISOLATED%20RECURRENCE%20OF%20SEROUS%20ENDOMETRIAL%20CANCER%20IN%20BRCA1%20MUTATED%20PATIENT.mp4?dl=0>

SF022 / #580

## IDENTIFICATION OF INGUINAL SENTINEL LYMPH NODES IN RECURRENT VULVAR MELANOMA

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**Abstract Body:** Introduction: Vulvar melanoma has a high propensity for lymphatic spread to inguinal lymph nodes. Groin sentinel lymph node biopsy is considered a part of the management of primary vulvar melanoma. Yet, the role of performing sentinel lymph node biopsy in the management of patients with negative nodes in primary surgery, who develop recurrent vulvar melanoma, is less clear than in the case of primary tumors. Nevertheless, lymph nodes status in recurrent disease can provide valuable information to guide further therapy. Sentinel mapping in a previously scarred area is challenging and the most suitable mapping technique has not been determined. In this video, we demonstrate the technical feasibility of repeat sentinel lymph nodes biopsy for recurrent vulvar melanoma using intraoperative fluorescent indocyanine green (ICG) detection. Description: The video demonstrates ICG mapping technique in recurrent vulvar melanoma. The injection site and ICG positive nodes are shown. Implication: Sentinel mapping in recurrent vulvar melanoma with ICG tracer technique is feasible, even in previously dissected groins.

SF023 / #590

## VULVECTOMY- AN OPERATIVE PROCEDURE FOR CA VULVA

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**Abstract Body:** INTRODUCTION Increasing knowledge and understanding of the disease has allowed surgical procedures for the treatment of carcinoma of the vulva to become more conservative and individualized to each patient. The exact procedure used depends upon the site, size, and histologic features of the tumor. DESCRIPTION- Preoperative preparation — All women require explanation and counseling about the procedure. General anesthesia is administered. The patient is positioned in lithotomy. The skin is prepared and draped. The patient is examined and the skin to be incised is marked with a pen. A urethral catheter is inserted into the bladder Skin incision is begun with scalpel and the dissection is taken through the subcutaneous fat to the deep fascia and pubic ramus until the intended vaginal resection margin is reached with scalpel, scissors and diathermy. The dissection is carried down toward the clitoral attachments by sweeping the specimen off the periosteum of the pubic bones conserving the deep fascia until the clitoral attachments are reached. The suspensory ligament of the clitoris is clamped, divided, and ligated. The urethro-vaginal incision is now made circumferentially, ensuring that the required margin around the tumor is maintained. The tip of a scalpel Kelly forceps is passed through the specimen in the midline to isolate the crura divide and then suture ligated with absorbable sutures The specimen is detached completely, and hemostasis is secured. The wound closed primarily. CONCLUSION- Adequate surgical resection with microscopic tumor-free margin should be the key concern. Oncological resection should be equated with functional outcome.