Settings University hospital in Korea.
Patients A 52-year-old Korean woman underwent laparoscopic secondary cytoreduction for recurrent ovarian cancer and previous laparoscopic primary debulking surgery
Interventions: Laparoscopy Measurements/Results A 52-year-old Korean woman had a laparoscopic primary optimal debulking surgery on September 22, 2015. The FIGO stage IIIC was confirmed and she received 12 cycles of paclitaxel/carboplatin chemotherapy. Since then, it had been checked as NED state for 6 months. During follow up, lab results showed elevation of CA125, and recurrence was confirmed by PET-CT imaging. We performed LAVH with BSO, CDS mass excision, pelvic and para-lymphadenectomy during primary debulking surgery. In addition, diaphragm and omentectomy were performed. She received adjuvant chemotherapy with paclitaxel/carboplatin for 12 cycles. We performed the laparoscopic secondary cytoreductive surgery on November 28, 2017. Peritoneal cavity and diaphragm were clear and showed no metastatic nodule. Metastatic lymph nodes were confirmed along the left iliac vessels like seen in the previous PET-CT imaging and we resected them. What was seen as recurrence around right para-colic gutter area were metastatic nodule on the cecum surface. We removed the nodules and repaired the bowel serosa. She is receiving chemotherapy with stable disease at this time.
Conclusions Our experience indicate that laparoscopy is a feasible and safe approach to optimal cytoreduction for patients with recurrent ovarian cancer in case of laparoscopic primary debulking surgery.

IGCS20_1510

474 RESECTION OF PERIANAL CIS WITH V-Y GRAFT RECONSTRUCTION

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V-Y flap for reconstruction after perianal resection of CIS

Perianal CIS should be resected if the lesion is large, invasion cannot be ruled out or if it extends into the anal canal. Split thickness skin grafts do not take well around the anus and strictures may occur.

The V-Y advancement flap is ideal as it can be advanced 2–3 cm with an excellent blood supply.

This video will show the technique of resection of a large perianal CIS extending into the anal canal, preservation of the anal sphincter and reconstruction with V-Y flap.

IGCS20_1075

475 ROBOTIC ASSITED INGUINPFEMORAL LYMPHADENECTOMY FOR VULVAL CARCINOMA

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Introduction Vulval carcinoma accounts for 3–5% of all gynaecological cancers. The primary treatment of vulval carcinoma is local excision ±inguinofemoral lymphadenectomy. Inguinal node sates is an important prognostic indicator, this makes lymph node assessment important for all cases of vulval carcinoma except the superficially invasive carcinomas. Here we demonstrate our technique of robotic assisted inguinofemoral lymphadenectomy for vulval carcinoma.
Description The biggest problem with inguinofemoral lymphadenectomy is short term and long term morbidity associated with the procedure, especially wound complications. Various techniques have been tried to reduce morbidity like separate incisions, sentinel node mapping, saphenous sparing and video endoscopic approach. From December 2014 to March 2020,15 patients of vulval carcinoma underwent 21(9 unilateral and 6 bilateral) Robotic Assisted Inguinofemoral lymphadenectomy at our institute. Mean age of patients was 59 yrs (32–73). Mean operative time was 69 min and mean blood loss was 40 ml. Mean number of node harvested were13(8–23). There was no conversion. No intraoperative complication was observed. Postoperative superficial wound infection was seen in 2/21 procedures and prolonged seroma aspiration was required in 4/21 procedures. Final histopathology showed metastasis in 4/21 cases.In this video we describe the patient positioning, port placement and technique of the procedure.
Conclusions Robotic assisted inguinofemoral lymphadenectomy is safe and feasible with less wound related morbidity than conventional procedure. Need multi institutional study to evaluate long term complications, safety and survival data.

IGCS20_1121

476 STANDARD LAPAROSCOPIC BILATERAL PELVIC SENTINEL LYMPH NODE DETECTION WITH RADIOTRACER, BLUE DYE AND PERMANENT INSTRUMENTS

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Introduction Pelvic sentinel lymph node (SLN) in initial stage endometrial cancer may result in higher rates of bilateral detection after a combination of radiotracer and blue dye. In this video we demonstrate a standardized and reproducible laparoscopic standard SLN technique, with permanent instruments, completely performed by surgeons in training.
Methods A 69 years old patient presented a uterine Stage IA G2 endometrioid adenocarcinoma. Less than 50% myometrial invasion was observed at preoperative MRI. At board review, a minimally invasive class A hysterectomy with bilateral salpingoophorectomy and SLN was indicated. Technetium-99 was injected into the cervix the day before surgery, and scintigraphy confirmed bilateral pelvic nodes (external iliac on the right side and interiliac on the left side). At the operating room, patent blue (2cc in 2cc of saline), was injected at 3 and 9 o'clock in the cervix, just after throcar insertion.
Results This video demonstrates a standard step-by-step laparoscopic SLN using double detection technique and permanent instruments. Pelvic lateral spaces dissection was

important to identify all marked nodes. There were 2 blue nodes in each pelvic side: obturator/interiliac and external iliac. All 4 were positive in ex-vivo gamma-probe assessment. After the procedure, there were no other sites of gamma-probe detection.
Conclusion SLN detection with combined blue dye and radiotracer may result in an adequate bilateral pelvic detection in early stage endometrial cancer. This standard technique may require only permanent laparoscopic instruments, representing less costs and high reproductibility.

IGCS20_1287

477 ROBOTIC ILEAL NEOVAGINA

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Introduction Patients submitted to pelvic exenteration with wet colostomy have limited options for vaginal reconstruction. The objective of this video is to demonstrate that vaginal reconstruction (neovagina) using the ileal segment as an alternative for these patients.
Methods We present an educational video demonstrating step-by-step the technique for robotic ileal neovagina.
Results A 28 years old patient was submitted to a pelvic exenteration and reconstruction with terminal wet colostomy due to a late central recurrence after chemorradiation for Stage IIIB cervical cancer. After 3 years of follow-up, there was no evidence of recurrence, and an ileal neovaginal reconstruction was performed. This video demonstrates a surgical technique, using approximately 25–30 cm of the distal ileum segment. This isolated segment formed the neovagina and was anastomosed to the remaining vaginal dome. The patient had good postoperative recovery and in a couple months recovered sexual function.
Conclusions Robotic ileal neovagina is an option for patients who had pelvic exenteration with wet colostomy.

IGCS20_1335

478 ROBOTIC ASSISTED LAPAROSCOPIC RESECTION OF RECTOVAGINAL CLEAR CELL CARCINOMA MASS ARISING FROM ENDOMETRIOSIS

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Introduction Increasing evidence indicates there is malignant transformation of ovarian and non ovarian endometriosis into mainly endometrioid, and clear cell histologies. Patients that have suspicious symptoms, physical exam findings, or abnormal imaging studies should be evaluated to rule out malignancy. We briefly review the patients history and surgical case as the disease can be elusive.
Methods This is a surgical case report involving a single patient. The provider is a Gynecologic Oncologist and minimally invasive surgeon that has extensive experience in the treatment of endometriosis. The surgical technique for endometriosis resection and ovarian cancer debulking is reviewed in this video.
Results Pathology specimens of the vaginal cuff/vagina, iliocecum, and appendix were positive for clear cell carcinoma. Negative margins were achieved at the vagina.

Patient was treated with adjuvant chemotherapy with whole pelvic and vaginal brachytherapy.
Conclusion Management of patients with cancer arising from endometriosis can be challenging. Patients with endometriosis should be evaluated for malignancy with suspicious imaging findings. Optimal surgical resection followed by adjuvant chemotherapy or/and radiation is the current recommendation. Robotic Assisted Laparoscopy is feasible and may be preferable for debulking/resection of complex masses in the rectovaginal space in obese patients.

IGCS20_1343

479 UTERINE TRANSPOSITION IN A CASE OF RECTAL MALIGNANCY

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Uterine transposition is a surgical technique first described by Dr. Reitan Riberio. This is fertility preserving surgery for patients with rectal/anal cancer requiring pelvic radiation. The uterus is transported out of the field of radiation and repositioned when radiotherapy is completed.
Case Report A 36 year old woman presented with new onset peri-anal pressure symptoms on a background of no significant medical history. Examination revealed a hard irregular circumferential rectal tumor from dentate line, 5 cm in length. Histology reported a moderately differentiated adenocarcinoma. TNM stage T3cN2bM0. This case was discussed at the colorectal multidisciplinary team meeting. A plan was made for fertility-preserving uterine transposition and formation of loop colostomy. The patient would then commence pelvic radiation with concomitant chemotherapy. Following this the patient would undergo interval abdomino-perineal resection (APR) with re-implantation of uterus plus adjuvant chemotherapy.
Procedure A video attached shows the procedure of uterine transposition and the subsequent respositioning. This was done laparoscopically, with ligation of the round ligaments and mobilisation of the gonadal vessels to the level of the kidney bilaterally. Uterine arteries were ligated and colpotomy performed. The uterus was then transported to the upper abdomen and fixed to the abdominal wall. A cervical stoma was then formed.

The second video demonstrates the repositioning of the uterus to the pelvis following the completion of radiotherapy. The round ligaments are reattached bilaterally. Intravenous Verdye was administered and preservation of the blood supply to the uterus was demonstrated through an infrared camera lens.
Conclusion Uterine transposition represents a novel approach to fertility preserving surgery.