

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 radio-tracer 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

R Ribeiro, A Munhóz*, HK Rabelo, A Vargas, A Tsunoda, J Linhares. *Hospital Erasto Gaertner, Brazil*

10.1136/ijgc-2020-IGCS.416

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 chemoradiation 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

¹M White, ²F Nezhath*. ¹NYU Winthrop Hospital, USA; ²Weill Cornell Medical College, USA

10.1136/ijgc-2020-IGCS.417

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

M OBrien*, F Donohoe, B Boyd, R McVey, T Walsh, A Brannigan, D Brennan. *UCD School of Medicine, Ireland*

10.1136/ijgc-2020-IGCS.418

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 repositioning. 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 Verdyne 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.