2022-VA-1035-ESGO THE CASE OF LAPAROSCOPIC ANTERIOR RECTAL RESECTION AND RETRANSPLANTAION OF THEURETER WITH THE USE OF ICG

[1]Ewa Milnerowicz-Nabzdyk, [2]Marek Fiutowski, [1]Krzysztof Nowak, [1]Zofia Borowiec. *[1]Department of Oncological Gynecology, Dept Director Ewa Milnerowicz-Nabzdyk MD PhD Associate Prof., Centre of Oncology, Opole, Poland; [2]Department of Urology and Oncological Urology, Dept Director Paweł Kowal Md PhD, Provicial Hospital, Wrocław, Poland*

10.1136/ijgc-2022-ESGO.426

Introduction/Background Presenting the method of laparoscopic anterior rectal resection andretransplantation of the ureter in the case of deep infiltrating endometriosis(DIE)

Methodology 28 – year old lady with the history of dyschezia 9/10, dysmenorhoea 9/10,dyspareunia 6/10, dysuria 7/10, infertility, left huge hydronephrosis whichwere explained by urologist as a consequence of anatomical variation of thevassel.She had the trial of cystoscopical ureteric JJ stent insertion prior to plannedsurgery with no success. 2 weeks later she had done laparoscopic

Results She had done segmental resection of the anterior rectum with the end to endrecto- sigmoid colon anastomosis due to 6 cm nodule of the rectum, theintraabdominal insertion of the JJ stent to the left ureter after cutting the wall ofureter 10 cm from the bladder due to impossible JJ cystoscopical stenting withsimultaneous retransplantation of the left ureter. All procedure was done incontrol of vascularity by ICG both the bowel and the ureter. Both anastomosis ofthe colon and the uretero-bladder were protected by fibrine glue. The bladderwas isolated from rectum with the flap of omentum. 5 weeks after surgicalprocedure the JJ stent was removed from the ureter. Proper function of thebowel and the ureter were proved in control visit – 6 weeks after surgery.In histopathology: endometriotic nodule of the bowel and ureter werediagnosed.The result of the surgery was complete realising from the pain and tailoredsurgery on colon and ileum due to low grade neoplasma of appendix.

Conclusion Laparoscopy is a perfect method for tailored and radical surgery inDIE and multiorgans surgery with all advantages of the minimally invasiveaccess. Complete realising of the pain was huge success of the surgery.

2022-VA-1036-ESGO PROTECTED LAPAROSCOPIC LARGE OVARIAN CYST ASPIRATION – A FIVE STEPS ALTERNATIVE TO LAPAROTOMY

Houssein El Hajj, Carlos Martinez Gomez, Adrien Boscher, Mathilde Duchatelet, Delphine Hudry, Eric Leblanc, Fabrice Narducci. *Gynecologic Oncology, Oscar Lambret Cancer Center, Lille, France*

10.1136/ijgc-2022-ESGO.427

Introduction/Background In this video, we describe a five-step surgical technique allowing to safely incise and aspirate the content of large ovarian cysts through a single port laparoscopic incision. This allows performing laparoscopic oophorectomies instead of large xypho-pubic laparotomies.

Methodology A Stepwise demonstration of the technique

Results Ovarian masses, especially cysts, are common gynecological conditions. However, depending on their size, large adnexal cysts are usually managed with transverse or midline laparotomies. This is to prevent cyst ruptures and abdominal contamination and ensure the oncological safety of the procedure. Different leak-proof aspiration techniques were described in the literature allowing for safe large cyst aspiration and adnexectomy through a mini-laparotomy incision or via laparoscopy (2,3,6–10). We describe a five steps surgical technique allowing for closed aspiration of ovarian intracystic fluid and adnexectomy while respecting oncological safety.

Interventions Step 1: Perform diagnostic laparoscopy to rule out peritoneal carcinomatosis contraindicating this procedure then after cyst exposition, thoroughly dry the cyst wall.

Step 1 Bis: Cut the cuff of a sterile glove to prepare a 46 square piece of membrane

Step 2: Place a protective gauze, then apply the surgical glue to the ovarian cyst wall followed by the glove/membrane application. Perform a purse suture through the glove/membrane and the ovarian wall superficially to ensure further adhesion and prevent ovarian fluid spillage.

Step 3: Incise the ovarian wall then introduce the aspiration cannula and tighten the pursen suture to aspirate the cystic fluid.

Step 4: After aspiration is complete, tighten the suture and close the glove to guarantee a closed space and prevent abdominal contamination.

Step 5: Perform laparoscopic oophorectomy or cystectomy. Safely remove the specimen in an endoscopic retrieval bag through the trocar incision.

Conclusion This technique allows safe laparoscopic large ovarian cysts resections while respecting oncologic safety and preventing intraabdominal spillage and contamination.

2022-VA-1050-ESGO LAPAROSCOPY IS A PERFECT METHOD FOR TAILORED AND RADICAL SURGERY IN DIE AND MULTIORGANS SURGERY WITH ALL ADVANTAGES OF THE MINIMALLY INVASIVEACCESS. COMPLETE REALISING OF THE PAIN WAS HUGE SUCCESS OF THE SURGERY

[1]Ewa Milnerowicz-Nabzdyk, [1]Maja Mrugała, [1]Krzysztof Nowak, [2]Tomasz Sachańbiński. *[1]Department of Oncological Gynecology, Dept Director Ewa Milnerowicz-Nabzdyk MD PhD Associate Prof., Centre of Oncology, Opole, Poland; [2]Department of Surgical Oncology, Dept Director Tomasz Sachańbiński MD PhD, Centre of Oncology, Opole, Poland*

10.1136/ijgc-2022-ESGO.428

Introduction/Background Presenting the method of laparoscopic anterior rectal resection, partial sigmoidcolon resection, right hemicolectomy and extended hysterectomy in the patientwith deep infiltrating endometriosis (DIE) diagnosed with coexisting of lowgrade appendiceal mucinous neoplasm. (LAMN).

Methodology 37 – year old lady with the history of multiple laparoscopic and laparotomicintervention due to endometriosis and infertility qualified to laparoscopicintervention.

Results She had done laparoscopic segmental resection of the sigmoid colon and anteriorrectum resection with end to end anastomosis, total extended hysterectomy,right hemicolectomy with side to side anastomosis, cystoscopy with protective JJstenting of both ureters due to massive adhesiolysis of the ureters.In histopathology: multifocal endometriotic infiltration of the bowel with the bigendometrotic nodules on rectum, sigmoid colon and cecum, low gradeappendiceal mucinous

neoplasma in appendix and adenomyosis of the ureters.The result of the surgery was complete realising from the pain and tailoredsurgery on colon and ileum due to low grade neoplasma of appendix.

Conclusion Laparoscopy is a perfect method for both tailored and radical surgery in DIE andearly stages of cancer as LAMN.

2022-VA-1059-ESGO OMENTAL FLAP AS A SPACER TO REDUCE ACUTE BOWEL TOXICITY AFTER ADJUVANT RADIOTHERAPY

[1]Elaine Leung, [2]Yash Choudhary, [2]Sofia Parveen, [2]Anthony Packwood, [3]Zahra Pervaiz, [3]Audrey Kwong, [2]Indrajit Fernando, [3]Kavita Singh. *[1]Institute of Cancer and Genomics Sciences, University of Birmingham, Birmingham, UK; [2]University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK; [3]Sandwell and West Birmingham NHS Trust, Birmingham, UK*

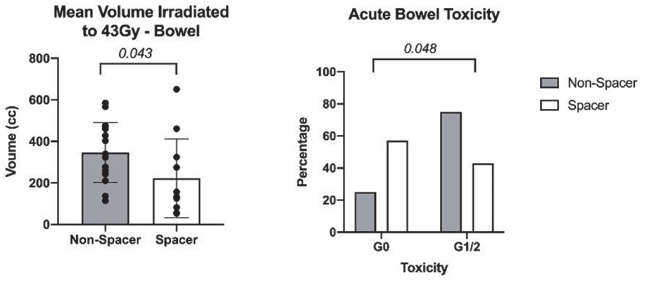
10.1136/ijgc-2022-ESGO.429

Introduction/Background Adjuvant pelvic radiotherapy is recommended for selected high-risk patients with cervical and endometrial cancer after surgery. However, the segment of bowel that replaces the empty space in the pelvis may receive an unintentionally high dose of radiation, which increases bowel toxicity. This video and the accompanying data described the use of an omental flap as a spacer to reduce post-radiation bowel toxicity after adjuvant radiotherapy for gynaecological cancers.

Methodology

The Technique The omentum was mobilised and separated from the hepatic flexure of the transverse colon. The flap was then brought into the pelvis along the left paracolic gutter and placed between the rectum and bladder. There is also the option to mobilise the omentum from the greater curvature of the stomach. Finally, the omental flap was secured with interrupted 2.0 Vicryl sutures to the bladder and lateral pelvic peritoneum.

Outcome data Patients who received adjuvant radiotherapy who had data on radiation dosage administered, radiation dosage received on bowel and acute toxicity were included.



Abstract 2022-VA-1059-ESGO Figure 1

Results The results of 38 patients who have received adjuvant radiotherapy between 2011–2021 were evaluated (14 had spacers; 24 did not have spacers). There was no significant difference in age, cancer sites, length of follow-up, radiation dosage received (45Gy for both groups) between the two groups. Patients who had spacers had significantly lower volume of bowel receiving high dose (43Gy) of radiation (133 cc versus 331.5 cc; p=0.043) and less acute toxicity (42.9% versus 75% G1/2 acute toxicity; p=0.048), compared to the non-spacer group.

Conclusion The use of omental spacers could reduce post-radiation acute bowel toxicity; its use should be routinely considered in patients undergoing gynaecological cancer surgery who are likely to require adjuvant radiotherapy.

2022-RA-1062-ESGO UTERINE GRANULOCYTIC SARCOMA AS AN EXTRA-MEDULLARY RELAPSE OF ACUTE MYELOID LEUKAEMIA IN AN ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION RECIPIENT

[1]Deborah Bandeira, [2]Mariana Rietmann da Cunha Madeira, [2]Marianne Borges Landau, [3]Andréa Rodrigues Cordovil Pires. *[1]Gynecology, Hospital Naval Marcílio Dias, Rio de Janeiro, Brazil; [2]Hematology, Hospital Naval Marcílio Dias, Rio de Janeiro, Brazil; [3]Fonte Medicina Diagnóstica LTDA., Niterói, Brazil*

10.1136/ijgc-2022-ESGO.430

Introduction/Background Myeloid Sarcoma (MS) is an uncommon condition characterised by proliferation of immature myeloid cells in extra-medullary sites. The most common are lymph nodes, central nervous system, bones, and soft tissues. MS of the gynaecological tract is rare, especially in the uterine cervix. Patients with acute myeloid leukaemia (AML) are prone to have MS at any moment of the disease, especially after bone marrow transplantation (BMT).

Methodology Molecular biology, immunohistochemical and immunophenotypic analysis of an unusual case of MS in the cervix without evidence of bone marrow recurrence, two years after an allogeneic BMT.

Results A nulliparous 32-year-old patient, attending the haematological service due to AML since 2018 at a quaternary Brazilian Naval Hospital, complained of neuropathic and acute abdominal pain. Clinical examination revealed several soft tissue tumorations resembling MS and an abdomen/pelvic magnetic resonance imaging (MRI) peculiarly demonstrated a large uterine mass with compression of the right ureter and pyelocalyceal dilation. Gynaecological clinical exam exhibited a large violaceus mass about 4 cm with anterior and right vaginal wall infiltration. The hypothesis was primary cervical cancer stage IV. The biopsy revealed a massive infiltration of immature myeloid cells with the expression of anti-ERG and myeloperoxidase antibodies. The immunophenotypic analysis of the bone marrow aspirates showed the patient still had a complete remission with minimum residual disease (MRD) negative and a variable number of tandem repeats (VNTR) with full donor chimerism. The patient started chemotherapy with a hypomethylating agent and BCL-2 inhibitor Venetoclax.

Conclusion Decision making on the treatment of cervical MS is challenging due to the absence of gynaecological classification guidelines. In patients in this age group with no offspring, the choice of therapy should consider the fertility issue. Finally, MS should be a differential diagnosis in a patient with a uterine mass and a previous medical history of AML.