may be limited by increasing the number of SLNs sampled, not all detected nodes should be taken but only the first draining node in the channel pathway has to be removed and labeled as SLN. This strategy permits to perform a real SLN-mapping and avoids considering as SLNs non-SLNs which correspond in fact to distal migration of tracer beyond the true SLN. However, in case of truly separate channels which may correspond to distinct pathway, more SLNs should be sample.

**Conclusions**

NIR fluorescence ICG demonstrated its ability for real-time intraoperative visualisation and detection of SLN in early-stage cervical cancer.

**IGCS19-0428**

**107 PRIMARY VAGINAL SARCOMA: CASE REPORT AND REVIEW OF THE LITERATURE**

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**Objective**

To demonstrate a subxiphoid approach to the resection of enlarged cardiophrenic lymph nodes (CPLNs) in primary cytoreductive surgery for advanced ovarian cancer (OC).

**Methods**

We assembled video footage from a primary debulking surgery performed for a patient with OC and cardiophrenic lymphadenopathy. The lymph nodes were resected in addition to the abdominopelvic tumor debulking, leaving the patient with no gross residual disease.

**Results**

Key components of the subxiphoid approach for cardiophrenic lymphadenectomy are shown. These include entering the thoracic cavity by incising under the xiphoid process, resecting enlarged lymph nodes, and closing the defect. The vertical midline abdominal incision is extended to expose the xiphoid process. The CPLNs are identified. The pleural cavity may be entered to improve exposure. The surgeon can palpate the enlarged lymph nodes and remove them through the subxiphoid opening. After adequate hemostasis is achieved and a chest tube placed, the defect is closed.

**Conclusions**

Using still photographs and video, we demonstrate the technique for accessing the mediastinum through a subxiphoid approach, obviating the necessity of entering through the diaphragm.

**IGCS19-0421**

**109 LAPAROSCOPIC TREATMENT OF REFRACTORY CHYLOS ASCITES AFTER ENDOMETRIAL CANCER SURGICAL STAGING**

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**Objective**

Chylous ascites is a rare condition following gynecologic surgery, with an eminent clinical management. Refractory cases with persistent symptoms may occur.

**Objective**

The main objective of this video is to demonstrate an alternative treatment for chylous ascites after lymphadenectomy in patients who did not respond adequately to a conservative clinical approach.

**Methods**

In this case-report, a 52-year-old patient with a uterine Stage II G2 endometrioid adenocarcinoma underwent complete laparoscopic surgical staging. The initial procedure included a type B total hysterectomy with bilateral salpingoo-forectomy, with pelvic and para-aortic lymphadenectomy. Final report included 30 para-aortic and 22 pelvic lymph nodes, all free of disease.

Patient evolved with increased abdominal volume and discomfort on the 15th postoperative day, diagnostic/therapeutic paracentesis was performed, with a diagnosis of chylous ascites.

A conservative clinical management failed to control the symptoms. An alternative surgical treatment was offered with laparoscopic exploration.

**Results**

This video demonstrates the surgical findings and the surgical technique. The patient received a high fat solution 6 hours before surgery. After draining all chylous ascites, the

**IGCS19-0404**

**108 A SUBXIPHOID APPROACH TO THE RESECTION OF ENLARGED CARDIOPHRENIC LYMPH NODES IN PRIMARY TREATMENT OF ADVANCED OVARIAN CANCER**

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**Objective**

To demonstrate a subxiphoid approach to the resection of enlarged cardiophrenic lymph nodes (CPLNs) in primary cytoreductive surgery for advanced ovarian cancer (OC).

**Methods**

We assembled video footage from a primary debulking surgery performed for a patient with OC and cardiophrenic lymphadenopathy. The lymph nodes were resected in addition to the abdominopelvic tumor debulking, leaving the patient with no gross residual disease.

**Results**

Key components of the subxiphoid approach for cardiophrenic lymphadenectomy are shown. These include entering the thoracic cavity by incising under the xiphoid process, resecting enlarged lymph nodes, and closing the defect. The vertical midline abdominal incision is extended to expose the xiphoid process. The CPLNs are identified. The pleural cavity may be entered to improve exposure. The surgeon can palpate the enlarged lymph nodes and remove them through the subxiphoid opening. After adequate hemostasis is achieved and a chest tube placed, the defect is closed.

**Conclusions**

Using still photographs and video, we demonstrate the technique for accessing the mediastinum through a subxiphoid approach, obviating the necessity of entering through the diaphragm.