



Upper abdominal debulking surgery for ovarian cancer total colectomy, total peritonectomy, and extended upper abdominal debulking surgery

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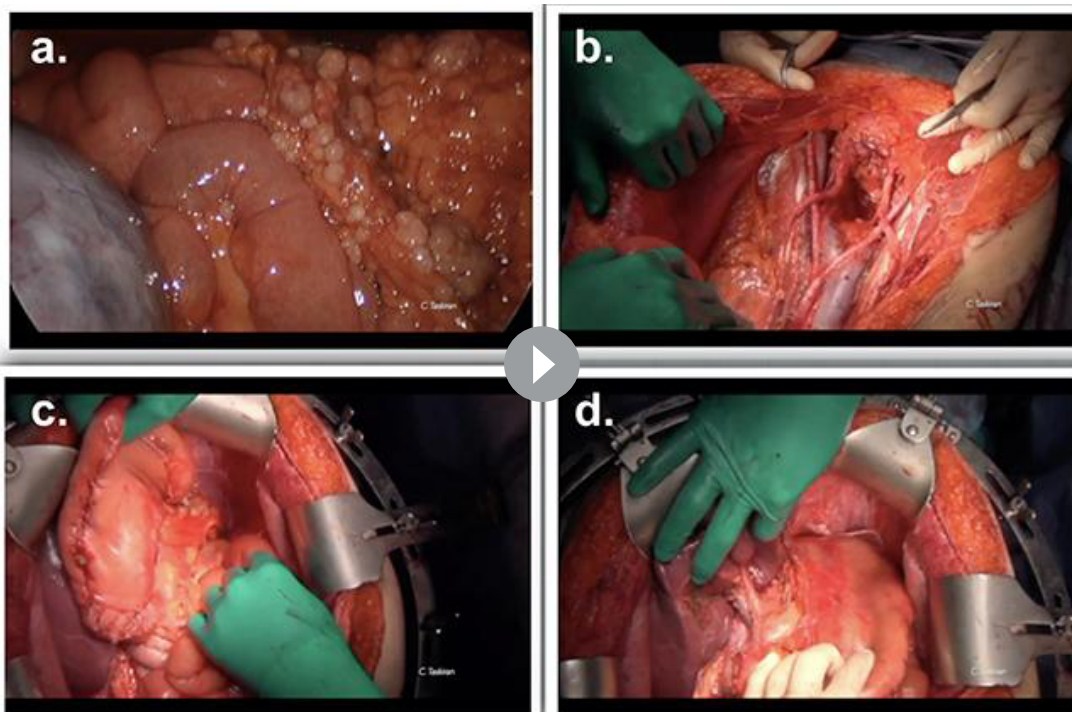
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Ovarian cancer is the leading cause of death among gynecological malignancies. Primary maximal cytoreduction is associated with significantly improved survival.^{1,2} The aim of this video is to present a primary extended maximal cytoreductive surgery.

A 37-year-old woman was admitted with abdominal swelling and pelvic pain. Pelvic examination and ultrasonography revealed ascites and bilateral adnexal masses. Magnetic resonance imaging showed an 11 cm right adnexal mass, 7 cm left adnexal mass, omental thickening, disseminated peritoneal implants, liver metastases, and enlarged lymph nodes in the right obturator fossa. The Fagotti score of the patient was 10. Total abdominal hysterectomy, bilateral salpingo-oophorectomy, total omentectomy, total peritonectomy, bilateral diaphragmatic

stripping, total colectomy and end ileostomy, splenectomy, bilateral pelvic–para-aortic lymphadenectomy, cholecystectomy, dissection of the porta hepatis, liver metastasectomy, and transabdominal cardiophrenic lymph node dissection were performed as part of maximal primary cytoreduction. Transient end ileostomy was performed with a decision for late anastomosis. Detailed informed consent was taken prior to the procedure, explaining all the possible surgical procedures needed for tumor-free resection including total colectomy and transient stoma formation.

We do not perform standard systematic lymphadenectomy for surgical treatment of ovarian cancer since the Lymphadenectomy in Ovarian Neoplasms trial at our center. However, in the current patient, radiologically positive lymph nodes reaching up



Video 1.



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to 2.5cm were found at both pelvic and para-aortic lymphatics. During the operation, macroscopically positive large lymph nodes scattered through the bilateral pelvic and para-aortic regions were identified and, consequently, systematic lymphadenectomy was performed as part of the primary debulking surgery.(Video 1)

We did not encounter any grade 3 or 4 adverse events in either the early or late post-operative period. The patient had an unremarkable post-operative recovery. She stayed in the intensive care unit for 2 days and was discharged from the hospital on post-operative day 15. She was enrolled into IMagyn050/GOG 3015/ENGOT-OV39 phase III trial.³ The patient is still free of recurrence after 19 months.

Primary cytoreduction with no residual disease has a major impact on survival of patients with ovarian cancer. The optimal management of ovarian cancer should be directed by expert gynecological oncologists and a multidisciplinary team at centers dedicated to the treatment of ovarian cancer.

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Contributors CT is the primary surgeon and supervisor. He supervised the concept and design of this surgical video as well as the manuscript. DV was primarily responsible for the concept and design of this surgical video and the

manuscript under the supervision of CT. He contributed to the operation as an assistant surgeon. BG was primarily responsible for the filming and editing process of the video. AE was primarily responsible for the filming and editing process of the video and contributed to the operation as an assistant surgeon. ST is the primary surgeon and supervisor. He contributed to the operation as a thoracic surgeon. MA also supervised the concept and design of the video and contributed to the operation as a surgeon. EB contributed to the operation as a general surgeon.

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