closing the vaginal cuff as the first step of the minimally invasive surgery. However, for patients with the Ia1 stage, there is no need for extensive vaginal margin. Moreover, performing laparoscopic hysterectomy without a uterine manipulator is challenging. In this context, vNOTES provides an easy solution.

Description We performed a cervical cerclage invaginating the external cervix orifice followed by conventional vNOTES hysterectomy with bilateral salpingectomy. The patient was positioned in stirrups in Trendelenburg position and standard sterilization was performed. After cervical cerclage, a circular incision was made around the uterine cervix and the following structures were sealed and divided by an advanced bipolar device: uterosacral ligaments, anterior bladder pillars, parametria. Then, a self-constructed vaginal port with alexis® and surgical glove was inserted through the vagina. Pneumoperitoneum was inflated and the sealing/division of uterine arteries, round ligaments, ovarian ligaments, and broad ligaments were completed.

Conclusion vNOTES may provide a safe minimally invasive hysterectomy for Ia1 cervical carcinoma.

IGCS20_1115

468 LATERALLY EXTENDED PARAMETRECTOMY (LEP)

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Introduction Laterally Extended Parametrectomy (LEP) was imagined by Ungar and Palfalvi as a more radical surgical procedure for the treatment of lymph node positive stage Ib and stage IIb cervical cancer.

Methods The aim of the technique is to remove the entire parametrial tissue containing lymphatic structures from the pelvic side wall.

Results LEP superposes to a type D Querleu-Morrow radical hysterectomy, extending the lateral limits of the dissection not only to the medial surface of hypogastric vessels, but to true borders of the pelvic side wall. Its rationale was to avoid the need of aggressive and deleterious postoperative radiotherapy for patients with positive pelvic lymph nodes or parametria in which the final histology suggested a complete removal of the potentially tumor containing lymph-vessel and lymph node containing fibro-fatty tissue. LEP may be also taken into consideration during pelvic exenteration, when the tumor involves the soft structures of the pelvic side wall, for a more extensive pelvic side wall dissection.

During LEP, together with the visceral branches of hypogastric vessels, all the parietal branches are also divided (ilio-lumbar, obturator, gluteal superior and inferior and internal pudendal vessels) at the level where the vessels leave or enter into the pelvis. LEP can be performed on one or both pelvic sides, depending on parametrial invasion or presence positive lymph nodes uni- or bilaterally.

Conclusion LEP provides a good chance for survival without the toxicity of radiotherapy for pelvic lymph node positive stage Ib or IIb cervical cancer patients.

IGCS20_1321

469 LAPAROSCOPIC PRIMARY REPAIR OF DUODENAL PERFORATION AFTER LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY

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Objective To present of laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy for the patient with endometrial carcinoma.

Patients A 78-year-old woman with postmenopausal bleeding and thickened endometrium presented to our department. The histopathology of biopsied endometrium revealed grade 1 endometrioid adenocarcinoma. The MRI shows an about 5 cm sized tumor within the endometrial cavity suspicious myometrial invasion.

Interventions We perform the laparoscopic staging surgery. No intraoperative complications were recognized. However, on postoperative day 1, the color of intra-abdominal drainage change from serosanguinous to dark green. We strongly suspected small bowel perforation and perform secondary laparoscopic surgery immediately. We scrutinized the small bowel and found the perforation site on duodenum. The perforation occurred at the horizontal part of duodenum ventrally vena cava. We carried out laparoscopic primary repair with 3-0 vicryl. Double layer closure was done by interrupted suture in first layer and Lambert suture for second layer. Then, we placed drainage into the duodenal repair site and traced the small bowel meticulously. We reviewed the video of primary surgery. We thought that the thermal injury was occurred by ultrasonic cutting and coagulating device during the lymphadenectomy in pre-caval area just below duodenum or mechanical micro-perforation is made during lifting the duodenum by dissecting forcep. After duodenal repair, endoscopically guided placement of nasogastric tube was performed. Gastrography did not show any leakage at the site of duodenal repair on postoperative day 3.

Conclusions Immediate laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy is safe and feasible.

IGCS20_1469

470 LAPAROSCOPIC RESECTION OF BULKY PARA-AORTIC LYMPH NODE METASTASIS

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Objective To present of laparoscopic resection of bulky para-aortic lymph node metastasis discovered during laparoscopic restaging surgery for unexpected ovarian malignancy

Patients A 45-year-old woman with prior laparoscopic bilateral salpingo-oophorectomy, presented to our department with unexpected ovarian malignancy which was resulted from the high grade serous carcinoma. Preoperative PET CT scan shows enlarged lymph node in aorto-caval area and no abnormal finding in peritoneal cavity and previous operative site.

Interventions We planned to perform laparoscopic restaging surgery to obtain knowledge about the stage. Laparoscopic restaging surgery included peritoneal washing cytology, LAVH, pelvic lymphadenectomy, para-aortic lymphadenectomy, omentectomy, appendectomy, and multiple peritoneal biopsies. We encountered about 6 cm sized Isolated huge para-aortic lymph node metastasis just before the para-aortic lymphadenectomy. Peritoneal incision was made from right common iliac artery to the duodenum. The bulky nodes were encased and severely densely adhered to important aorta and inferior vena cava. We detached peri-nodal tissue from the vessels meticulously not to rupture of metastatic nodal capsule. Resected nodal specimen carried in the endo pouch was extracted though the opened vaginal vault. The final histopathological results showed lymph node metastases of 4 out of 44 para-aortic lymph nodes and the other of resected tissues were tumor-free. The final diagnosis was FIGO stage IIIC of ovarian serous carcinoma. She is receiving chemotherapy at this time and healthy since then.

Conclusions Our experience indicate that laparoscopy is a feasible and safe approach to resection of bulky para-aortic lymph node metastasis during laparoscopic debulking surgery for gynecologic malignancies.

IGCS20_1161

471 EXTRAPERITONEAL LAPAROSCOPIC PELVIC LYMPHADENECTOMY FOR CERVICAL CANCER STAGING IN TWIN PREGNANCY

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Introduction In locally advanced cervical cancer the lymph node surgical staging is used to determine the disease spread before definitive treatment. Regarding pregnancy complicated by this neoplasm, a patient's wish should guide individualized approaches to possibly postpone chemoradiation and reduce fetal complications. The aim of this study is to demonstrate the extraperitoneal technique and to show the anatomy from an unusual angle in order to spread knowledge.

Methods We present a case of a 39-year-old woman with squamous cell carcinoma staged as FIGO IB2 diagnosed at 8 weeks of gestation due to a vaginal bleeding. Her first ultrasonography revealed a monochorionic diamniotic twin gestation. At 16 weeks we performed an extraperitoneal pelvic lymphadenectomy with bilateral access followed by an amplified conization and cervical cerclage.

Results The operative length was 320 minutes, 220 minutes for bilateral lymphadenectomy. Blood loss was minimal and the patient remained stable throughout the procedure. On the first postoperative day, she had moderate pelvic pain requiring opioid use. An obstetric ultrasonography was performed on the second postoperative day before hospital discharge, in which both fetuses had heartbeat, amniotic fluid was normal and the remaining cervix measured transvaginally was 1 cm.

Conclusions Despite being underused by surgeons, the extraperitoneal laparoscopic approach for pelvic lymphadenectomy is feasible. Particularly in twin pregnancies, where the uterus size

may hinder access to pelvic spaces, this route becomes useful not only to avoid abdominal organs or vessels injuries but also to decrease future intestinal adhesions.

IGCS20_1129

472 LAPAROSCOPIC APPROACH FOR CERVICAL OR VAGINAL MALIGNANCIES IN PATIENTS WITH PREVIOUS HISTERECTOMY. A REPORT OF THREE CASES

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Objective To show three different cases of laparoscopic approach in patients with previous hysterectomy.

Settings Three patients with cervical or vaginal cancer with previous hysterectomy, solved by laparoscopy.

Methods The first patient has personal history of ovarian cancer, treated with surgery with subtotal hysterectomy and intra-peritoneal chemotherapy. In oncological follow up she has cervical tumour whose biopsy indicates a relapse of her disease.

The second patient has a personal history of total hysterectomy in 2010 for high-grade squamous intraepithelial (HSIL) cervical lesions. In annual gynaecological control a posterolateral lesion was identified in the vaginal cuff. It's biopsy informed a squamous carcinoma.

The third patient has a history of subtotal hysterectomy for benign disease.

Annual pap smear shows HSIL. Cervical biopsy informed a squamous carcinoma. On physical examination the patient had a 2 cm tumor without evidence of parametrial involvement. IB1 FIGO stage.

In all three cases we begin with an exploratory laparoscopy in order to discard intraperitoneal disease. we used a vaginal acrylic tube as a colpotomizer.

In each case, the radicality was adjusted to the disease the patients.

Conclusion After hysterectomy, cervical or vaginal malignancies could be diagnosed. In order to solve them, we choose the laparoscopic approach. Is important in this kind of surgeries, to have a colpotomizer that facilitates the procedure. In our cases we used a vaginal acrylic tube, resistant to the monopolar energy. The radicality of each surgery depends on the malignancy and the patient.

IGCS20_1491

473 SECONDARY LAPAROSCOPIC CYTOREDUCTION FOR RECURRENT OVARIAN CANCER IN CASE OF LAPAROSCOPIC PRIMARY DEBULKING SURGERY

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Objective To investigate the feasibility of laparoscopic secondary cytoreduction in patients with recurrent ovarian cancer with previous laparoscopic primary debulking surgery

Design Case study.