

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

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EXTRAPERITONEAL LAPAROSCOPIC PELVIC LYMPHADENECTOMY FOR CERVICAL CANCER STAGING IN TWIN PREGNANCY

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10.1136/ijgc-2020-IGCS.410

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

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

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10.1136/ijgc-2020-IGCS.411

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

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

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10.1136/ijgc-2020-IGCS.412

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

Design Case study.