

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.

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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.

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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.

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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.

Settings University hospital in Korea.

Patients A 52-year-old Korean woman underwent laparoscopic secondary cytoreduction for recurrent ovarian cancer and previous laparoscopic primary debulking surgery

Interventions: Laparoscopy Measurements/Results A 52-year-old Korean woman had a laparoscopic primary optimal debulking surgery on September 22, 2015. The FIGO stage IIIC was confirmed and she received 12 cycles of paclitaxel/carboplatin chemotherapy. Since then, it had been checked as NED state for 6 months. During follow up, lab results showed elevation of CA125, and recurrence was confirmed by PET-CT imaging. We performed LAVH with BSO, CDS mass excision, pelvic and para-lymphadenectomy during primary debulking surgery. In addition, diaphragm and omentectomy were performed. She received adjuvant chemotherapy with paclitaxel/carboplatin for 12 cycles. We performed the laparoscopic secondary cytoreductive surgery on November 28, 2017. Peritoneal cavity and diaphragm were clear and showed no metastatic nodule. Metastatic lymph nodes were confirmed along the left iliac vessels like seen in the previous PET-CT imaging and we resected them. What was seen as recurrence around right para-colic gutter area were metastatic nodule on the cecum surface. We removed the nodules and repaired the bowel serosa. She is receiving chemotherapy with stable disease at this time.

Conclusions Our experience indicate that laparoscopy is a feasible and safe approach to optimal cytoreduction for patients with recurrent ovarian cancer in case of laparoscopic primary debulking surgery.

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474 RESECTION OF PERIANAL CIS WITH V-Y GRAFT RECONSTRUCTION

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V-Y flap for reconstruction after perianal resection of CIS

Perianal CIS should be resected if the lesion is large, invasion cannot be ruled out or if it extends into the anal canal. Split thickness skin grafts do not take well around the anus and strictures may occur.

The V-Y advancement flap is ideal as it can be advanced 2–3 cm with an excellent blood supply.

This video will show the technique of resection of a large perianal CIS extending into the anal canal, preservation of the anal sphincter and reconstruction with V-Y flap.

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475 ROBOTIC ASSITED INGUINPFEMORAL LYMPHADENECTOMY FOR VULVAL CARCINOMA

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Introduction Vulval carcinoma accounts for 3–5% of all gynaecological cancers. The primary treatment of vulval carcinoma

is local excision ±inguinofemoral lymphadenectomy. Inguinal node sates is an important prognostic indicator, this makes lymph node assessment important for all cases of vulval carcinoma except the superficially invasive carcinomas. Here we demonstrate our technique of robotic assisted inguinofemoral lymphadenectomy for vulval carcinoma.

Description The biggest problem with inguinofemoral lymphadenectomy is short term and long term morbidity associated with the procedure, especially wound complications. Various techniques have been tried to reduce morbidity like separate incisions, sentinel node mapping, saphenous sparing and video endoscopic approach. From December 2014 to March 2020,15 patients of vulval carcinoma underwent 21(9 unilateral and 6 bilateral) Robotic Assisted Inguinofemoral lymphadenectomy at our institute. Mean age of patients was 59 yrs (32–73). Mean operative time was 69 min and mean blood loss was 40 ml. Mean number of node harvested were13(8–23). There was no conversion. No intraoperative complication was observed. Postoperative superficial wound infection was seen in 2/21 procedures and prolonged seroma aspiration was required in 4/21 procedures. Final histopathology showed metastasis in 4/21 cases.In this video we describe the patient positioning, port placement and technique of the procedure.

Conclusions Robotic assisted inguinofemoral lymphadenectomy is safe and feasible with less wound related morbidity than conventional procedure. Need multi institutional study to evaluate long term complications, safety and survival data.

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476 STANDARD LAPAROSCOPIC BILATERAL PELVIC SENTINEL LYMPH NODE DETECTION WITH RADIOTRACER, BLUE DYE AND PERMANENT INSTRUMENTS

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Introduction Pelvic sentinel lymph node (SLN) in initial stage endometrial cancer may result in higher rates of bilateral detection after a combination of radiotracer and blue dye. In this video we demonstrate a standardized and reproducible laparoscopic standard SLN technique, with permanent instruments, completely performed by surgeons in training.

Methods A 69 years old patient presented a uterine Stage IA G2 endometrioid adenocarcinoma. Less than 50% myometrial invasion was observed at preoperative MRI. At board review, a minimally invasive class A hysterectomy with bilateral salpingoophorectomy and SLN was indicated. Technetium-99 was injected into the cervix the day before surgery, and scintigraphy confirmed bilateral pelvic nodes (external iliac on the right side and interiliac on the left side). At the operating room, patent blue (2cc in 2cc of saline), was injected at 3 and 9 o'clock in the cervix, just after trocar insertion.

Results This video demonstrates a standard step-by-step laparoscopic SLN using double detection technique and permanent instruments. Pelvic lateral spaces dissection was