

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.

IGCS20_1121

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