RESECTION OF PERIANAL CIS WITH V-Y GRAFT RECONSTRUCTION

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V-Y flap for reconstruction after perianal resection of CIS
Perianal skin 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.

ROBOTIC ASSISTED INGUINOFEMORAL 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 status 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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**ROBOTIC ILEAL NEOVAGINA**

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**Introduction** Patients submitted to pelvic exenteration with wet colostomy have limited options for vaginal reconstruction. The objective of this video is to demonstrate that vaginal reconstruction (neovagina) using the ileal segment as an alternative for these patients.

**Methods** We present an educational video demonstrating step-by-step the technique for robotic ileal neovagina.

**Results** A 28 years old patient was submitted to a pelvic exenteration and reconstruction with terminal wet colostomy due to a late central recurrence after chemoradiation for Stage IIIIB cervical cancer. After 3 years of follow-up, there was no evidence of recurrence, and an ileal neovaginal reconstruction was performed. This video demonstrates a surgical technique, using approximately 25–30 cm of the distal ileum segment. This isolated segment formed the neovagina and was anastomosed to the remaining vaginal dome. The patient had good postoperative recovery and in a couple months recovered sexual function.

**Conclusions** Robotic ileal neovagina is an option for patients who had pelvic exenteration with wet colostomy.

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**ROBOTIC ASSISTED LAPAROSCOPIC RESECTION OF RECTOVAGINAL CLEAR CELL CARCINOMA MASS ARISING FROM ENDOMETRIOSIS**

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**Introduction** Increasing evidence indicates there is malignant transformation of ovarian and non-ovarian endometriosis into mainly endometrioid, and clear cell histologies. Patients that have suspicious symptoms, physical exam findings, or abnormal imaging studies should be evaluated to rule out malignancy. We briefly review the patients history and surgical case as the disease can be elusive.

**Methods** This is a surgical case report involving a single patient. The provider is a Gynecologic Oncologist and minimally invasive surgeon that has extensive experience in the treatment of endometriosis. The surgical technique for endometriosis resection and ovarian cancer debulking is reviewed in this video.

**Results** Pathology specimens of the vaginal cuff/vagina, iliocelecum, and appendix were positive for clear cell carcinoma. Negative margins were achieved at the vagina.

**Conclusion** Uterine transposition represents a novel approach to fertility preserving surgery.