important to identify all marked nodes. There were 2 blue
nodes in each pelvic side: obturator/interiliac and external
iliac. All 4 were positive in ex-vivo gamma-probe assessment.
After the procedure, there were no other sites of gamma-
probe detection.
Conclusion SLN detection with combined blue dye and radio-
tracer may result in an adequate bilateral pelvic detection in
early stage endometrial cancer. This standard technique may
require only permanent laparoscopic instruments, representing
less costs and high reproducibility.

IGCS20_1287

ROBOTIC ILEAL NEOVAGINA

R Ribeiro, A Munhoz*, HK Rabelo, A Vargas, A Tsunoda, J Linhares. Hospital Erasto Gaertner, Brazil

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 recon-
struction (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 IIIB cervical cancer. After 3 years of follow-up, there
was no evidence of recurrence, and an ileal neovaginal recon-
bruction was performed. This video demonstrates a surgical
technique, using approximately 23–30 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 recov-
ered sexual function.
Conclusions Robotic ileal neovagina is an option for patients
who had pelvic exenteration with wet colostomy.

IGCS20_1335

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

1M White, 2F Nezhat*. 1NYU Winthrop Hospital, USA; 2Weill Cornell Medical College, USA

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 abnor-
mal imaging studies should be evaluated to rule out malign-
ancy. 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 mini-
mally invasive surgeon that has extensive experience in the
treatment of endometriosis. The surgical technique for endo-
metriosis resection and ovarian cancer debulking is reviewed
in this video.
Results Pathology specimens of the vaginal cuff/vagina, ilioce-
cum, and appendix were positive for clear cell carcinoma.
Negative margins were achieved at the vagina.
Patient was treated with adjuvant chemotherapy with whole
pelvic and vaginal brachytherapy.
Conclusion Management of patients with cancer arising from
endometriosis can be challenging. Patients with endometriosis
should be evaluated for malignancy with suspicious imaging
findings. Optimal surgical resection followed by adjuvant chem-
otherapy or/and radiation is the current recommendation.
Robotic Assisted Laparoscopy is feasible and may be preferable
debulking/resection of complex masses in the rectovaginal
space in obese patients.

IGCS20_1343

UTERINE TRANSPOSITION IN A CASE OF RECTAL
MALIGNANCY

M O’Brien*, F Donohoe, B Boyd, R McVey, T Walsh, A Brannigan, D Brennan. UCD School of Medicine, Ireland

Introduction Uterine transposition is a surgical technique first described by
Dr. Reitan Riberio. This is fertility preserving surgery for
patients with rectal/anal cancer requiring pelvic radiation. The
uterus is transported out of the field of radiation and reposi-
tioned when radiotherapy is completed.
Case Report A 36 year old woman presented with new onset
peri-anal pressure symptoms on a background of no signifi-
cant medical history. Examination revealed a hard irregular
circumferential rectal tumor from dentate line, 5 cm in
length. Histology reported a moderately differentiated adeno-
carcinoma. TNM stage T3cN2bM0. This case was discussed
at the colorectal multidisciplinary team meeting. A plan was
made for fertility-preserving uterine transposition and forma-
tion of loop colostomy. The patient would then commence
pelvic radiation with concomitant chemo-therapy. Following
this the patient would undergo interval abdomino-perineal
resection (APR) with re-implantation of uterus plus adjuvant
chemotherapy.
Procedure A video attached shows the procedure of uterine
transposition and the subsequent repositioning. This was done
laparoscopically, with ligation of the round ligaments and
mobilisation of the gonadal vessels to the level of the kidney
bilaterally. Uterine arteries were ligated and colpotomy per-1
formed. The uterus was then transported to the upper abdo-
men and fixed to the abdominal wall. A cervical stoma was
then formed.
The second video demonstrates the repositioning of the
uterus to the pelvis following the completion of radiotherapy.
The round ligaments are reattached bilaterally. Intravenous
Verdye was administered and preservation of the blood supply
to the uterus was demonstrated through an infrared camera
lens.
Conclusion Uterine transposition represents a novel approach
to fertility preserving surgery.