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480 SURGERY FOR RECTOSIGMOID PERITONECTOMY IN ADVANCED OVARIAN CANCER: SURGICAL TECHNIQUE OF VISCERAL SEGMENTAL SEROSECTOMY AND 8-YEAR EXPERIENCE

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Introduction Tumors infiltrating rectosigmoid colon is commonly found during cytoreduction in ovarian cancer. Low anterior resection (LAR) or visceral serosal segmentectomy (VSS) can be performed for removing tumors on the rectosigmoid colon. LAR is associated with decreased bowel function, and conservatively ablating tumors on rectosigmoid colon by VSS might be safe without compromising the quality of life.
Methods From Jan 2013 to June 2020, we performed 83 cases of stage IIB to IVB ovarian cancer surgery with resection of tumors involving the rectosigmoid colon. Also, VSS was considered when the length of the tumor extent of the rectosigmoid colon was less than 18 cm, and there was no evidence of mucosal invasion, and in the other cases, LAR was performed.
Results First, the rectosigmoid colon is mobilized, and then, mesorectal excision was done, and VSS can be performed. Exposure of the muscle layer or mucosal layer can be repaired. After that, tagging suture is done at the edge, and the resected serosa area is folded and form a bowel loop. A bubble leak test was performed after the serosal repair is completed. Among 83 patients, there were no differences in clinicopathologic characteristics between LAR (n=39) and VSS (n=44) group. In terms of surgical extent, LAR showed more combined procedures related to bowel surgery. Also, there were no differences in survival, recurrence pattern, and surgical complications.
Conclusions Visceral Segmental Serosectomy is feasible and can be safely performed without significant complications and comparable survival outcomes.

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481 LAPAROSCOPIC APPROACH TO BULKY PELVIC LYMPH NODES: TIPS AND TICKS

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Introduction With the increased use of minimally invasive techniques for advanced gynecological neoplasms, progressively more challenging lymph nodal debulking are being performed. Our objective is to present a detailed strategy to safely performed pelvic lymphadenectomy in patients with bulky lymph node metastasis.
Method We present a video demonstrating tips and tricks to resect bulky pelvic lymph nodes using laparoscopy.
Results Pelvic spaces dissection is the first step to achieve surgical field control during pelvic lymphadenectomy, specially in patients with bulky metastasis. After that, proximal and distal dissection of any vessels close to bulky lymph nodes is mandatory if there is risk of bleeding. Dissection of such nodes starts in the heathy tissue and not direct ate the any area adorned to major vessels. A combination of blunt and sharp dissection usually allows resection of most bulky lymph nodes without vascular resection. Some nerves may be dissected and preserved as well. In selected cases, harmonic energy may be useful.
Conclusion Laparoscopic resection pelvic bulky lymph nodes is feasible, but can be demanding and requires different strategies in order to be safe and effective.

IGCS20_1135

482 MINIMALLY INVASIVE BLEEDING MANAGEMENT DURING PELVIC LYMPHADENECTOMY

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Introduction Bleeding is certainly one of the most common complications in minimally invasive surgery for gynecologic cancer, specially during the pelvic lymphadenectomy. To master bleeding control is mandatory to all surgeons performing such procedures. The objective of these video is to demonstrate bleeding management alternatives during minimally invasive pelvic lymphadenectomy.
Method We present a video demonstrating the basic and advanced principles of bleeding control, during pelvic lymphadenectomy.
Results The first part of the video presents the basic principles of bleeding management including, compression, anatomy knowledge, proximal and distal dissection, and bipolar coagulation along surgical field control. The second part is focused in different techniques as clipping suturing.
Conclusion Bleeding management using minimally invasive surgery is feasible. All surgeons have to master several different strategies to achieve bleeding control avoiding unnecessary conversion to open surgery.

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483 RETROPERITONEAL BLEEDING MANAGEMENT DURING LAPAROSCOPIC LYMPHADENECTOMY

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Introduction Minimally invasive surgery (MIS) still an evolving technique and it has been used progressively more for complex procedures. At the same time, complications management using MIS is also evolving and conversion is becoming less common. It's important to master different strategies to approach complications, specially bleeding because this is one of the major causes of conversion. It's our objective to demonstrate different strategies to control venous and arterial bleeding during MIS.
Method Using a series of videos we present the 4 most used techniques of bleeding control: compression, coagulation, clipping and suturing.

Results Simple compression can control the majority of small retroperitoneal bleeding, sometimes associated with hemostatic agents. Bleeding from small tributary vessels can be controlled using bipolar energy. Another option is the use of clips, especially when there isn't a safe place to use bipolar energy or there is a defect in the vessel wall. It is important to avoid clipping large portions of the vessel wall, as well as to avoid adicional damage. For larger lacerations the suturing techniques is best approach. Before performing the suture, it is important to achieve control of the surgical area. In robotic assisted laparoscopy the same principles must be followed. Instead all the approaches shown, there is some cases that laparoscopic bleeding control is not possible and conversion is needed.

Conclusion It is possible to achieve bleeding control by MIS in different ways. Each technique can be appreciated in different situations. It is very important to the surgeon to master all bleeding control strategies.

IGCS20_1145

484 LAPAROSCOPIC NERVE SPARING RADICAL HYSTERECTOMY: MEASURE TO PREVENT TUMOR SPILLAGE FOR BETTER PROGNOSIS AND PRESERVATION OF VOIDING FUNCTION BASED ON CLINICAL PELVIC ANATOMY

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Introduction LACC trial suggests intraoperative tumor manipulation and dissemination may compromise survival of early stage cervical cancer with total laparoscopic radical hysterectomy (TLRH). We examined oncological outcome of TLRH with abdominal radical hysterectomy (ARH) and evaluated our surgical technique.

Description A case of cervical cancer T1b1 is presented in this video. Patient is 49 years old and endocervix tumor of 1.5 cm is identified in uterine cervix. TLRH is done by Okabayashi method. Technique for good visual field is standardized to reproduce Okabayashi method in every case. TLRH is combined with measures to prevent tumor spillage: 1) avoidance of usage of uterine manipulator, 2) clipping of venous drainage from uterus before manipulating uterine cervix, and clipping central side of lymph drainage before pelvic lymph node dissection, 3) irrigate vagina and close vaginal cuff before colpotomy. Cox proportional hazard model confirmed that oncologic outcomes were similar between 2 groups (29 cases in TLRH group and 35 cases in ARH group), including disease free survival (DFS, HR: 0.2441, 95%CI: 0.02852–2.09, p=0.198) and overall survival (OS, HR: 1.676, 0.1045–26.85, p=0.7152). Local recurrence was observed in 4 cases of ARH group (11%) but none in TLRH group. Metastasis was observed in 1 case of ARH group and 1 case of TLRH group.

Conclusion/Implications TLRH done by Okabayashi method is accepted when combined with preventive method of tumor spillage. Tumor should be isolated, and irrigation of vagina and vaginal cuff closure before colpotomy is needed in both groups.

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485 LAPAROSCOPIC ASSISTED INFRALEVATOR POSTERIOR EXENTERATION WITH VULVOVAGINAL RECONSTRUCTION

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Introduction Recurrent cervical cancer following surgery and pelvic radiotherapy is a complex disease to treat. It is also difficult to differentiate field change cancers of the lower genital tract from recurrent cervical cancer. Exenterative surgery is commonly indicated for central recurrences with no involvement of pelvic side wall structures or lymphnodes as complete resection is feasible with better oncological outcomes.

We present a surgical film of a unique case who developed disease (? recurrent/field change cancer) on the vulva with extension to posterior vagina and anal mucosa.

Methods A 50 year old lady presented with a malignant growth on the vulva extending to lower vagina and anal canal. She did not have lateral side wall disease or lymph nodal involvement or distant metastasis. She had undergone non radical hysterectomy for an undiagnosed cervical cancer and had received adjuvant pelvic radiation elsewhere 12 months prior to referral to our hospital. We performed Laparoscopic Assisted Infralevator Posterior Exenteration with Vulvovaginal Reconstruction using V-Y advancement flaps.

Results Her postoperative recovery was uneventful. Histopathology confirmed squamous cell cancer and margins of resection were free of tumor. Two suspicious sub-centimeter nodules in the pelvic peritoneum was positive for tumor for which she received adjuvant chemotherapy.

Conclusion Laparoscopic Assisted Infralevator Posterior Exenteration with Vulvovaginal reconstruction even though a complex procedure facilitates early postoperative recovery and timely administration of adjuvant therapy when indicated.

IGCS20_1448

486 TECHNIQUES OF QUADRANT WISE CYTOREDUCTIVE SURGERY IN ADVANCED EPITHELIAL OVARIAN CANCER: TOTAL PARIETAL PERITONECTOMY + RETROGRADE HYSTERECTOMY + MESENTRIC STRIPPING & GLISSONS CAPSULECTOMY

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Objective Cytoreductive surgery is the cornerstone of therapy for advanced epithelial ovarian cancer. Optimal cytoreduction defined as removal of all visible macroscopic disease has shown to improve disease free & overall survival in several studies. Addressing the disease in the upper abdomen in ovarian cancer is of at most significance for optimal cytoreduction apart from lower abdomen disease. Surgery in the upper