**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 adiational damage. For larger lacerations the suturing techniques are 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.

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**IGCS20_1145**

**LAPAROSCOPIC NERVE SPARING RADICAL HYSSTERECTOMY: 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.

**Conclusion**

Laparoscopic nerve sparing radical hysterectomy 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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**IGCS20_1198**

**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 were 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.

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**IGCS20_1448**

**TECHNIQUES OF QUADRANT WISE CYTOREDUCTIVE SURGERY IN ADVANCED EPITHELIAL OVARIAN CANCER: TOTAL PARIETAL PERITONECTOMY + RETROGRADE HYSTERECTOMY + MESENTERIC 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 most significance for optimal cytoreduction apart from lower abdomen disease. Surgery in the upper
abdomen is very challenging and needs sound knowledge of surgical anatomy, standard practice of surgical techniques over-
time for better outcomes.

Methods This video shows various techniques of cytoreductive surgery done quadrant wise with description of regional applied surgical anatomy and voice over by a experienced gynec-oncosurgeon over a period of 15 years.

Right upper quadrantectomy shows techniques of glisson capsulectomy, ponta hepaticus dissection, diaphragm stripping and resection, lesser omentectomy & bursectomy.

Left upper quadrantectomy shows techniques of diaphragm resection, splenectomy and tail of pancreas resection, total supra-colic omentectomy & omental bursectomy.

Lower abdominal surgery shows techniques of retrograde hysterectomy with pouch of douglasectomy and pelvic peritonectomy, bowel resection and anastomosis.

Video also shows techniques of total parietal peritonectomy, mesenteric stripping & management of nodules on bowel surface.

This video also shows how to use different surgical gadgets and energy sources for optimizing the available resources to achieve optimal cytoreduction- use of CUSA, harmonics, monopolar cautery with sharp and round tip blades using high cautery setting, also single swab and double swab technique for peritonectomy.