640 RAISING ADEQUATE VAGINAL MARGINS DURING COLPOTOMY FOR CERVICAL CANCER

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Introduction/Background* Adequate surgical vaginal margins are pre-requisite for improving oncological outcomes in cervical cancer and precancer. Raising the margins through vaginal route helps in visualizing and measuring the vaginal and is more accurate than performing colpotomy from a open abdominal/Minimal access route.

Methodology Following completion of ligation of uterine vessels with or without adequate parametrium depending on the indication for radicality (abdominal/minimal access route/schautas vaginal hysterectomy), surgeon moves to the bottom end of the patient. Cervix is visualised and held with volsellum. Circumferential vaginal margin which needs to be removed is marked with cautery. Vaginal mucosa is infiltrated with saline with or without adrenaline. With the help of electrical diathermy vaginal margins are raised all around and separated from underlying cervix. Care should be taken not to be too close to bladder or rectum during dissection. Bladder and pouch of douglas peritoneum is incised and uterus/cervix delivered depending on the procedure (tracheectomy/radical hysterectomy)

Result(s)* Vaginal is closed with absorbable sutures and specimen sent for final histopathology.

Conclusion* Adequate Vaginal margin is a major prognostic factor in cervical cancer. Inadequate or positive margin is associated with recurrence and poor oncological outcomes, hence adjuvant postoperative radiation is indicated in such scenario. Direct visualization and measurement of vaginal to be removed and performing vaginal colpotomy ensures adequate vaginal margin and also prevents the disease being exposed to peritoneal cavity especially in minimal access surgery.
period between 2008-2018. Multiple variables were analyzed related with histopathological study, surgical complications, adjuvant treatments, follow-up and current status of the patients. 

**Result(s)** 109 radical hysterectomies were performed for cervical cancer during the study period. Average age is 46.5 years (range 25-76 years). Most of the patients (n = 101) had stage IB1. The mean tumor size is 1.8 cm (0.4-5 cm). In the first 30 days after surgery, 3 fistulas were detected. In 99.1% the margins were free of disease, only one patient presented margin involvement. Two patients had a tumor stage greater than IB1 (1 IB2 and 1 IIA2). The mean number of lymph nodes extracted was 19.8, of those being affected 11.9% (n = 12), 18.3% (n = 20) received adjuvant treatment with radiotherapy and concomitant chemotherapy, of these 13 were for positive lymph nodes. Therefore, the rate of patients who received adjuvant treatment with N0 was 8.3%. We have only had one recurrence in less than two years of follow up (1/93).

**Conclusion** HUMIC is a reference in gynecological oncology for the province of Las Palmas with trained personnel with exclusive dedication (QI2) and participating in multicenter studies (QI3). It has a multidisciplinary tumor board where all patients are presented according to recommendations of scientific societies (QI4-5) before and after surgery (QI6-7). We present a 2.7% urological fistula (QI8 and QI9 < 3%) of them during learning curve and a patient with BMI of 38. We reached a 99.1% rate of free margins of disease (QI10 > 97%). In 2% we found a staging greater than IB1 (QI11 < 10%). Pelvic lymphadenectomy or SLN (Sentix) was performed at 100% the patients (QI13 > 98%). 8.3% received adjuvant treatment with N0 (QI15 < 15%). If there is indication, fertility sparing treatment is offered and currently it is performed in our center (QI14 100%). We had a 2-year recurrence rate of 1% (QI12 < 10%).

The only indicator we do not reach is the number of cases (minimum QI1 of 15), since our mean is 10 radical hysterectomies per year. Nevertheless, last year we performed 15 surgeries, which given our geographical location, we think it allows us to continue as a Reference Center.