

mm under direct visualization using monopolar cautery. The mucosa edges were reapproximated with V-lock suture.

Results Pathology showed squamous mucosa with high-grade vaginal intraepithelial neoplasia and a focal area of invasion (with depth of invasion <1 mm). The patient tolerated the procedure well and was discharged from Day Surgery without any postoperative complications.

Conclusion Transvaginal endoscopic resection for superficially invasive vaginal lesions can be performed safely and provide accurate diagnosis with excellent visualization.

SF012/#204

10 STEPS TO APPROACH LARGE OVARIAN MASSES THROUGH VNOTES (VAGINAL NATURAL TRANSLUMINAL ENDOSCOPIC SURGERY)

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10 steps to approach large ovarian masses through vNOTES.

Introduction VNOTES (vaginal Natural Orifices Transluminal Endoscopic Surgery) is a novel technique that allows a laparoscopic approach to the pelvic and abdominal cavity through the vagina. It seems to facilitate large ovarian masses (with benign characteristics) removal when compared to conventional laparoscopy.

Description We recommend 10 steps to approach large ovarian masses through vNOTES. Each step is explained in the surgical video.

- Step 1. Select suitable case.
- Step 2. Setting up the patient and the surgical team.
- Step 3. Accessing the cavity.
- Step 4. Inserting vaginal port.
- Step 5. Cavity inspection.
- Step 6. Sealing and division.
- Step 7. Bag the cyst.
- Step 8. Cavity revision.
- Step 9. Revise the inner ring of the vaginal port.
- Step 10. Closing the vaginal vault.

Conclusion It is feasible to approach large ovarian masses through vNOTES.

SF013/#236

ROBOTIC APPROACH FOR A TOTAL HYSTERECTOMY BILATERAL SALPINGO-OOPHORECTOMY AND SUCTION CURETTAGE OF A 20-WEEK SIZE UTERUS WITH GESTATIONAL TROPHOBLASTIC NEOPLASIA

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Introduction Gestational trophoblastic neoplasia (GTN) is a malignant trophoblastic disease following either molar or non-molar pregnancies. GTN is primarily treated through uterine evacuation using suction curettage followed by observation or adjuvant chemotherapy based on WHO risk scoring.^{1,2} In patients who have completed child-bearing, hysterectomy is an acceptable option and may decrease time to remission and

required chemotherapy cycles.² In patients presenting with large volume uterine disease, evidence of metastasis, and high-risk WHO scoring, patients are treated with multi-agent chemotherapy including Etoposide, Methotrexate, Actinomycin-D, Cyclophosphamide, and Vincristine (EMA-CA).^{1,2} EMA-CO has significant risks of complications, including acute hemorrhage and trophoblastic emboli.^{2,3} In patients with large uteri, surgical risks include uterine perforation and acute hemorrhage,⁴ requiring a large laparotomic incision. Accordingly, there is a need for risk-reducing minimally invasive approaches in the surgical treatment of GTN.

Description The patient is a 53 year old G4P4 presenting with an enlarged uterus of 20 cm with snowstorm appearance, a beta-hCG >400 000IU, lung metastases and a WHO risk score of 8. Preoperatively her blood pressure was 168/105. She underwent a robotic total hysterectomy and bilateral salpingo-oophorectomy, and guided suction curettage. Blood loss was minimal. The patient was scored post-procedure as WHO low risk (3). She received methotrexate, and switched to Actinomycin-D after a plateau in beta-hCG. Her beta-hCG is normal 5 months later.

Conclusion We present a minimally invasive approach that ameliorates the surgical and chemotherapy risks of uterine rupture, acute hemorrhage, and trophoblastic emboli, with a normalization of beta-hCGs after treatment with single-agent chemotherapy.

SF014/#370

LAPAROSCOPIC REPAIR OF OBTURATOR NERVE INJURY AT THE TIME OF PELVIC LYMPHADENECTOMY

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Introduction The obturator nerve is formed by the lumbar plexus, receiving its fibers from the anterior division of L2–4. Clinically, obturator nerve injury manifests with sensorial loss at the medial aspect of thigh, pain at medial portion of the groin and ipsilateral adductor weakness. The risk of obturator nerve injury is increased during pelvic lymphadenectomy and surgeries for gynecologic malignancies. Here, we present a video film of full-thickness transection of obturator nerve at the time of pelvic lymphadenectomy in a patient who underwent laparoscopic surgery for endometrial cancer. The transected nerve was primarily repaired through a laparoscopic approach at the time of surgery. The patient experienced a full recovery with no motor function deficiencies.

Description In this surgical film we present an 83-year-old woman, G2P2, who was diagnosed with a grade 3 endometrioid endometrial adenocarcinoma. She underwent a laparoscopic hysterectomy and sentinel lymph-node biopsies as well as resection of enlarged external iliac node. During the procedure, we identified a complete transection of the obturator nerve. To enable an end to end repair, the external iliac artery and vein were mobilized. The proximal end of the nerve was identified lateral to these vessels. An end-to-end anastomosis of the nerve was performed using Prolene sutures. The patient experienced an uneventful post-operative recovery. She discharge home on post-operative day 2, able to ambulate independently with no assistance.