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.

**SF0102/#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.

**SF0103/#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 Vin瑞tine (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.
Conclusion Obturator nerve injuries are a well-recognized complication of pelvic lymphadenectomy. Immediate laparoscopic nerve repair, can facilitate earlier motor recovery and prevent the need for laparotomy.

Description Identify the boundaries - Lateral border - develop retroperitoneal space by division of round ligament laterally, divide peritoneum along the medial border of psoas muscle with identification of genitofemoral nerve toward paracolic gutter - Medial border – obliterated umbilical artery - dissect along lateral border to level of common iliac vessels bifurcation - Inferior border - obturator nerve – identify obturator foramen following pubic bone with nerve seen below - Caudal border – deep circumflex vessels - Cranial border – bifurcation of common iliac vessels - Lymph node en-bloc dissection technique - Orientation from lateral to medial and caudal to cranial - Initiate from lateral and caudal borders and dissect from external iliac vessels - Once below external iliac vein follow pubic bone to identify obturator nerve as it crosses the obturator foramen, acknowledging corona mortis vessel - Collect lymph nodes within anatomical boundaries - Ensure haemostasis.

Conclusion/Implications We present this case as an aide memore of a basic gynaecological oncology technique. This is an essential surgical skill to develop with knowledge and practice for all subspecialists in training. https://www.dropbox.com/s/b2k20eph9aomb5a/BPLND%20IGCS.mp4?dl=0

Introduction Cervical cancer is the 2nd most common cancer in Indian women (as per globocan 2018). For many years, radical hysterectomy is the treatment of choice for early stage cervical cancer. This procedure has been traditionally performed via laparotomy but with the introduction of robotic assisted radical hysterectomy, blood loss during procedure, hospital stay, post-operative complications is relatively reduced.

Description The video illustrates a sequential narrative of operative steps of our robotic assisted radical hysterectomy and bilateral pelvic lymph node dissections in a 46-year-old female with squamous cell carcinoma of cervix. She presented with proliferative growth of 2x2 cm in the cervix, fornices free, bilateral parametrium and rectal mucosa free. The urinary bladder was dissected downward, the retroperitoneal space opened and visualized important structures like ureters and iliac vessels. Uterine arteries cauterized, clipped and cut at the level of its origin, ureters dissected from medial leaf of broad ligament peritoneum down to its entrance into the parametrium tunnel of Wertheim. Pararectal and paravesical spaces created. The infundibulopelvic ligament cauterized and cut laterally, pelvic wall peritoneum of broad ligament incised downward to base of uterusacral ligament, uterosacral ligament cauterized and cut closed to rectum. Colpotomy done specimen delivered vaginally without spillage. Bilateral pelvic lymph node dissection was done and specimen delivered vaginally, vault closure done with v-lock sutures.

Conclusion Certain studies demonstrate the safety and feasibility of Robotic assisted radical hysterectomy for early-stage cervical cancer. It provides benefits such as less bleeding, reduced in hospital stay and decrease in post-operative complication.

Introduction Systematic pelvic lymph node dissection is a standard procedure conducted in the management of cervical and high-risk endometrial cancers. This requires a precise understanding of anatomical landmarks in addition to surgical approach, with present’s confusion for trainees amidst multiple learning techniques. Trainees must develop economy of movement and maximise lymph node yield whilst avoiding potential complications including injury to nerves and vessels as well as post-operative morbidity.

Conclusion/Implications We present this case as an aide memore of a basic gynaecological oncology technique. This is an essential surgical skill to develop with knowledge and practice for all subspecialists in training. https://www.dropbox.com/s/b2k20eph9aomb5a/BPLND%20IGCS.mp4?dl=0

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