

SF018/#632

**MAYLARD INCISION: A TRANSVERSE INCISION FOR COMPLEX GYNECOLOGIC SURGERY**

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**Introduction** Maylard incision is a transverse abdominal incision characterized by the ligation of inferior epigastric vessels and the transection of rectus abdominus muscles. It provides a good surgical exposure. The aims of this video is to detail Maylard incision technique.

**Description** A transverse skin incision is made four cm above the symphysis pubis. After dissection of subcutaneous tissue, transversalis fascia is opened. Rectus abdominus muscles are separated from the fascia. Inferior epigastric vessels are located at the external edge of rectus abdominus muscles. They are dissected, ligated and cut. The rectus abdominus muscles are sectioned using bipolar device. The parietal peritoneum can be opened. After the surgery, the parietal peritoneum is closed using a running suture. Rectus abdominus muscles can be autotransplanted but it is not mandatory.

**Conclusion** Maylard incision provides a good surgical exposure, a cosmetic, reproducible technique with less complications and pain comparing to midline incision. Hands on training are required to perform this technique.

SF019/#636

**VASCULAR INJURY IN ROBOT-ASSISTED PARA-AORTIC LYMPHADENECTOMY**

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First robot-assisted para-aortic lymphadenectomy performed in gynecological oncology in our country for surgical staging of cervical cancer in a patient with radiological evidence of pelvic lymph node involvement. Description of the performance of docking for para-aortic lymphadenectomy by robot-assisted surgery and the presentation of a vascular lesion during dissection of the interaortocaval nodes and its management with vascular clip. Although unplanned conversion-to-open is a rare event occurring in less than 1% of robotic-assisted cases, it is associated with worse outcomes and carries significant morbidity and potentially life-threatening consequences. In the setting of massive hemorrhage, timely and effective emergency undocking followed by emergency laparotomy and obtaining vascular control may be lifesaving. In this case we used a vascular clip to control the bleeding and avoid converting to an open procedure. The presence of vascular lesions during robotic-assisted surgery can occur in up to 3%, depending on the series reviewed. Keep calm and recognize the bleeding site accurately to avoid collateral damage. The surgeon should have knowledge about the different techniques that can be used to control major bleeding. Vascular clips applied properly by trained surgeons provide a safe option for vascular control injury in robotic gynecology surgery. Future research should be aimed at finding the best bleeding control technique in robotic surgery.

SF020/#652

**USE OF A VAGINALLY ADAPTED GAMMA PROBE IN THE VIDEOLAPAROSCOPIC SENTINEL LYMPH NODE RESEARCH**

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**Introduction** The use of videolaparoscopy in the management of gynecological cancer has gained ground due to the possibility of offering quality treatment with benefits in relation to pain and postoperative recovery, mainly. Despite making it possible to conduct sentinel lymph node research, there is still a limitation regarding the use of the laparoscopic gamma probe, due to the high cost and low frequency of use in institutions that normally have the conventional gamma probe used in open surgery. The purpose of this video is to show the possibility of using the conventional gamma-probe vaginally in laparoscopic surgeries.

**Description** The video shows the challenge that the surgeon often faces when searching for sentinel lymph nodes using patent blue, when the lymphatic pathways and the sentinel are not stained on either or both sides. In this situation, the use of the Technetium-99m injection in the cervix and lymph node research using a gamma-probe protected by a sterile glove introduced vaginally may be an alternative, contributing to the sentinel meeting.

**Conclusion** The use of the adapted gamma-probe used vaginally can contribute to the investigation of the sentinel lymph node by a minimally invasive route when a laparoscopic probe is not available, especially in cases of early endometrial cancer, in which only the sentinel lymph node biopsy is sufficient for staging, and can be useful to find lymph nodes and avoid systematic lymphadenectomy and its consequences.

SF021/#830

**MINIMALLY INVASIVE SECONDARY CYTOREDUCTIVE SURGERY FOR HEPATO-RENAL RECESS ISOLATED RECURRENCE OF SEROUS ENDOMETRIAL CANCER IN BRCA1 MUTATED PATIENT**

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**Introduction** This film shows the surgical management of a young BRCA1 mutated woman affected by a recurrence of serous endometrial carcinoma (SEC). This aggressive subtype of endometrial cancer recurs in 30–80% of cases and shares most of its molecular features with serous ovarian cancer. The role of BRCA mutations in this setting is still not completely understood. The

aim of this film was to show how a minimal invasive surgical approach is safe and feasible in selected patients.

**Description** In the video we present the case of a hepato-renal recess isolated recurrence of serous endometrial carcinoma. Patient positioning and port placement were critical to achieve an optimal exposure of the liver 6th segment and the Morrison's pouch. An extensive removal of visceral adhesions was performed and the metastasis was then exposed. The tumor infiltrated the liver parenchyma for less than 2 cm. A superficial wedge resection was executed until complete removal of the lesion. The procedure has been performed in 90 minutes. Post-operative course was unremarkable and the patient was discharged on post-operative day 3. The patient was able to resume her oral PARP inhibitor after 10 days. Histopathology report confirmed the metastatic localization of a high-grade serous cancer.

**Conclusions** Potential benefits of minimally invasive approach include reduced blood loss, less pain, faster recovery and a short interval to chemotherapy. The personalised treatment of recurrent endometrial serous cancer should be guided by the molecular pattern of the disease and by the surgical skills with a multidisciplinary approach. video: <https://www.dropbox.com/s/glhyzy7na510ls/MINIMALLY%20INVASIVE%20SECONDARY%20CYTOREDUCTIVE%20SURGERY%20FOR%20HEPATO-RENAL%20RECESS%20ISOLATED%20RECURRENT%20OF%20SEROUS%20ENDOMETRIAL%20CANCER%20IN%20BRCA1%20MUTATED%20PATIENT.mp4?dl=0>

SF022/#580

#### IDENTIFICATION OF INGUINAL SENTINEL LYMPH NODES IN RECURRENT VULVAR MELANOMA

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**Introduction** Vulvar melanoma has a high propensity for lymphatic spread to inguinal lymph nodes. Groin sentinel lymph node biopsy is considered a part of the management of primary vulvar melanoma. Yet, the role of performing sentinel lymph node biopsy in the management of patients with negative nodes in primary surgery, who develop recurrent vulvar melanoma, is less clear than in the case of primary tumors. Nevertheless, lymph nodes status in recurrent disease can provide valuable information to guide further therapy. Sentinel mapping in a previously scarred area is challenging and the most suitable mapping technique has not been determined. In this video, we demonstrate the technical feasibility of repeat sentinel lymph nodes biopsy for recurrent vulvar melanoma using intraoperative fluorescent indocyanine green (ICG) detection.

**Description** The video demonstrates ICG mapping technique in recurrent vulvar melanoma. The injection site and ICG positive nodes are shown. Implication: Sentinel mapping in recurrent vulvar melanoma with ICG tracer technique is feasible, even in previously dissected groins.

SF023/#590

#### VULVECTOMY- AN OPERATIVE PROCEDURE FOR CA VULVA

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**Introduction** Increasing knowledge and understanding of the disease has allowed surgical procedures for the treatment of carcinoma of the vulva to become more conservative and individualized to each patient. The exact procedure used depends upon the site, size, and histologic features of the tumor.

**Description** Preoperative preparation — All women require explanation and counseling about the procedure. General anesthesia is administered. The patient is positioned in lithotomy. The skin is prepared and draped. The patient is examined and the skin to be incised is marked with a pen. A urethral catheter is inserted into the bladder. Skin incision is begun with scalpel and the dissection is taken through the subcutaneous fat to the deep fascia and pubic ramus until the intended vaginal resection margin is reached with scalpel, scissors and diathermy. The dissection is carried down toward the clitoral attachments by sweeping the specimen off the periosteum of the pubic bones conserving the deep fascia until the clitoral attachments are reached. The suspensory ligament of the clitoris is clamped, divided, and ligated. The urethro-vaginal incision is now made circumferentially, ensuring that the required margin around the tumor is maintained. The tip of a scalpel Kelly forceps is passed through the specimen in the midline to isolate the crura divide and then suture ligated with absorbable sutures. The specimen is detached completely, and hemostasis is secured. The wound closed primarily.

**Conclusion** Adequate surgical resection with microscopic tumor-free margin should be the key concern. Oncological resection should be equated with functional outcome.

## E-Posters

### E-Poster Viewing

EPV001/#119

#### SCREENING AND IDENTIFICATION OF NOVEL CHEMOTHERAPY AGENTS IN PLATINUM-RESISTANT OVARIAN CANCER

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**Objectives** To screen the efficacy of potential chemotherapeutics against platinum-sensitive & resistant ovarian cancer cell lines.

**Methods** We performed in-vitro screening on mithramycin, an antineoplastic antibiotic; telaglenastat, a glutaminase inhibitor; savolitinib, a c-met tyrosine kinase inhibitor; and AMG-232, an MDM2 inhibitor. We tested all agents against a platinum-resistant cell line (OVCAR3) and a platinum-sensitive line (CAOV3). Additionally, we tested mithramycin against UWB1.289, a BRCA mutant, and an induced platinum-resistant UWB1.289 line. DMSO and cisplatin were the negative and positive controls, respectively, and we performed all experiments in triplicate. Cell viability was determined by measuring cellular ATP content.

**Results** The IC50 values of mithramycin ranged from 42.4 to 65.5 nM. Cisplatin IC50 values ranged from a median of 2067 to 7267 nM. The IC50 values of telaglenastat, savolitinib, and AMG-232 did not reach a level of 10µm in any of the