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THE CASE OF LAPAROSCOPIC ANTERIOR RECTAL RESECTION AND RETRANSPPLAINTATION OF THEURETER WITH THE USE OF ICG

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**Introduction/Background** Presenting the method of laparoscopic anterior rectal resection and retransplantation of the ureter in the case of deep infiltrating endometriosis (DIE).

**Methodology** 28-year-old lady with the history of dyschezia 9/10, dysmenorrhea 9/10, dyspareunia 6/10, dysuria 7/10, infertility, left huge hydronephrosis which were explained by urologist as a consequence of anatomical variation of the vesicovaginalis. She had the trial of cystoscopic ureteric JJ stent insertion prior to planned surgery with no success. 2 weeks later she had done laparoscopic results.

**Results** She had done segmental resection of the anterior rectum with the end to end recto-sigmoid colon anastomosis due to 6 cm nodule of the rectum, enteroinadrenal infiltration of the JJ stent to the left ureter after cutting the wall of ureter 10 cm from the bladder due to impossible JJ cystoscopic stenting with simultaneous retransplantation of the left ureter. All procedure was done in control of vascularity by ICG both the bowel and the ureter. Both anastomosis of the colon and the ureterobladder were protected by fibrine glue. The bladder was isolated from rectum with the flap of omentum. 5 weeks after surgical procedure the JJ stent was removed from the ureter. Proper function of thebowel and the ureter were proved in control visit – 6 weeks after surgery. In histopathology: endometriotic nodule of the bowel and ureter were diagnosed. The result of the surgery was complete realising from the pain and tailored surgery on colon and ileum due to low grade neoplasma of appendix.

**Conclusion** Laparoscopy is a perfect method for tailored and radical surgery in DIE and multiorgans surgery with all advantages of the minimally invasive access. Complete realising of the pain was huge success of the surgery.

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**2022-VA-1036-ESGO**

PROTECTED LAPAROSCOPIC LARGE OVARIAN CYST ASPIRATION – A FIVE STEPS ALTERNATIVE TO LAPAROTOMY

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**Introduction/Background** In this video, we describe a five-step surgical technique allowing to safely incise and aspirate the content of large ovarian cysts through a single port laparoscopic incision. This allows performing laparoscopic oophorectomies instead of large xiphopubic laparotomies.

**Methodology** A Stepwise demonstration of the technique

**Results** Ovarian masses, especially cysts, are common gynecological conditions. However, depending on their size, large adnexal cysts are usually managed with transverse or midline laparotomies. This is to prevent cyst ruptures and abdominal contamination and ensure the oncological safety of the procedure. Different leak-proof aspiration techniques were described in the literature allowing for safe large cyst aspiration and adnexectomy through a mini-laparotomy incision or via laparoscopy (2,3,6–10). We describe a five steps surgical technique allowing for closed aspiration of ovarian intracystic fluid and adnexectomy while respecting oncological safety.

**Interventions**

1. **Step 1**: Perform diagnostic laparoscopy to rule out peritoneal carcinomatosis contraindicating this procedure then after cyst exposition, thoroughly dry the cyst wall.

2. **Step 1 Bis**: Cut the cuff of a sterile glove to prepare a 46 square piece of membrane.

3. **Step 2**: Place a protective gauze, then apply the surgical glue to the ovarian cyst wall followed by the glove/membrane application. Perform a purse suture through the glove/membrane and the ovarian wall superficially to ensure further adhesion and prevent ovarian fluid spillage.

4. **Step 3**: Incise the ovarian wall then introduce the aspiration cannula and tighten the purse suture to aspirate the cystic fluid.

5. **Step 4**: After aspiration is complete, tighten the suture and close the glove to guarantee a closed space and prevent abdominal contamination.

6. **Step 5**: Perform laparoscopic oophorectomy or cystectomy. Safely remove the specimen in an endoscopic retrieval bag through the trocar incision.

**Conclusion** This technique allows safe laparoscopic large ovarian cysts resections while respecting oncologic safety and preventing intraabdominal spillage and contamination.

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LAPAROSCOPY IS A PERFECT METHOD FOR TAILORED AND RADICAL SURGERY IN DIE AND MULTIORGANS SURGERY WITH ALL ADVANTAGES OF THE MINIMALLY INVASIVEACCESS. COMPLETE REALISING OF THE PAIN WAS HUGE SUCCESS OF THE SURGERY

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**Introduction/Background** Presenting the method of laparoscopic anterior rectal resection, partial sigmoidcolon resection, right hemicolecotomy and extended hysterectomy in the patient with deep infiltrating endometriosis (DIE) diagnosed with coexisting of lowgrade appendicesal mucinoplasm. (LAMN).

**Methodology** 37-year-old lady with the history of multiple laparoscopic and laparotomiceintervention due to endometriosis and infertility qualified to laparoscopic intervention.

**Results** She had done laparoscopic segmental resection of the sigmoid colon and anteriorrectum resection with end to end anastomosis, total extended hysterectomy,right hemicolecotomy with side to side anastomosis, cystoscopy with protective JJstenting of both ureters due to massive adhesiolysis of the ureters. In histopathology: multifocal endometriotic infiltration of the bowel with the bigendometromatic nodules on rectum, sigmoid colon and cecum, low gradeappendicesal mucinoplasm. 

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