Abstracts

2022-VA-1035-ESGO  THE CASE OF LAPAROSCOPIC ANTERIOR RECTAL RESECTION AND RETRANSPALANTIAOOF THEUEREUTER WITH THE USE OF ICG

Ewa Milnerowicz-Nabzdyk, ¹Marek Pińskoski, ²Krzysztof Nowak, ³Zofia Borowiec.
¹Department of Oncological Gynecology, Dept Director Ewa Milnerowicz-Nabzdyk MD PhD Associate Prof., Centre of Oncology, Opole, Poland; ²Department of Urology and Oncological Urology, Dept Director Paweł Kowal MD PhD, Provincal Hospital, Wroclaw, Poland

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, dysmenorhoea 9/10, dyspareunia 6/10, dysuria 7/10, infertility, left huge hydronephrosis which explained by urologist as a consequence of anatomical variation of the vas- sel. 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 She had done segmental resection of the anterior rectum with the end to endrecto-sigmoid colon anastomosis due to 6 cm nodule of the rectum, the intraduodenal insertion of the JJ stent to the left ureter after cutting the wall of the bladder due to impossible JJ cystoscopic stenting with simultaneous retransplantation of the left ureter. All procedure was done 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.

2022-VA-1036-ESGO  PROTECTED LAPAROSCOPIC LARGE OVARIAN CYST ASPIRATION – A FIVE STEPS ALTERNATIVE TO LAPAROTOMY

Houssein El Haji, Carlos Martinez Gomez, Adrien Boschet, Mathilde Duchatelet, Delphine Hudry, Eric Leblanc, Fabrice Naruducci. Gynecologic Oncology, Oscar Lambret Cancer Center, Lille, France

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 oophorectomy instead of large xpho-pubic 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 Step 1: Perform diagnostic laparoscopy to rule out peritoneal carcinomatosis contraindicating this procedure then after cyst exposition, thoroughly dry the cyst wall.

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

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.

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

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

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.

2022-VA-1050-ESGO  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

Ewa Milnerowicz-Nabzdyk, ¹Maja Mügala, ²Krzysztof Nowak, ³Tomasz Sacharbiński.
¹Department of Oncological Gynecology, Dept Director Ewa Milnerowicz-Nabzdyk MD PhD Associate Prof., Centre of Oncology, Opole, Poland; ²Department of Surgical Oncology, Dept Director Tomasz Sacharbiński MD PhD, Centre of Oncology, Opole, Poland

Introduction/Background Presenting the method of laparoscopic anterior rectal resection, partial sigmoidcolon resection, right hemicolectomy and extended hysterectomy in the patient with deep infiltrating endometriosis (DIE) diagnosed with coexisting of low grade appendiceal mucinous neoplasm. (LAMN).

Methodology 37 – year old lady with the history of multiple laparoscopic and laparotomic intervention 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 hemicolectomy with side to side anastomosis, cystectomy with protective JJ stenting of both ureters due to massive adhesiolyis of the ureters. In histopathology: multifocal endometriotic infiltration of the bowel with the bigendometrotic nodules on rectum, sigmoid colon and cecum, low gradeappendiceal mucinous
OMENTAL FLAP AS A SPACER TO REDUCE ACUTE BOWEL TOXICITY AFTER ADJUVANT RADIOTHERAPY

1Elaine Leung, 2Yash Choudhary, 3Sofia Parveen, 4Anthony Packwood, 5Zahra Pervaiz, 6Audrey Kwong, 7Indrajit Fernando, 8Kavita Singh. 1Institute of Cancer and Genomics Sciences, University of Birmingham, Birmingham, UK; 2University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK; 3Sandwell and West Birmingham NHS Trust, Birmingham, UK

Introduction/Background Adjuvant pelvic radiotherapy is recommended for selected high-risk patients with cervical and endometrial cancer after surgery. However, the segment of bowel that replaces the empty space in the pelvis may receive an unintentionally high dose of radiation, which increases bowel toxicity. This video and the accompanying data described the use of an omental flap as a spacer to reduce post-radiation bowel toxicity after adjuvant radiotherapy for gynaecological cancers.

Methodology

The Technique The omentum was mobilised and separated from the hepatic flexure of the transverse colon. The flap was then brought into the pelvis along the left paracolic gutter and placed between the rectum and bladder. There is also the option to mobilise the omentum from the greater curvature of the stomach. Finally, the omental flap was secured with interrupted 2.0 Vicryl sutures to the bladder and lateral pelvic peritoneum.

Outcome data Patients who received adjuvant radiotherapy who had data on radiation dosage administered, radiation dosage received on bowel and acute toxicity were included.

Results

The results of 38 patients who have received adjuvant radiotherapy between 2011–2021 were evaluated (14 had spacers; 24 did not have spacers). There was no significant difference in age, cancer sites, length of follow-up, radiation dosage received (45Gy for both groups) between the two groups. Patients who had spacers had significantly lower volume of bowel receiving high dose (43Gy) of radiation (133 cc versus 331.5 cc; p=0.043) and less acute toxicity (42.9% versus 75% G1/2 acute toxicity; p=0.048), compared to the non-spacer group.

Conclusion The use of omental spacers could reduce post-radiation acute bowel toxicity; its use should be routinely considered in patients undergoing gynaecological cancer surgery who are likely to require adjuvant radiotherapy.

UTESIREGranulocytic Sarcoma as an Extra-medullary Relapse of Acute Myeloid Leukaemia in an Allogeneic Haematopoietic Stem Cell Transplantation Recipient

1Deborah Banderia, 2Mariana Rietmann da Cunha Madeira, 3Marianne Borges Landau, 4Andréa Rodrigues Cordovil Pires. 1Gynecology, Hospital Naval Marcílio Dias, Rio de Janeiro, Brazil; 2Hematology, Hospital Naval Marcílio Dias, Rio de Janeiro, Brazil; 3Fonte Medicina Diagnóstica LTDA., Niterói, Brazil

Introduction/Background Myeloid Sarcoma (MS) is an uncommon condition characterised by proliferation of immature myeloid cells in extra-medullary sites. The most common are lymph nodes, central nervous system, bones, and soft tissues. MS of the gynaecological tract is rare, especially in the uterine cervix. Patients with acute myeloid leukaemia (AML) are prone to have MS at any moment of the disease, especially after bone marrow transplantation (BMT).

Methodology

Molecular biology, immunohistochemical and immunophenotypic analysis of an unusual case of MS in the cervix without evidence of bone marrow recurrence, two years after an allogeneic BMT.

Results

A nulliparous 32-year-old patient, attending the haematological service due to AML since 2018 at a quaternary Brazilian Naval Hospital, complained of neuropathic and acute abdominal pain. Clinical examination revealed several soft tissue tumourations resembling MS and an abdomen/pelvic magnetic resonance imaging (MRI) peculiarly demonstrated a large uterine mass with compression of the right ureter and pyelocalyceal dilatation. Gynaecological clinical exam exhibited a large violaceous mass about 4 cm with anterior and right vaginal wall infiltration. The hypophysis was primary cervical cancer stage IV. The biopsy revealed a massive infiltration of immature myeloid cells with the expression of anti-ERG and myeloperoxidase antibodies. The immunophenotypic analysis of the bone marrow aspirates showed the patient still had a complete remission with minimum residual disease (MRD) negative and a variable number of tandem repeats (VNTR) with full donor chimerism. The patient started chemotherapy with a hypomethylating agent and BCL-2 inhibitor Venetoclax.

Conclusion

Decision making on the treatment of cervical MS is challenging due to the absence of gynaecological classification guidelines. In patients in this age group with no offspring, the choice of therapy should consider the fertility issue. Finally, MS should be a differential diagnosis in a patient with a uterine mass and a previous medical history of AML.