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

She had done segmental resection of the anterior rectum with no success. 2 weeks later she had the trial of cystoscopic ureteric JJ stent insertion as a consequence of anatomical variation of the ureter. Proper function of the bowel and the ureter 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 in the case of deep infiltrating endometriosis (DIE). The result of the surgery was complete realising from the pain was huge success of the surgery.

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 vesicle. She had the trial of cystoscopic ureteric JJ stent insertion prior to planned surgery with no success. 2 weeks later she had done laparoscopic segmental resection of the anterior rectum with the end to endrecto- sigmoid colon anastomosis due to 6 cm nodule of the rectum, the intraabdominal insertion of the JJ stent to the left ureter after cutting the wall of ureter 10 cm from the bladder due to impossible JJ cystoscopical 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 uretero-bladder 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 the bowel 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 tailorsurgery 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.

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.
neoplasma in appendix and adenomyosis of the ureters. 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 both tailored and radical surgery in DIE and early stages of cancer as LAMN.

**OMENTAL FLAP AS A SPACER TO REDUCE ACUTE BOWEL TOXICITY AFTER ADJUVANT RADIOTHERAPY**

**Abstract** 2022-VA-1059-ESGO

**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.