**Introduction/Background** Minimal invasive surgery in gynecological cancer offers benefits over laparotomy in terms of fewer operative complications. There are two approaches to para-aortic lymphadenectomy: transperitoneal and extraperitoneal. The transperitoneal approach offers a greater working space and familiar landmarks, but sometimes requires bowel mobilization. The advantages of the extraperitoneal approach include operative feasibility in spite of previous abdominal surgery, decreased risk of direct bowel injury, and bowel adhesion formation. The disadvantages are a small working space, limited landmarks, and the risk of becoming disoriented. The use of some techniques to increase the surgical field may be helpful by making surgery easier and faster.

**Methodology** We present a video with four surgical techniques to improve the viewing area in extraperitoneal para-aortic lymphadenectomy.

**Results** Accessory trocar for instrument insertion to raise the upper peritoneum in the form of a tent. Placement of a clamp on the umbilical trocar placed in the peritoneal cavity to facilitate the outflow of CO2 to allow further distension of the retroperitoneal area. Pneumatic balloon or Foley catheter can be placed to prevent the escape of CO2 into the intraperitoneal space in case of accidental opening of the peritoneum during entry into the retroperitoneal field. For advanced surgeons, node dissection can be performed with an advanced sealing instrument with one hand while the other hand is used to lift the upper peritoneum in a tent to increase the working space.

**Conclusion** Laparoscopic para-aortic lymphadenectomy is a procedure with technical difficulties. The most important and basic requirements for appropriate lymphadenectomy are a correct surgical field development and a precise knowledge of anatomy to prevent accidental injuries. The use of some tricks can help to improve the surgical field to facilitate the surgical procedure.

**SONOGRAPHIC ASSESSMENT OF FEATURES SUSPICIOUS OF UTERINE SARCOMA: EVALUATION OF THEIR USE IN PREOPERATIVE PREDICTION OF MALIGNANCY**

1. Alexandra M Knipprath-Mészáros, 1Alessandra Tozzi, 2Annkatrin Butenschoen, 1Huberta Reina, 3Andreas Scharzau, 1Viola Heinzlmann-Schwarz, 2Gwendolin Manegold-Brauer. 1Gynecological Cancer Center, University Hospital Basel, Basel, Switzerland; 2Department of gynecologic ultrasound and prenatal diagnostics, University Hospital Basel, Basel, Switzerland; 3Ovarian Cancer Research, Department of Biomedicine, University Hospital Basel, Basel, Switzerland

**Methodology**

\[ \text{SPS} = 1 \times (\text{rapid growth} + \text{irregular borders} + \text{ovoid mass}) + 0.5 \times (\text{high blood flow} + \text{disorganization}) + 0 \times \text{other} \]

**Results**

- **Sensitivity:** 93.75%
- **Specificity:** 99.8%
- **PPV:** 57.7%
- **NPV:** 97.9%

AUC was 0.95. The most common sonographic criteria leading to a false positive score in myomas were rapid growth and high blood flow. For the detection of sarcoma/mesenchymal tumors, a threshold of >1, sensitivity was 93.75%, specificity 97.9%, PPV and NPV 57.7% and 99.8%, respectively. The AUC was 0.95.

**Conclusion** The use of the SPS could help to distinguish between myomas and sarcomas, with a high probability of benign histology if the score is negative. A higher risk of malignancy is given when \( \geq 1 \) criteria are present in postmenopausal women. For premenopausal women, rapid growth and high blood flow may lead to false positive scores; a score \( \geq 2 \) increases accuracy. We suggest the use of the SPS in the triage of patients with suspected myometrial lesions.