Methods Patients with histologically confirmed H-SIL and/or VIN 2–3 will be treated with Pembrolizumab 200 mg flat dose every 3 weeks for 5 cycles. Within 4 weeks from the last Pembrolizumab administration patients will be submitted to surgical conization (either cold knife conization or LEEP) and/or partial or radical vulvectomy. During the screening phase patients will receive blood and stool specimen’s collection. Genotyping for HPV will be performed at baseline, surgery and at safety follow up visit.

Results Trial in progress: there are no available results at the time of submission.

Conclusions Trial in progress: there are no available conclusions at the time of submission.

Surgical films

Surgical session: Video highlights

FF001/#573 NEAR-INFRARED ANGIOGRAPHY FOR ASSESSMENT OF RECTOSIGMOID ANASTOMOSES IN GYNECOLOGIC SURGERY

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Introduction Rectosigmoid resections are frequently needed to achieve complete disease clearance during surgery for ovarian cancer. A severe complication from rectosigmoid resections is anastomotic leakage. Near infrared angiography (NIR) has been introduced to assess perfusion of vascular pedicles. Given the interest in usage of NIR to evaluate perfusion during rectosigmoid anastomoses, we have put together an instructional video demonstrating the setup and usage of this technology.

Description Intraoperative setup for NIR will require a PINPOINT endoscopic fluorescence imaging system including a 10 mm laparoscope, a PINPOINT rigid scope introducer, and 25 mg of indocyanine green (ICG) dye. After the segment of colon with disease is isolated and divided, perfusion is tested in the proximal limb by injecting 5 mL of the reconstructed ICG intravenously, allowing one minute for the dye to mobilize, and visualizing the bowel with the 10 mm laparoscope. A perfusion defect is identified, and the decision is made to further resect the segment of bowel without perfusion. After this step, the trimmed proximal limb is brought down to the pelvis and anastomosed with the distal limb. Perfusion is tested after anastomosis by bringing placing the PINPOINT rigid scope introducer over the 10 mm laparoscope and introducing the scope through the anus until the anastomotic ring is identified. 5 mL of ICG is re-injected. Perfusion is tested again and found to be adequate.

Conclusion/Implications Assessment of rectosigmoid anastomoses performed for gynecologic surgery using NIR with ICG is feasible, can be performed without the need for numerous additional instruments.
Radical trachelectomy with LEER is a feasible treatment option for locally advanced cervical cancer. We performed type C1 parametrectomy with mesometrial resection while preserving uterine artery on the right side and LEER on the left side during radical trachelectomy after neoadjuvant chemotherapy. Due to her strong desire for fertility, we conducted radical trachelectomy with LEER. After neoadjuvant chemotherapy using five cycles of weekly cisplatin, left PM remained despite LNM regression. We record all SLNB in our unit for quality assurance and training purposes. We review these videos for unanticipated challenges during identification of sentinel lymph nodes, especially when undertaken with microscopic examination and immunohistochemical staining. Prospective trials and a meta-analysis have found that the SLNB with indocyanine green has a high sensitivity and low false negative rate for the detection of pathological lymph nodes. This surgical video clip provides specific steps of pelvic and para-aortic SLN mapping. In this video, we demonstrate how to easily apply a reversible Pringle maneuver with daily use resources. A xifo-pleural incision was performed for cytoreductive procedure, exposing the entire abdominal cavity. After identification of the epiploic (or Winslow) foramen, from lateral to medial, the lesser omentum was sectioned to safely access the portal triad. A Foley catheter, without the connection extremity, was inserted posterior to the hepatoduodenal ligament structures. A loop with the tip of the catheter passed through the lateral opening offers an adequate tourniquet for intermittent blood supply interruption, at the end of the procedure the tourniquet is relieved by pulling the loose end through the catheter opening. The second Pringle maneuver was performed with a laminar drain and a segment of a catheter, clipped with a vascular clamp. Both techniques can be applied by laparoscopy, and are detailed in another video.

Conclusion/Implications This video demonstrates the useful Pringle maneuver, performed with simple and reproducible technique.