Conclusion/Implications It is vital for surgeons to completely and systematically inspect pelvic lymphatic channels to identify sentinel lymph nodes in endometrial cancer patients to ensure accurate staging. Video footage and still photographs were gleaned from unedited surgical films recorded at our institution and from institutional artists’ illustrations. Patients with early-stage uterine cancer, undergoing laparoscopic staging surgery using intracervical dye for SLN mapping, were included.

Surgical session: Best oral film submissions

**FF006/#223**

RADICAL CYTOREDUCTIVE SURGERY OF THE UPPER ABDOMEN FOR ADVANCED OVARIAN CANCER

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Introduction Volume of residual disease following cytoreductive surgery for patients with advanced ovarian, fallopian tube, and peritoneal carcinoma is one of the most important factors for overall survival. Extensive upper abdominal resections was not initially part of the surgical armamentarium of advanced ovarian cancer management for Gynecologic Oncologists. Large-volume upper abdominal tumor involving the diaphragm, liver, and/or spleen was deemed ‘unresectable,’ and the patient was left with suboptimal residual disease. The incorporation of upper abdominal comprehensive surgical techniques has led to a significant improvement in optimal cytoreduction rates, and ultimately improved progression-free and overall survival.

Description In this film we demonstrate the steps of open abdominal radical debulking surgery for high-grade ovarian carcinoma including a splenectomy, pancreatectomy, and full thickness diaphragm resection with excision of a cardiophrenic lesion. We also demonstrate potential complications as well as strategies to repair and limit these.

Conclusion/Implications This surgical film demonstrates the feasibility and techniques involved for performing a splenectomy, pancreatectomy, and full thickness diaphragm resection with excision of a cardiophrenic lesion. Additionally, we demonstrate strategies to limit and manage post-operative complications associated with these surgeries. We hope this video will provide physicians with tools to incorporate into their practice in order to improve outcomes for their patients.

**FF008/#1092**

USE OF MODIFIED FASCIOCUTANEOUS MARTIUS FLAP FOR VAGINAL RECONSTRUCTION: A CASE REPORT

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Introduction The vaginal morbidity caused by radical surgeries and, or radiotherapy is a significant distress cervical cancer treatment-related. Developing techniques that can reestablish sexual function is essential for providing a better quality of life for those patients.

Description The purpose of this video is to highlight a robotic-assisted modified Martius fasciocutaneous flap technique for vaginal reconstruction. A 27-year-old patient, FIGO IIIC1 cervical carcinoma referred for concurrent platinum-based chemoradiation and treated successfully. After treatment, she developed severe vaginal stenosis becoming unable to have vaginal sexual intercourse. Five years later, she underwent vaginal reconstruction using two simultaneous approaches—an abdominal robotic total hysterectomy with bilateral salpingooophorectomy and total colpectomy. Perineal access was used to make a modified Martius fascio-cutaneous flap to create the neovagina. The distal portion of the neovagina was attached to the remaining urovaginal ligaments robotically. The surgery took 4 hours and the patient was discharged from hospital on the next day. She recovered well and in the follow up visit, the measurement of the neovagina was 9 cm. She successfully had sexual relations with penetration 6 months after the procedure.

Conclusion/Implications The primary purpose of this video article is to demonstrate the step by step technique of the modified Martius fasciocutaneous flap as an alternative vaginal reconstruction for patients with severe vaginal stenosis after being treated with radiotherapy or radical primary surgical procedure. This technique is relatively simple and has minor morbidity, allowing the gynecologist to restore the patient’s sexual function without engaging other types of specialists in the procedure.

**FF009/#275**

ROBOTIC RADICAL HYSTERECTOMY WITHOUT UTERINE MANIPULATOR OR VAGINAL TUBE

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Introduction The purpose of this study is to introduce robotic radical hysterectomy with tagged uterine suture instead of using a uterine manipulator or vaginal tube.

Description A total of 4 ports were used; first port was located left at 8 cm from umbilicus, second port was 20 mm sized at umbilicus, third port was located right at 8 cm from umbilicus, and fourth was located right at 8 cm from the third port (near the right flank). Uterus was tied with needle-straightened multifilament Vicryl 2–0 and tagged uterus was manipulated by fourth arm of the robot. If additional traction is required, instrument was inserted though the umbilical trocar site. During operation, the tagged uterus was successfully manipulated and appropriate parametrical space was exposed. Pathologically, all surgical margins were not involved with cancer. No tumor cells were seen in cytologic exam before and after the colpotomy.

Conclusion/Implications Robotic radical hysterectomy can be easily and safely done with the traction of tagged uterine suture.