MULTIDISCIPLINARY APPROACH FOR ROBOTIC REPAIR OF RECTOVAGINAL FISTULA IN A PATIENT WITH HISTORY OF RECTAL CANCER AND FAILED PREVIOUS ENDOSCOPIC REPAIR

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Introduction This is a 65-year-old female with history of invasive rectosigmoid adenocarcinoma status post low anterior resection complicated by anastomotic dehiscence and pelvic abscess. She underwent sigmoidoscopy with closure of dehiscence with Endo suture. Patient was asymptomatic for 3 years when she presented with rectovaginal fistula, status post failed attempted sigmoidoscopy with Endo suture.

Description Under general anesthesia first cystoscopy was performed and ureteral catheters were placed and indocyanine green was injected for identification of the ureters. Uterine manipulator with cup was placed to assist in identification of the rectovaginal space. Laparoscopic portion of the operation started with mobilization of the omentum from the hepatic flexure for later use. Using the images technology ureters were identified and proceeded with posterior cul-de-sac dissection to identify the fistula tract. After the fistula tract was identified, surgical clips and sutures from previous failed repair were removed. The rectovaginal space was fully developed and necrotic and nonviable tissue from the vagina and rectal edges were completely removed. Placement of the uterine manipulator in the vagina and the rectal sizer in the rectum facilitated identification of these two organs better. The vagina was closed transversely with one layer of 0 barb sutures and rectum was close in two layers. Finally, mobilized omentum was brought down and placed and secured between the rectum and vagina.

Conclusion/Implications Patient had no complication intraop and postop and was discharged home on postop day 2. She was seen 2 and 6 weeks postop with no fistula recurrence and is doing well.

On-demand surgical film cinema: Breast cancer

ICG FIRE FLY BASED SLNB SENTINEL NODE FOR CARCINOMA BREAST USING HAND HELD ICG FLOURESCENCE PROBE: NEW TECHNIQUE LYMPHA

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Introduction SLNB is standard of care in Early Breast cancer. Traditionally dual technique, using Radiocolloid and hand held gamma probe and Blue dye is used. Disadvantage is its expensive and cumbersome and need for mandatory dependency on nuclear medicine department is requiree and its not dynamic imaging but static. so Low energy resource setting countries cannot use it. So hand held ICG fluorescence imaging probe and ICG SLNB for breast cancer is cost economical and easy and no need for nuclear medicine department and easy to replicate and dynamic imaging per op LYMPHA surgery to prevent lymphoedema.

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Conclusion/Implications This video shows technique of ICG fluorescence SLNB for breast cancer and primary LVA Lympho venous anastomosis LYMPHA using hand held ICG probe.

SF002/#87 SINGLE-SITE LAPAROSCOPIC RADICAL TRACHELECTOMY WITHOUT A UTERINE MANIPULATOR

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Introduction Report regarding single-site laparoscopic radical trachelectomy (RT) is still absent at the present stage, for which the feasibility and safety of this surgery remains a question. We herein introduce the single-site laparoscopic RT without a uterine manipulator for a nulligravida patient with early-stage cervical cancer to preserve fertility without compromising the oncology outcomes.

Description A 29-year-old woman who was diagnosed with stage IB1 (FIGO 2018) cervical cancer underwent the single-site laparoscopic (RT) plus pelvic lymphadenectomy without the manipulator. We used our expertise with single-site laparoscopic technique to perform space development as much as possible before the ligaments were resected. First, the bilateral round ligaments were sutured to form a coil, and the uterus was suspended by sutures from different directions according to the different operative requirements. Second, prior to colpotomy, a vagino-purse-string suture was formed to avoid spreading of tumor cells. The operative time was 300 minutes, and blood loss was 20 mL. No perioperative complications occurred and the residual cervix and vagina were restored to its original anatomy after 6 months. Postoperative pathological results suggested that the patient did not need radiotherapy or chemotherapy. So far, the surgical scar becomes invisible and the patient has resumed normal menstruation and sexual life.

Conclusion/Implications Single-site laparoscopic RT plus pelvic lymphadenectomy without the manipulator should be deemed as a safe and feasible therapeutic option for patients with early-stage cervical cancer for fertility preservation. More cases shall be in place to better evaluate the postoperative efficacy and pregnancy outcomes of such procedure to a further step.