Description A 34-year-old IB1 FIGO stage squamous cell cervical cancer underwent a combined robotic laparoscopic-vaginal radical trachelectomy with enclosed colpotomy and without manipulator. After spontaneous pregnancy, she underwent a laparoscopic free needle cerclage. The pregnancy progressed with preterm amniotic membranes rupture and fetal loss at 19 weeks. Another spontaneous pregnancy occurred and an elective abdominal cerclage with Mersilene double suture by robotic-assisted laparoscopic technique was done. Ultrasonographically, the internal os, the endocervix, and the gestational sac were maintained under visualization throughout the procedure. At the same time, two robotic needle holders drove two needles symmetrically, passing from the posterior to the anterior portion of the cervical isthmus junction perpendicularly to the uterine axis and a blockage suture sequencing knots were made on the remaining cervix. Another identical suture was performed caudally. At 31 weeks, asymptomatic premature cervical dilatation was noted, and the patient was hospitalized. C-section was performed at 33 weeks and two days, and a healthy male infant was born.

Conclusion/Implications The cervix is a fundamental structure for the development and the maintenance of a pregnancy. Different from patients with cervical incompetence, where there is data sustaining cervix cerclage, the literature is poor on the maintenance of pregnancy in post-trachelectomy patients. This was a case report of a favorable evolution of pregnancy after cerclage in a patient with surgical removal of the cervix as cancer treatment.

On-demand surgical film cinema: Ovarian cancer

SF014/#934 USEFUL TIPS FOR A SAFE DIAPHRAGMATIC PERITONEAL STRIPPING

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Introduction A complete cytoreductive surgery significantly impacts prognosis for ovarian cancer patients. Peritoneal stripping is a key step to achieving complete macroscopic resection in the upper abdomen. To describe this technique, the literature is scarce and the training centers are limited.

Description In this video, our patients were placed in a low lithotomy position, with a xifo-pubic incision, under general anesthesia. All patients received pre-operative physiotherapy and nutritional support. The liver lobes were mobilized (described in another video*), and the margin between normal and involved peritoneal surface was marked with monopolar energy. It is important to identify the avascular plane between the diaphragmatic muscle and the affected peritoneum. Entering the muscle is indicated only if there is muscle infiltration by macroscopic tumor. Allis or Collin clamps supported manual traction to the borders of the peritoneum, while the liver is retracted medially. A small rounded surgical sponge may be used to push the muscle off the peritoneal surface (blunt dissection), reducing the need for monopolar energy. When the Morison pouch is involved, the same principles may be applied. For the left diaphragmatic stripping, the left lobe is mobilized, and the infiltrated peritoneum is similarly removed.

Conclusion/Implications This video demonstrates some useful tips to achieve a complete cytoreductive procedure that includes hepatorenal pouch, and right and left diaphragmatic peritoneal stripping.

SF015/#341 SECONDARY LAPAROSCOPIC CYTOREDUCTION FOR RECURRENT OVARIAN CANCER IN CASE OF LAPAROSCOPIC PRIMARY DEBULキング SURGERY

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Introduction To investigate the feasibility of laparoscopic secondary cytoreduction in patients with recurrent ovarian cancer with previous laparoscopic primary debulking surgery

Description Patients: A 52-year-old Korean woman underwent laparoscopic secondary cytoreduction for recurrent ovarian cancer and previous laparoscopic primary debulking surgery

Interventions: Laparoscopy Measurements/Results: A 52-year-old Korean woman had a laparoscopic primary optimal debulking surgery. The FIGO stage IIIIC was confirmed and she received 12 cycles of paclitaxel/carboplatin chemotherapy. Since then, it had been checked as NED state for 6 months. During follow up, lab results showed elevation of CA125, and recurrence was confirmed by PET-CT imaging. We performed LAVH with BSO, CDS mass excision, pelvic and para-lymphadenectomy during primary debulking surgery. In addition, diaphragm and omentectomy were performed. She received adjuvant chemotherapy with paclitaxel/carboplatin for 12 cycles. We performed the laparoscopic secondary cytoreductive surgery on November 28, 2017. Peritoneal cavity and diaphragm were clear and showed no metastatic nodule. Metastatic lymph nodes were confirmed along the left iliac vessels seen in the previous PET-CT imaging and we resected them. What was seen as recurrence around right para-olic gutter area were metastatic nodule on the cecum surface. We removed the nodules and repaired the bowel serosa. She is receiving chemotherapy with stable disease at this time.

Conclusion/Implications Our experience indicate that laparoscopy is a feasible and safe approach to optimal cytoreduction for patients with recurrent ovarian cancer in case of laparoscopic primary debulking surgery.

SF016/#728 ROLE OF THORACOSCOPY IN PATIENTS WITH EPITHELIAL OVARIAN CANCER AND STAGE IVA IN A DEVELOPING COUNTRY

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Introduction Ovarian cancer is the most lethal gynecologic malignancy and in 75% of cases are diagnosed in advanced...