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. Ultrasoundographically, 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

Introduction A complete cytoreductive surgery significantly impacts prognosis for ovarian cancer patients. Diaphragmatic 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.
Abstracts

stages unfortunately 30% of patients with advanced ovarian cancer present pleural effusion at the time of initial diagnosis, that has been associated with worse disease-free survival and overall survival.

Description A 48-year-old women who present a 3-month history of bloating and abdominal pain. Tomography of the abdomen and chest showing left pleural effusion with bilateral adnexal masses, peritoneal carcinomatosis and a ca 125 of 1753. The patient was given 4 chemotherapy cycles with partial imaging and serological response. Control images showed persistence of pleural effusion in the left hemithorax that was previously compromised by adenocarcinoma, so it was decided to perform left thoracoscopy to define secondary pleural involvement. The main finding during thoracoscopy is evidence of a 5 cm lesion at the level of the left diaphragmatic peritoneum with full thickness infiltration with no other lesions in pleura cavity. The patient was taken to a complete abdominal cytoreduction by laparotomy with an adequate clinical evolution pending the restart of chemotherapy.

Conclusion/Implications It is important that metastatic involvement of pleural effusion has a high correlation with pleural involvement. The main prognostic factor for overall survival in ovarian cancer is complete cytoreduction, not why we must establish the areas affected by this neoplasm and define the possibility of undergoing surgery. Video assisted thoracoscopy is a low-morbidity procedure that allows us to evaluate pleural and mediastinal involvement in patients with pleural effusion.

SF018/#345 LAPAROSCOPIC RESTAGING SURGERY FOR OVARIAN CANCER MIMICKING A PARASITIC MYOMA DISCOVERED DURING LAVH FOR UTERINE ADENOMYOSIS AFTER HIFU

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10.1136/ijgc-2022-igcs.578

Introduction To present laparoscopic restaging surgery for ovarian cancer mimicking a parasitic myoma discovered during LAVH for huge uterine adenomyosis after HIFU.

Description A 49-year-old Korean woman with severe dysmenorrhea and abnormal uterine bleeding to our department. She had received High intensity focused ultrasound (HIFU) for adenomyosis six years ago. Pelvic MRI showed typical adenomyosis feature with huge uterus with ill-defined myometrial lesion. We planned to perform laparoscopically assisted vaginal hysterectomy on September 13 2021. We discovered small mass mimicking parasite myoma on right paracolic gutter. After hysterectomy, we removed the myoma like mass and the mass was sent frozen section histological analysis revealed a diagnosis of serous carcinoma. We performed abdominal exploration and washing cytology. Additionally, we discovered small tumor nodules on both ovarian surface covered by huge adenomyoma. We finished the initial surgery to do baseline study for ovarian cancer. We performed the laparoscopic restaging surgery for ovarian cancer after baseline study on September 30, 2021. The FIGO stage IIIIC was confirmed based on the final histopathological result.

Conclusion/Implications Laparoscopic restaging surgery for ovarian cancer mimicking a parasitic myoma discovered during LAVH for huge uterine adenomyosis after HIFU was safe and successful.

SF019/#1087 LAPAROSCOPIC STAGING FOR OVARIAN CANCER

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10.1136/ijgc-2022-igcs.579

Introduction Exploratory laparoscopy is an essential step for surgical staging in advanced ovarian cancer. With two objectives: -to determine the best therapeutic strategy by evaluating the possibility of primary debulking surgery -to perform biopsies to confirm the diagnosis and to allow molecular analysis. We propose a step by step video about laparoscopic staging in advanced ovarian cancer.

Description We present a step-by-step laparoscopic exploration of the abdominal cavity for staging in advanced ovarian cancer, using Peritoneal Carcinomatosis Index, areas by areas. We want to show what are the pitfalls and blocking points for a primary debulking surgery.

Conclusion/Implications We wish to show how to perform a rigorous exploration of the abdomen and how to make efficient and safe biopsies for a better management of the patients in advanced ovarian cancer.

SF020/#48 TECHNIQUE OF QUADRANT WISE ULTRA RADICAL OPTIMAL CYTOREDUCTION TECHNIQUES WITH TOTAL PARIETAL PERITONECTOMY AND HIPEC FOR EPITHELIAL OVARIAN CANCER

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10.1136/ijgc-2022-igcs.580

Introduction Optimal Cytoreduction CCO is the only sure Prognostic marker of good DFS and OS thats available with Gynecological oncologist in advanced Ovarian cancer. But its not what we do in Pelvis alone that matters, but what we do and how we handle upper abdomen and diaphragm and Pontis hepatis and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonectomy and upper abdomen Optimal CRS quadrant wise to achieve Optimal CRS with HIPEC.

Description Optimal Cytoreduction CCO is the only sure Prognostic marker of good DFS and OS thats available with Gynecological oncologist in advanced Ovarian cancer. But its not what we do in Pelvis alone that matters, but what we do and how we handle upper abdomen and diaphragm and Pontis hepatis and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonectomy and upper abdomen Optimal CRS quadrant wise to achieve Optimal CRS. The Gliisson capsuulectomy with Diaphragm resection and Mesentric stripping and managing Pontis Hepaticus and Pouch of Douglucosectomy and retro grade hystrectomy, and then HIPEC.

Conclusion/Implications We have done over 500 advanced ultra radical surgery with HIPEC and 1100 ultra radical upper abdominal CRS without HIPEC and morbidity and and mortality is standardised after learning curve of 70 cases with these technique of Ball Point caurugi with 90 setting spray.