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 to mention that metastic involvement of pleural effusion has a high correlation with pleural involvement. The main prognostic factor for overall survival in ovarian cancer is complete cytoreduction, that’s 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 ADENOMYSIS AFTER HIFU**

Joong Sub Choi*, Jeong Min Eom, Un Suk Jung, Jaeman Bae, Won Moo Lee, Yeon Kyung Kim. HANYANG UNIVERSITY COLLEGE OF MEDICINE, Obstetrics and Gynecology, SEOUL, Korea, Republic of

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**

1Léa Pauly*, 2Fabien Reyal, 1Enora Laas, 1Jean Guillaume Feron, 1Virginie Fourchotte, 1Fabrice Leaunou. 1Institut Curie, Paris, Paris, France; 2Institut Curie, Department of Surgery, Paris, France

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**

Sp Somashekhar*. Manipal Comprehensive Cancer Centre, Gynec and Surgical Oncology, Bangalore, India

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 hepati and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonecotmy 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 hepati and upper abdomen disease that translates to good OS. This video shows systematically the surgical technique of Peritonecotmy and upper abdomen Optimal CRS quadrant wise to achieve Optimal CRS, the Glisson capsulectomy with Diaphragm resection and Mesentric stripping and managing Pontis Hepaticus and Pouch of Douglaslecomy and retro grade hysterectomy, 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 caurgy with 90 setting spray.
mode and systematic quadrant wise approach to high PCI ca ovarian cases. this video shares this technique in this.

On-demand surgical film cinema: Rare tumors

SF021/#1115
RECURRENT EXTRAMAMMARY PAGET’S DISEASE OF THE VULVA WITH PERIURETHRAL AND ANAL INVOLVEMENT

1Romelyn Impero-Onglao*, 2Jericho Thaddeus Luna. 1University of the Philippines, Manila – Philippine General Hospital, Obstetrics and Gynecology, Manila, Philippines; 2University of the Philippines, Manila – Philippine General Hospital, Obstetrics and Gynecology, Metro Manila – Manila, Philippines

Introduction Extramammary Paget’s disease (EMPD) of the vulva is a rare neoplasm that usually arise from the apocrine gland bearing areas with high rates of recurrence. We report a case of a 67-year-old female who previously underwent wide excision of primary EMPD five years prior. The lesions recurred four years after, and showed a 14 by 18 cm erythematous lesion with red patches and plaques. ‘Cake-icing appearance’ of the lesion spread from 2 cm above the urethral meatus up to 3 cm below the anal opening, to the right genitocrural fold and 3 cm from the left genitocural fold. A wide excision involving distal urethrectomy, partial vulvectomy, anal mucosectomy with split-thickness skin grafting and sigmoid loop colostomy was done.

Description A 2-centimeter margin was obtained around the lateral extent of the lesions. The incision involved a depth of 1 cm of subcutaneous tissues. The distal urethra was excised en bloc with the skin lesions including a 1-cm margin of anal mucosa. Following mucosectomy, the anal mucosa was then mobilized and pulled towards the external anal sphincters, to which it was anchored using circumferential interrupted Vicryl 3–0 sutures. Frozen section was done to check for adequacy of margins. It noted involvement at the 7 o’clock position of the anal mucosa, hence additional mucosa was excised. Laparoscopic sigmoid loop colostomy was performed followed by Split thickness skin grafting.

Conclusion/Implications Wide local excision remains the mainstay treatment of EMPD. Positive margins may not be associated with recurrence or overall survival; limiting the resection margins may be considered.

On-demand surgical film cinema: Surgical techniques and perioperative management

SF022/#737
HUDSON POSTERIOR EXENTERATION, WITH THE USE OF ICG FLUORESCENCE TO ASSESS COLORECTAL ANASTOMOSIS AND URETERAL INTEGRITY

1Dong Bach Nguyen*, 1Sara Forte, 2Andrew Zakhari, 1Beatriz Navarro Santana, 1Laurence Bernard, 1Frédéric Guyon. 1Institut Bergonié, Gynécologie Oncologie, Bordeaux, France; 2McGill University Health Centre, Obstetrics and Gynecology, Montreal, Canada

Introduction The surgical approach to hysterectomy for ovarian cancer has remained largely unchanged since Hudson described the en-bloc resection of fixed ovarian tumors using a retrograde technique in 1968. When a colorectal resection is required for optimal debulking, anastomotic leak remains a significant concern. While the traditional techniques used to evaluate for anastomotic perfusion lack accuracy, data from a recent systematic review and meta-analysis favours the use of ICG intra-op to reduce the incidence of anastomotic leak and associated need for re-intervention.

Description The video aims to present the surgical steps to a Hudson procedure with colorectal resection, ending with the use of ICG fluorescence to assess the perfusion of the colorectal anastomosis and ureters. The surgical approach can be summarized in the following ten steps: (1) retroperitoneal dissection of the vascular pedicles and ureters, and transection of the IP ligament; (2) dissection of the paravesical and pararectal spaces; (3) lateral and pre-vesical peritonectomy; (4) ureterolysis and transection of the ureterine vessels; (5) transection of the vesicouterine and uterosacral ligaments; (6) colpotomy; (7) mesorectal dissection and distal rectal transection; (8) proximal rectosigmoid transection; (9) vaginal vault closure and colorectal anastomosis; (10) assessment of colorectal anastomosis and ureteral vascularization by ICG fluorescence.

Conclusion/Implications This video presented 10 reproducible steps to perform a Hudson procedure with colorectal resection for ovarian cancer. The use of ICG as an adjunct to assess the vascularization of the colorectal anastomosis appears to reduce the risk of anastomotic leak in colorectal surgery, and may be of interest in gynecologic-oncologic surgery.