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On-demand surgical film cinema: Rare tumors

RECURRENT EXTRAMAMMARY PAGET’S DISEASE OF THE VULVA WITH PERIURETHRAL AND ANAL INVOLVEMENT

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10.1136/ijgc-2022-igcs.581

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 genitocrural 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 lesion. 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

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

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10.1136/ijgc-2022-igcs.582

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 ureteric vessels; (5) transection of the vesicouterine and uterosacral ligaments; (6) colpotomy; (7) mesocolic 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.

SURGICAL TECHNIQUE OF TOTAL MESOMETRICAL EXCISION FOR CERVICAL CANCER

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10.1136/ijgc-2022-igcs.583

Introduction Total mesometrial excision is a surgical technique used for compartmental excision of mesometrium combining the radicality in the clearance of nodes and preserving the hypogastric plexus of nerves. This technique is indicated in the surgical treatment of early cervical cancers.

Description This surgical film demonstrates the technique of total mesometrial excision of cervical cancers. The operation begins with retroperitoneal access, pelvic lymphadenectomy, dissection, and clearance of vascular and ligamentous mesometrium while preserving and safeguarding the ureter. This operation also includes the clearance of second echelon nodes from pre-sacral and common iliac nodal basins.

Conclusion/Implications Total mesometrial excision involves the development of embryological planes around the Mullerian compartment with adequate clearance of paracervical and para-aortic lymph nodes for appropriate surgical management of cervical cancer. Adherence to the surgical principles and replication of classic techniques can minimize the morbidity associated with the radicality of the operation.