STANDARDIZED EN-BLOC LYMPHADENECTOMY
FOCusing on Vesicohypogastric Fascia

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Introduction This video aims to demonstrate a technique for safe and easy en bloc pelvic lymphadenectomy, focusing on the vesicohypogastric fascia. Our technique makes surgeons to perform safe and safe for bleeding and obturator nerve injury.

Description Dissecting the lymph node from the vesicohypogastric fascia, and external iliac vessels from the iliopsoas muscle Split adipose tissue and check obturator nerve from the medial side. Ligating external/internal inguinal nodes and the obturator artery and vein Dissecting the nodes of the levator ani muscle Dissecting the internal iliac artery and bifurcation of the internal and external iliac arteries Ligating the common iliac lymph node Dissecting from the origin of inferior gluteal vessels Dissecting the lymph node from the vesicohypogastric fascia

Conclusion/Implications Key surgical concepts are that first, dissection of the medial and lateral borders, checking the obturator nerve on the caudal side, and dissection of the iliac artery bifurcation at late lymphadenectomy stages. Under the bifurcation, under the origin of obturator artery, there are lumbosacral trunk, gluteal vein. We should be conscious about these structures to avoid injury. Vesicohypogastric fascia is used as ‘natural retractor’ for lymphadenectomy in minimally invasive surgery.

LAPAROSCOPIC TYPE II RADICAL HYSTERECTOMY WITH LYMPHADENECTOMY FOR HIGH RISK ENDOMETRIAL CANCER: APPRECIATION OF DEEP PELVIC ANATOMY

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Introduction Use of laparoscopic staging surgery for localised endometrial cancer requires a thorough knowledge of the deep pelvic spaces. This gains more importance for cases with variant and uncommon pathology with variable involvement of parametrium.

Description This video vignette highlights a smooth conduct of a similar staging procedure and focusses on the principles of total meso-metrial excision for high risk endometrial cancer. Our patient is a 62 years lady presented with post-menopausal vaginal bleeding. Endometrial biopsy showed a poorly differentiated carcinoma. Staging MRI showed disease limited to uterus with suspicious extension into parametrium. She underwent Laparoscopic Type II radical hysterectomy with bilateral pelvic lymphadenectomy and para-aortic lymph node sampling. Specimen was retrieved via vaginal route. Total blood loss was 300 mL. Patient was discharged on post-operative day 3. Histopathology report showed serous carcinoma of the endometrium with free margins and no metastases to pelvic and retroperitoneal lymph nodes. Standardized conduct of an adequate staging surgery for endometrial cancer includes sequential conduct of the following steps: Total mesometrial excision with bilateral pelvic lymphadenectomy. Dissection of the round ligament and infundibulo-pelvic ligament. Dissection of lateral para-vascular space and obturator space. Dissection of medial para-vascular space. Dissection of uterine artery at origin from internal-iliac artery. Dissection in Mackenrodt’s tunnel. Vaginal cut & Specimen delivery. Vault closure. Para-aortic lymph node dissection. Infra-colic omentectomy (as indicated)

Conclusion/Implications Orientation to anatomy of the deep pelvic spaces helps in a systematic conduct of a technically challenging procedure.

DECOMPRESSION TECHNIQUE IN A LARGE OVARIAN CYST ASSUMED TO BE BENIGN: A SURGICAL APPROACH

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Introduction Ovarian neoplasms are common gynecological problems affecting females of all ages. Rapidly growing masses with malignant potential require surgical management. Avoiding the leakage of cystic contents for tumors has become a challenge. Therefore, exploratory laparotomy has been the most common surgical method to minimize the risk of spillage and intraperitoneal seeding in cases of possible malignancy. However, large incisions are prone to infection, dehiscence, prolonged hospital stay, and patient recovery. As such, mini-laparotomy through decompression of ovarian neoplasms has been done. This is a case of a 33-year-old nulligravid who sought consult due to increasing abdominal girth of five months with associated bloatedness and early satiety. Ultrasound showed an ovarian mass measuring 27.43 x 23.36 x 11.71 cm with 1B and no M features by IOTA rules. The surgical plan was to do controlled decompression with limited tissue manipulation and tumor spillage using Dermabond Advance.

Description An intraumbilical incision was done to expose the tumor surface. Dermabond was applied on an avascular area where a sterile glove was applied. A small incision was made at the base of the glove, adherent to the tumor, draining and collapsing the cyst, preventing spillage of tumor contents. Once the tumor was decompressed, it was exteriorized with the glove still attached. Left salpingo-oophorectomy was performed thereafter.

Conclusion/Implications Our procedure provides further evidence of the safety and feasibility of spillage-free surgical techniques. Given the rarity of these conditions, other studies and cooperation among specialized centers are essential to define treatment standards.

LAPAROSCOPIC HUGE METASTATIC LYMPH NODE DISSECTION VIA RETROPERITONEAL SPACE

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Introduction This case is stage IIIA1(ii) ovarian cancer, and when retroperitoneal lymph node dissection is performed,