STANDARDIZED EN-BLOC LYMPHADENECTOMY FOCUSING ON VESICOHYPOGASTRIC FASCIA

Kenzo Chikazawa*, Ken Imai, Ryo Konno. Jichi Medical University Saitama Medical Center, Obstetrics and Gynecology, Saitama, Japan

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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 make surgeons to perform simple 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 ▪ Dissecting the vascular sheath of external iliac vessels ▪ Split adipose tissue and check the obturator nerve from the medial side ▪ Ligate 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

Swapnil Patel*, Amar Prem, Durgatosh Pandey, MPM/MCC and HBCH, Tata Memorial Centre, Department of Surgical Oncology, Varanasi, India

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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-vesical space and obturator space Dissection of medial para-vesical space Ligation 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.

LAPAROSCOPIC HUGE METASTATIC LYMPH NODE DISSECTION VIA RETROPERITONEAL SPACE

Geonwoo Lee*, Chungnam National University Hospital, Obstetrics and Gynecology, Daejeon, Korea, Republic of

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Introduction This case is stage IIIA1(ii) ovarian cancer, and when retroperitoneal lymph node dissection is performed,
Eventual resection of liver implants becomes an essential knowledge for the surgical treatment of ovarian cancer.

**Description** This video demonstrates surgical techniques using current surgical equipment for hepatic lobes mobilization, and access to the entire liver for non-anatomical resections. Initial mobilization of the right and left hepatic lobes is demonstrated, with division of the triangular and coronary ligaments. The falciform and the round ligaments are common sites of neoplastic involvement, and to reduce umbilical vessels bleeding, ligation of the round ligament was useful. After mobilization, we demonstrate the resection of Glisson’s capsule implants, with manual hemostatic control and field exposure.

Non-anatomical liver resections may benefit from an adequate vascular control of the hepatic hilum with a Pringle Maneuver. Manual and/or traction with stitches improve exposure for a nodule resection. Hemostasis was performed with Argon Beam energy (2,3). Surgical technique during laparoscopic resections is comparable, and in this video we used Ultrasonic scalpel with an active suction device exposure. Larger ducts and blood vessels should be clipped and ligated, and application of an hemostatic agent. Drainage was not indicated.

**Conclusion/Implications** This video demonstrates reproducible standardized surgical techniques with simple materials for non-anatomical liver resections during ovarian cancer upper abdominal cytoreduction.