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 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 ilioisposas 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

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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 Ligation of uterine artery at origin from internal-iliac artery Dissection in Mackenroths’ tunnel Vaginal cut & Specimen delivery Vault closure Para-aortic lymph node dissection Infra-coolic 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, minimally invasive surgery 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,
open surgery is usually performed if the size is large. The authors want to show that successful resection can be achieved using the laparoscopic approach.

**Description** In this surgical method, before entering the abdominal cavity completely, only the peritoneum was left. The space was expanded to approach the retroperitoneal space. 4 ports were used, and advanced bipolar, articulating forceps and metal clips were used. The metastatic lymph node was present on the left side and was approached from the left side, and the area where the ureter enters the kidney did not expand. The root of the metastatic lymph node was in the space between the posterior renal vein and the anterior renal artery. After blunt dissection was performed around it, the root was ligated with a metal clip.

**Conclusion/Implications** When operating ovarian cancer, open surgery is performed if it is not in the early stage. Also, when lymph node dissection is performed, a ventral approach is used, and the bowel is lifted at this time, which may cause postoperative pain and complications.

However, if the retroperitoneal approach (side or dorsal) is performed, a sufficient field of view can be secured without directly touching the bowel, and the length of the incision can be shortened, thereby reducing complications after surgery. This surgical approach is considered to be a method that should be considered if it is any indication.

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**SF028/#694** LAPAROSCOPIC LEFT COMMON ILIAC VEIN INJURY AND REPAIR

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**Introduction** Injury to common iliac vessels is uncommon during gynecologic cancer surgery. However, resection of encasing metastatic lymph nodes will increase the risk. This video is representing a laparoscopic injury to the left common iliac vein during dissection of lymph nodes.

**Description** How to repair a vessel injury laparoscopically: – Don’t panic – Try to identify the site of injury – Chose the best angle to visualize the site of injury before starting the repair – Use prolene suture

**Conclusion/Implications** How to deal with such a challenging complication.

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**SF029/#1053** HEPATIC MOBILIZATION AND LIVER RESECTIONS DURING UPPER ABDOMINAL CYTOREDUCTIVE SURGERY IN OVARIAN CANCER

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**Introduction** Ovarian cancer is one of the most common gynecologic cancers and ranks eighth in mortality among women. More than 60% are detected in FIGO2018 stages III and IV. A complete cytoreduction is a significant prognostic factor. 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.

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**SF030/#801** ROBOTIC RESECTION OF VAGINAL ENDOMETRIAL ADENOCARCINOMA AFTER PREVIOUS HYSTERECTOMY FOR BENING DISEASE

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**Introduction** This video will show a robotic resection of a fundus vaginal adenocarcinoma after 20 years previous hysterectomy for being disease.

**Description** This video will show the technique of robotic resection of superior third of vagina tumor in a patient with 20 years before a hysterectomy for being disease.

**Conclusion/Implications** Due to the rarity of the case and the possibility of demonstrating the technique and anatomy by robotic way the video become interesting from the dactical point of view.