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.

**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.

**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.

**SF030/#801 ROBOTIC RESECTION OF VAGINAL ENDOMETRIAL ADENOCARCINOMA AFTER PREVIOUS HYSTÉRECTOMY 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 benign disease.

**Description** This video will show the technique of robotic resection of superior third of vagina tumor in a patient that had 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.

**SF031/#895 SINGLE-PORT ROBOTIC HYSTERECTOMY AFTER THE PREVIOUS TRACHELECTOMY**

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**Introduction** Radical trachelectomy is the universal treatment for patients with early-stage cervical cancer desiring to maintain fertility. The mean recurrence rate after trachelectomy is 3.3–3.7%. We demonstrated a single-port robotic hysterectomy to a patient with a history of robotic trachelectomy. The condition of the uterus and other organs, recovery status, and the difficulty of reoperation can be reviewed.

**Description** A 32-year nulliparous with recurrence of cervical cancer received the single-port robotic hysterectomy with