Description We use blue cap, hegar(13) for immobilizing uterine cervix. We use multi-articulating instrument, artisental, to move tissue in single site robotic surgery by Davinci Xi, and single port robotic surgery by Davinci SP. In both robot surgery, artisental is useful instrument to perform PLND hysterectomy without uterine manipulator.

Conclusion/Implications Using multi-articulating instrument is reasonable option to perform PLND hysterectomy without uterine manipulator by counteraction done.

SF035/#759 MANAGEMENT OF HUGE ADNEXAL CYSTADENOFIBROMA DURING PREGNANCY

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Introduction The choice of the surgical technique during pregnancy include considerations of uterine and fetal safety along with minimizing spillage technique this film will demonstrate an efficient safe surgical technique for huge cystadenofibroma during pregnancy.

Description This video describe a simple effective surgical approach to huge cyst 17 litters during pregnancy. The tips and tricks include didactic demonstration of pre-operative evaluation, minimizing spillage technique and pathological results.

Conclusion/Implications This is an efficient quick surgical solution with minimal morbidity for huge adnexal cyst during pregnancy

SF036/#1064 SINGLE DOCKING, POSITION AND SAME PORT TECHNIQUE FOR ROBOTIC PELVIC AND PARA-AORTIC LYMPHADENECTOMY IN HIGH RISK ENDOMETRIAL CANCER

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Introduction In high risk endometrial cancer after radical hysterectomy and systematic pelvic nodal dissection, para-aortic nodes dissection upto renal veins is required. If central docking is done, the arms don’t reach high par-aortic region upto renal veins, if side docking is done, it is not optimal for pelvic surgery. Most of the times, dual docking or change of position of both patient and robot is required. Intuitive recommended procedure card, ports placements fails to achieve this.

Description So we describe modified port placement enabling both pelvic and para-aortic node dissection with the description of these procedure after radical hysterectomy in our video with single docking, single position and same port placement technique

Conclusion/Implications This technique is advantages as it uses single docking and position with same ports for both pelvic and para-aortic nodal dissection, there by shortening the total time taken for the entire procedure and learning curve in the robotic surgeon.

SF037/#1072 TECHNIQUE TO AVOID SPILLAGE IN A LARGE OVARIAN MASS

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Introduction Removal of large ovarian cysts has a high risk of spillage. Various techniques have been described for benign cysts, using plastic self-retractors or a laparoscopic bag. This video highlights a technique for safely draining and removing a large ovarian mass.

Description 86 years old woman presented with abdominal distension and intraabdominal pressure symptoms for 6 months in Covid19 pandemic. She was anorexic, severely anaemic requiring blood transfusions, with severe bilateral pedal oedema. The eGFR=38. CT demonstrated a large abdominopelvis mass, with intraabdominal compression effect. A 10 cm midline laparotomy was performed. The suction tube was connected to the gas inflow valve of the 5 mm laparoscopic port. DERMABOND ADVANCED skin adhesive was applied over the external area of the bowel bag. The cyst surface was dried. Further adhesive was applied over the cyst wall, followed by the bag, and a gentle pressure for 2 minutes for a good seal. Once complete coverage was secured, the port with the suction attached was inserted. Ten litres of fluid were aspirated, an 40x20 cm cyst removed, containing 4L of bloodstained fluid.

Conclusion/Implications We recommend this technique because it is easy to perform, straightforward, and very simple in case of fluid filled enlarged ovarian cysts. The incision is small and there is a safe aspiration of the cyst contents. Patient’s recovery is fast. It can be used for benign cysts, known malignant cysts, where the dissemination is not of a concern, and in palliative cases where the performance status does not allow a more complex operation.

SF038/#1037 SPLENIC MOBILIZATION AND RESECTIONS IN CYTOREDUCTIVE SURGERY FOR OVARIAN CANCER

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Introduction More than 60% of all ovarian cancer patients are diagnosed in stages III and IV (FIGO 2018) (1). The vast majority will present upper abdominal disease, with splenic capsule, hilum or even parenchyma involvement. In this scenario, surgical techniques addressing partial or total splenectomy becomes an essential part of a complete cytoreductive surgery.

Description This video demonstrates surgical techniques using routine materials for implants resection in the spleen, including partial and total splenectomy. The combination of preoperative imaging and surgical Peritoneal Carcinomatosis Index
(PCI) evaluations may predict the precise technique indication. A posterior organ approach allows access to the splenocolic, splenophrenic, and splenorenal ligaments, which are identified and divided. Ligation of the short gastric vessels can be achieved with metallic clips or silk stitches. During a total resection due to parenchymal metastasis, dissection of the splenic hilum with ligation of the splenic artery followed by the splenic vein. We demonstrate two other cases with partial/capsular splenectomy with electrocautery and/or cold blade. Temporary clipping of the splenic vessels may be necessary for extended partial splenectomies, and will be described in another video.

Conclusion/Implications This video demonstrates reproducible standardized techniques for total or partial splenectomy in ovarian cancer cytoreduction.

**SF039/#1171** LAPAROSCOPIC POSTERIOR INFERIOR MEDIASTINAL PRONE POSITION LYMPHADENECTOMY FOR RECURRENT GYNECOLOGIC CARCINOMA

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**Introduction** There is a potential oncological benefit related to isolated recurrences surgical resection. The aim of this video is to demonstrate a prone position laparoscopic approach to posterior inferior mediastinal lymphadenectomy.

**Description** The patient had been treated for a pelvic gynecologic poorly differentiated carcinoma with a sarcomatoid component, 4 years before this salvage procedure. She had received a pelvic lymphadenectomy and a total hysterectomy. Her nodal recurrence was detected during follow-up and partially responded to platin-based chemotherapy. After a multidisciplinary discussion, surgical resection was offered. The patient was in a prone position, similar to the thoracic step for esophagectomy. Selective ventilation was followed by right side access (4 trocars). An anatomical review was performed as the pleural space was entered and the right lung collapsed with left selective ventilation. The dissection started with a mediastinal pleural dissection with regular bipolar and advanced bipolar, proximal to distal, from T10 to T12, between the thoracic aorta and the corpus vertebræ. Intercostal branches and azygos vein were preserved. All small vascular and lymphatic branches were sealed and/or clipped. The specimen was inserted into a bag and retrieved by the 12 mm incision. A thoracic drain was placed. Surgical time was 96 min, blood loss 12cc. Thoracic drain was retrieved on POD2 when the patient was discharged.

**Conclusion/Implications** The laparoscopic prone surgical approach is safe, feasible, and standardized for the thoracic/upper digestive surgeon, and should be considered for posterior mediastinal approaches. This video was presented at AAGL 2021 annual meeting.

**On-demand surgical film cinema: Vulvar and vaginal cancer**

**SF040/#1096** RADICAL LEFT HEMIVULVECTOMY, SUPERFICIAL RIGHT HEMIVULVECTOMY AND SENTINEL LYMPH NODE WITH INDOCYANINE GREEN

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**Introduction** Vulvar cancer accounts for 3–5% of malignant diseases of the female genital tract. The surgical management remains complex, because it can concern two types of patients, on the one hand elderly patients with heavy comorbidities, on the other hand younger patients with a high risk of alteration of the quality of life and sexuality.

**Description** We present the case of a 68 year-old woman, treated for a 20 mm squamous cell carcinoma of left hemivulva and high-grade vulvar intraepithelial neoplasia of left and right labia minora and clitoris. This patient is eligible for a sentinel node procedure. This surgical film shows a left radical hemivulvectomy, a right superficial hemivulvectomy and identification of bilateral sentinel lymph node with indocyanine green.

**Conclusion/Implications** Improvements like sentinel lymph node procedure in treatment of vulvar cancer contribute to the decrease of mortality and morbidity. The possibility of performing a hemivulvectomy also allows to reduce the consequences of vulvar surgery in a de-escalation strategy.

**SF041/#1128** ROBOT-ASSISTED RADICAL COLPOPARAMETRECTOMY IN VAGINAL CANCER

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**Introduction** Vaginal cancer is rare, and robotic-assisted surgical treatment is an exploratory field. The objective of this case report is to describe the robotic technique and the oncological results of a 37-year-old patient, two gravida two deliveries, who underwent a simple hysterectomy due to a persistent high-grade cervical lesion.

**Description** Three years later, she presented a high-posterior vaginal wall nodule. The colposcopy-guided biopsy revealed squamous cell carcinoma, while the MRI showed a 4.6 cm mass with no suspicious pelvic lymph nodes or lateral.