

Disclosures COI submitted where applicable.

**Introduction/Background** Predicting whether an ovarian tumour (OT) is malignant remains a challenge. Risk assessment strategies are used to select which patients with an OT should be referred to oncologic centres. However, their predictive value depends on the prevalence within a population. On hospital level, this prevalence is often known, but on a national level, these data are more difficult to obtain. Significant differences in prevalence exist between individual hospitals and single-centre study results should be generalised with caution. Therefore, we aimed to evaluate the prevalence of malignancy among surgically removed OTs and the accuracy of referral to oncologic centres in the Netherlands.

**Conclusion** Correct classification of OTs is crucial for treatment planning, patients' well-being and optimal use of health care resources. In the Netherlands, the majority of patients with early-stage OC are correctly referred. Because only 66 OCs were missed out of a total group of 6122 OTs, current risk assessment strategies generally selected the correct patients for referral. However, there is still room to improve preoperative risk assessment.

**Introduction/Background** Complete tumor resection is the most relevant prognostic factor for overall survival in high grade serous ovarian cancer (HGSOC) patients. The current



standard for classification of postoperative residual disease is surgeon's subjective evaluation at the end of surgery. Thus, a reliable objective predictive marker is currently missing.

**Methodology** In this prospective single-center study, patients with advanced HGSOE ( $\geq$  FIGO IIIA1), who underwent surgery between July 2021 and December 2022, were included. Tumor tissue from multiple intraperitoneal locations was obtained intraoperatively and blood samples were collected preoperatively, at day 2 and 10 postoperatively. Low-coverage whole genome sequencing (WGS) was used to identify structural variants (SV), single nucleotide variants (SNVs) and insertion deletions (InDels) in tumor tissue in order to develop personalized digital PCR (dPCR) fingerprint assays.

**Results** In all tumor samples of the 31 included patients, dPCR assays were successfully developed and validated, with a median of 5 biomarkers (SVs and SNVs) per patient. For each patient, an individual SV profile could be established, which remained largely constant throughout multiple tumor localizations of each patient. 30/31 (97%) patients had circulating tumor DNA (ctDNA) detected at baseline before surgery at levels ranging from 0.0005% to 31% variant allele frequency. ctDNA was persistently detected in all patients with macroscopic tumor residuals. A significant decrease in ctDNA was observed in 15/20 (75%) patients with advanced HGSOE and in 6/6 (100%) patients with stage IIIA1-IIIB disease, who had macroscopic complete resection. In 8/20 (40%) patients with complete resection, ctDNA decreased below the detection limit.

**Conclusion** In this feasibility study, tumor-informed ctDNA was preoperatively detectable in 97% participants. In patients with multiple tumor biopsies, the fingerprint was consistent for all tumor locations. A decrease in ctDNA detection correlated with complete tumor resection.

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cerclage position in a patient who wants to preserve her fertility.

**Methodology** The case is of a 26-year-old patient who underwent conization for CIN3 with a subsequent diagnosis of squamous cervical cancer stage FIGO IB1. After a negative laparoscopic bilateral pelvic nodes sampling and the radiologic evidence of a disease limited to the cervix the patient was candidate to trachelectomy according to her fertility sparing desire.

**Results** The vesico-uterine space is dissected and the bladder moved down. A window is made on the broad ligaments and bilateral ureterolysis performed. The recto-vaginal space is then dissected till the medial para-rectal fossa.

Circular colpotomy is vaginally performed with a 1 cm tissue rim and the cervix is closed with Vicryl stitches in a vaginal cuff to avoid tumor spread. Careful dissection of the anterior and posterior septa is then carried out until reunification with laparoscopic dissection. Bilateral parametrectomy is performed 5 mm cranially the uterine artery arches and 1 cm far from the cervix. Radical trachelectomy is finalized with a negative deep margin at the frozen section. The uterine isthmus is then sutured to the vagina.

In the second laparoscopic time a 3 mm monofilament polypropylene sling cerclage is bilaterally positioned from posterior to anterior through the broad ligaments opening and fixed anteriorly on the uterine isthmus to prevent an eventual preterm delivery.

**Conclusion** Laparoscopic assisted vaginal trachelectomy, is a feasible procedure combining the conservative advantages of the vaginal approach and the oncological safety of laparoscopic spaces dissection with good obstetric outcomes.

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## Video Sessions/Video Cinema

### 01. Cervical cancer

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#### LAPAROSCOPIC ASSISTED VAGINAL RADICAL TRACHELECTOMY WITH PROPHYLACTIC CERCLAGE: A SAFE FERTILITY SPARING TREATMENT FOR EARLY-STAGE CERVICAL CANCER

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**Introduction/Background** In recent years fertility sparing treatments are increasingly developing in patients with early-stage cervical cancer. Among these, trachelectomy represents a milestone with wide range of surgical approaches, evidence of oncological safety and positive obstetric outcomes.

This video shows how it is possible to perform a laparoscopic assisted vaginal radical trachelectomy with concomitant

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#### LAPAROSCOPIC NERVE SPARING EXTRAPERITONEAL PARAAORTIC LYMPHADENECTOMY; CASE PRESENTATION

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**Introduction/Background** laparoscopic extraperitoneal approach was introduced since 1995 which was primarily used for the evaluation of aortic metastases in patients with cervical cancer. The main advantages of extraperitoneal approach are allowing the surgeon to focus on the operative field without interference of the bowel, consequently overcoming issues related to obesity, and generating fewer de novo adhesions than the transperitoneal laparoscopic approach. In this abstract we will discuss the application of laparoscopic nerve sparing extraperitoneal lymphadenectomy in a patient with advanced cervical cancer associated with bulky paraaortic lymph node metastasis.

**Methodology** We applied the left sided laparoscopic nerve sparing extraperitoneal approach for excision of a 5 cm retroperitoneal paraaortic nodal mass for 39 years old female patient with history of Advanced cervical cancer stage IIICr. The decision of surgical removal of this bulky paraaortic nodal mass is to facilitate the effect of the definitive chemoradiotherapy.