

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-IIIIB 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.

Disclosures Study partially funded by SAGA Diagnostics.

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.

Disclosures This work was supported by French state funds managed within the 'Plan Investissements d'Avenir' and by the ANR (reference ANR-10-IAHU-02).

Video Sessions/Video Cinema

01. Cervical cancer

#87

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

^{1,2,3}Matteo Pavone*, ^{1,2,4}Marta Goglia, ³Giovanni Scambia, ⁵Cherif Akladios, ^{5,1,6}Lise Lecointre. ¹Institute of Image-Guided Surgery, IHU Strasbourg, Strasbourg, France; ²IRCAD, Research Institute Against Digestive Cancer (IRCAD) France, Strasbourg, France; ³Dipartimento per la salute della Donna e del Bambino e della Salute Pubblica, Fondazione Policlinico Universitario A. Gemelli, IRCCS, UOC Ginecologia Oncologica, Rome, Italy; ⁴Department of General Surgery, Sant'Andrea University Hospital, Sapienza University of Rome, Rome, Italy; ⁵Department of Gynecologic Surgery, University Hospitals of Strasbourg, Strasbourg, France; ⁶Cube UMR 7357-Laboratoire des Sciences de l'Ingénieur, de l'Informatique et de l'Imagerie, Université de Strasbourg, Strasbourg, France

10.1136/ijgc-2023-ESGO.61

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

#127

LAPAROSCOPIC NERVE SPARING EXTRAPERITONEAL PARAAORTIC LYMPHADENECTOMY; CASE PRESENTATION

Mohamed Hamdy*, Abdel Aziz A Sallam. Oncology Center Mansoura University, Mansoura, Egypt

10.1136/ijgc-2023-ESGO.62

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.

Results The excision of paraaortic nodal mass was done effectively through laparoscopic extraperitoneal approach with minimal blood loss no perioperative complication and 1 day hospital stay. The final pathology report reveals infiltration of the nodal mass by the same tumor cells.

Conclusion Laparoscopic extraperitoneal paraaortic lymphadenectomy is feasible, effective, and safe approach and has an added value of nerve sparing option and could be applied for wide range of patients with retroperitoneal nodal metastasis either for nodal staging or biopsy.

#420

SURGICAL PLANIFICATION OF 3D RECONSTRUCTION WITH ROBOTIC PARTIAL CYSTECTOMY AND COLPECTOMY FOR CERVICAL CANCER RECURRENCE

Sergi Fernandez*, Juan Carlos Torrejon, Marc Barahona, Ana Maria Muñoz, Yolanda Perez, Oscar Buisan, Lola Martí, Jordi Ponce. *Bellvitge University Hospital, Barcelona, Spain*

10.1136/ijgc-2023-ESGO.63

Introduction/Background Surgery is the only curative treatment in case of localized recurrence of cervical cancer in patients who had been treated with previous radiotherapy. Pelvic exenteration is the standard surgery; however, preservation of bladder or rectum is possible in some cases.

Methodology A 44-years-old patient was suspected for cervical cancer recurrence after 4 years of primary treatment with chemo-radiotherapy. MRI and PET/CT observed a lesion of 18x14mm in contact with vagina and bladder. 3D reconstruction was performed for surgical planification and tumor of 24x37mm was observed in the right fornix of vagina with clear margin from rectum but in contact with right ureter and bladder. According to 3D reconstruction, a conservative treatment of bladder and vagina was planned. Patient underwent partial cystectomy with ureteral re-implantation and right hemicolectomy by robotics.

Results The patient was discharged after 48h from surgery. After 30 days from surgery, no complications were recorded. Pathological results confirmed cervical adenocarcinoma with free margins.

Conclusion Optimal surgery planification is mandatory for challenging surgeries as pelvic recurrence by cervical cancer. 3D reconstruction, even augmented reality, are excellent tools for guiding surgery and for considering conservative treatments when is not compromise oncological radicality.

#578

A STEP-BY STEP SITE-RELAPSE MODIFIED LATERAL EXTENDED ENDOPELVIC RESECTION (LEER)

¹Marta Arnáez De La Cruz*, ¹Victor Lago, ¹Pablo Padilla-Iserte, ²Jose Antonio Pérez Álvarez, ³Luis Matute, ³Marta Gurrea, ³Santiago Domingo. ¹La Fe University and Polytechnic Hospital. Valencia, Spain, Valencia, Spain; ²Our Lady Candelaria University Hospital. Valencia, Spain, Tenerife, Spain; ³La Fe University and Polytechnic Hospital, Valencia, Spain

10.1136/ijgc-2023-ESGO.64

Introduction/Background Lateral pelvic sidewall involvement by gynecological tumors occurs in 8.3% of patients with cervical cancer after pelvic radiation. Laterally extended endopelvic resection (LEER), based on the ontogenetic compartment theory, provides a potential surgical option for patients for whom palliative therapy is the only alternative. This complex and ultraradical surgical technique allows a high rate of

complete resection in more than 70% of patients with gynecological cancers

Methodology Clinical case: We present a 34-year-old patient was diagnosed with locally advanced cervical cancer treated with chemoradiotherapy and brachytherapy. Lateral pelvic sidewall recurrence occurred three years later.

After the discussion at the multidisciplinary tumor board, it was decided LEER resection as the only curative option.

Results Video explain: At first, we dissected the innominate space to see perfectly and with safety the external iliac vessels, obturator Nerve and Lumbosacral Trunk.

Second step is the dissection of the ureter to his complete mobilization. We continue with the dissection internal iliac artery and its terminal branches.

When the dissection is finish, we can see all the structures as in the video. Then, we have to ligate with suture or hemoclip both internal iliac artery and its branches.

Next, we dissected the hypogastric nerve and ligate internal iliac vein.

We continue the resection of obturator nerve, vessels and muscle, reaching up to the greater sciatic foramen. At this point, nine step is the dissection of lumbosacral plexus.

To remove the surgical piece, it is necessary to ligate the ureter, later we introduce a double J catheter to reimplant the ureter.

Finally, we achieved the limit of the dissection in the elevator ani muscle, and dissected the tendinous arch, endopelvic fascia and elevator ani muscle, reaching the ischioanal fossa. We resect the parametrium and extract the piece.

Conclusion LEER is a curative option to consider in sidewall tumor recurrences

#766

21ST CENTURY ROBOTIC RADICAL HYSTERECTOMY SHOULD FOLLOW STRICT ONCOLOGIC PRINCIPLES, HAVE QUALITY CONTROL AND BE NERVE-SPARRING. PUPPETEER, STAPLER, BATH, DUAL INSUFFLATION, BLUE AND GREEN TO THE RESCUE

Hubert Fornalik*, Nicole Fornalik. *Lutheran Health Network, Fort Wayne, USA*

10.1136/ijgc-2023-ESGO.65

Introduction/Background Robotic approach to radical hysterectomy appears to facilitate precise dissection in pelvis. LACC trial and several retrospective studies demonstrated inferior survival of patients undergoing radical hysterectomy for cervical cancer via laparoscopic approach as compared to laparotomy. Concerns for lack of proper oncologic technique during laparoscopic cases arose with findings of unusual metastasis sites like omentum, peritoneum, and trocar sites.

Methodology Surgical videos from patients undergoing robotic nerve sparing radical hysterectomies for cervical cancer and for colorectal cancer metastatic to the uterus.

Results We demonstrate our modifications to robotic nerve sparing radical hysterectomy technique (adaptation of Okabayashi method). Puppeteer technique is used to provide countertraction without utilization of uterine manipulator. Stapler is used to transect vagina, allowing for en-block resection without tumor exposure to instruments and peritoneal cavity. Final specimen's bath and cytology provide quality control. Bladder insufflation, ureteral ICG injection and vaginal methylene blue, facilitate dissection, possibly decreasing chances for ureter devascularization.