

**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.

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

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**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)

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**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

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**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.