

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

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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.

Conclusion Robotic nerve sparing radical hysterectomy is a difficult and meticulous procedure that requires an experienced surgical team. It can be performed with strict adherence to oncologic principles. Future studies on laparoscopic or robotic approach to radical hysterectomy should include tumor spillage and nerve sparing quality controls as well as long term survival and quality of life assessments.

#768

EXTRAPERITONEAL PARAAORTIC LYMPHADENECTOMY IN PATIENTS WITH CERVICAL CANCER

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Introduction/Background To describe our technique for excision of the para-aortic, pre-aortic, pre-caval and laterocaval nodes using an extraperitoneal approach. This technique was developed to make the dissection and excision of the less accessible nodes in an easier and safer way by minimizing the risk of great vessels injury and bleeding.

Methodology Step-by-step description of the surgical procedure using video.

A 50-year-old woman with a body mass index of 36 underwent endoscopic extraperitoneal para-aortic lymphadenectomy for advanced high grade cervical adenocarcinoma FIGO IIC1r.

The patient underwent an endoscopic extraperitoneal para-aortic lymphadenectomy. An anatomical dissection is being performed being the upper limit of the dissection the left renal vein.

Results Firstly we complete a dissection of all the anatomical aortic limits until the renal vein and exeresis of aortic nodes. A plane just above the cava vein is carefully developed by pushing all the lymph nodes to the roof of the dissection.

Nodes are excised in four blocks, supramesenteric and inframesenteric aortic and precaval nodes.

Conclusion A complete para-aortic retroperitoneal dissection can be achieved with this extraperitoneal approach. Benefits of this technique are based on the absence of the bowel or other intraperitoneal structures invading the operative field given the barrier-free nature of the retroperitoneal space. Despite the challenge of the access to the right nodes in a retroperitoneal paraaortic lymphadenectomy they can be successfully excised reaching the renal vein including obese patients.

Extraperitoneal paraaortic lymph node dissection is a minimally invasive procedure that is an excellent and safe approach to the paraaortic area, with a low complication rate, sufficient number of lymph nodes, and short hospital stay. It seems to be a good alternative to the classic transperitoneal approach.

This new technique deserves to be used as a tool to identify lymph node positive patients who require extended-field radiation and/or chemotherapy.

#780

CERVICAL CANCER AND PREGNANCY: CESAREAN SECTION AND RADICAL HISTERECTOMY

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Introduction/Background Cervical cancer diagnosed during pregnancy is the most challenging situation since the pregnant uterus itself is involved. Where possible, standard treatment is applied during pregnancy.

Methodology A 28-year-old patient at 33 weeks of pregnancy with unremarkable medical, surgical, or family history. Diagnosis of moderately differentiated invasive adenocarcinoma of the cervix. During prenatal care, in a small rural hospital at the time of 28 weeks' gestation she had presented with abnormal vaginal bleeding. An exophytic cervical tumor measuring 3 cm diameter with no evidence of parametrial or vaginal involvement was found on physical examination. (FIGO 2018 stage: IB2). The physical examination was consistent with the previously described tumor in the cervix measuring 3 cm in diameter. The pelvic MRI showed an intrauterine gestation with a tumor measuring 19×16 x 10 mm on the anterior lip of the uterine cervix. There was no evidence of lymph node involvement. In addition, there was no parametrial or vaginal compromise.

The case was discussed by the Tumor Committee that recommended expectant management awaiting fetal maturity at 36 weeks (with one single dose of betamethasone 12 mg) and a Cesarean-radical hysterectomy at the time of delivery. The pregnancy continued with no other complications.

Results At 36 weeks' gestation a Cesarean section was performed through a Cherney incision. A male child was delivered (Apgar 8/9, 2830 gm). After delivery, a type C1 radical hysterectomy (Morrow–Querleu) with pelvic lymphadenectomy and bilateral oophorectomy was performed.

Conclusion After 5 years the patient is free of disease and the child is healthy.

This kind of management requires a multidisciplinary approach and a center of reference in gynecology oncology.

Disclosures Cesarean section and radical C1 hysterectomy is the option in this cases, performing the surgery at the same time.

The pathology report only describes five harvested pelvic lymph nodes. I would ask for a revision of the specimen and search for more nodes, since the most important anatomical landmarks for a bilateral pelvic lymphadenectomy were dissected, which should lead to a significant higher number of retrieved nodes. Therefore, indeed, postoperative IMRT is indicated to correct for an incomplete pelvic lymphadenectomy and to avoid pelvic sidewall recurrence.

#783

TOTAL LAPAROSCOPIC RADICAL PARAMETRECTOMY WITH PELVIC LYMPHADENECTOMY

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Introduction/Background Incidental finding of invasive cervical cancer discovered after simple hysterectomy for non-malignant indications is not uncommon.

For Those patients with early stage ; Radical Parametrectomy with upper vaginectomy and pelvic lymph node dissection is a preferred approach specially in treating young patients.

Traditionally this procedure was performed via laparotomy, minimally invasive approach is now proven feasible and effective.

Methodology -