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 IIIC1r.

The patient underwent an endoscopic extraperitoneal paraaortic 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 oophoropexy was performed.
Conclusion After 5 years the patient is free of desease 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 histerectomy 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 -