**#695**

**EXTRAPERITONEAL PARAAORTIC DEBULKING OF AN ENDOMETRIAL CARCINOMA SINGLE NODAL RELAPSE**

Maria Alonso-Espías*, Myriam Gracia, Virginia García-Pineda, María Dolores Diestro, Jaime Siegist, Alicia Hernández, Ignacio Zapardiel. La Paz University Hospital, Madrid, Spain

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**Introduction/Background** The extraperitoneal approach for paraaortic lymphadenectomy provides an excellent anatomical exposure, even in patients with obesity. Compared with laparotomic approach, extraperitoneal lymphadenectomy reduces considerably the adhesion rate, which is especially important in cases in which adjuvant treatment with radiotherapy will be necessary. Compared with transperitoneal approach, extraperitoneal approach with the removal of a single 2cm metastasis at the level of the aortic bifurcation. The initial suspicion was an endometrial cancer relapse.

In this video, we show step by step, the surgical management of a laparoscopic paraaortic debulking performed by extraperitoneal approach, with the removal of a single 2cm metastasis at the level of the aortic bifurcation. The pathology result reported a poorly differentiated carcinoma metastasis, of gynecological origin with loss of immunorexpression of MLH1 and PMS2. She received adjuvant chemotherapy with Paclitaxel and Carboplatin.

**Conclusion** The extraperitoneal laparoscopic approach is a good alternative for the treatment of paraaortic metastases providing an excellent anatomical exposure without increasing surgical time or complication rates.

**#764**

**ONCOVASCULAR SURGERY IN GYNECOLOGIC ONCLOGY: EN BLOC METASTATIC LYMPH NODE AND INFILTRATED INFERIOR VENA CAVA RESECTION FOLLOWED BY PATCH RECONSTRUCTION**

1^*Giuseppe Cucinella*, 1Mariano Catello Di Donna, 2Antonino Abbate, 1Gianmarco Accardi, 1Letizia Borsellino, 1Andrea Etrusco, 1Giulia Musico, 1Giuseppe Mascellino, 1Giulia Zaccaria, 1Nicolò Iatrino, 1Irene Di Figlia, 2Natalina Buono, 1Tania Spedale, 1Cettio Gullio, 1Sara Ministrello, 1Giulia Gambino, 1Giuseppe Pasó, 1Antonio Simone Laganà, 1Vito Chiantera. Unit of Gynecologic Oncology, ARNAS ‘Civico-Di Cristina-Benfratelli’, University of Palermo, Palermo, Italy; 2Department of Surgical, Oncological and Oral Sciences (Di.Chir.On.S.), University of Palermo, Palermo, Italy; 3Department of Health Promotion, Mother and Child Care, Internal Medicine and Medical Specialties (PROMISE), University of Palermo, Palermo, Italy

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**Introduction/Background** Advanced or recurrent gynecologic cancers with retroperitoneal lymphatic disease may involve the inferior vena cava (IVC), and achieving radical debulking of the disease in this scenario is challenging. The concept ‘oncovesascular surgery’ defines the case of tumor resection with simultaneous reconstruction of the great vessels when the tumor infiltrates or firmly adheres to the great vessels. The aim of this video is to demonstrate the surgical procedures for radical en bloc resection of metastatic lymph nodes and the infiltrated IVC followed by vascular reconstruction.

**Methodology** The indication for the debulking surgery was a first isolated recurrence of endometrioid endometrial cancer grade 2 (first diagnosis stage IB followed by external beam radiotherapy) in a 50-year-old patient with good performance status. Bulky precalv lymph nodes with infiltration of the IVC were identified, while other distant metastases were excluded. The multidisciplinary tumor board approved surgery as a treatment option.

**Results** The lymph node metastasis infiltrated the IVC with absence of a reliable dissection plane. After systemic heparin infusion and proximal and distal clamping of the vessel, we performed an en bloc resection of metastatic lymph nodes along with the infiltrated portion of the IVC. Subsequent vascular reconstruction was performed with a bovine patch. A Running suture (Prolene 5/0) was used to fix the patch in place. An intravascular heparin bolus was injected at the end of the procedure. Complete removal of macroscopic disease was achieved. No intraoperative or post-operative complications were observed.

**Conclusion** Tumor debulking with en bloc vascular resection and subsequent reconstruction is a feasible procedure, but requires accurate preoperative planning and an experienced surgical team. Gynecologic oncologists need to be familiar with the concept of ‘oncovesascular surgery’ in order to provide the best curative treatment even in the challenging case of advanced cancers with vascular involvement.