

#972 ROBOTIC RETROPERITONEAL LUMBAL LYPHADENECTOMY

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Introduction/Background A full-fledged alternative to laparotomy and laparoscopy for performing lumbar lymphadenectomy for cancer of the uterine body is retroperitoneal robotic access. This technique provides an optimal angle of direction of instruments to the area of para-aortic and paracaval lymph nodes, especially this access is convenient in patients with obesity, as well as in the case of local recurrence of tumors in the lumbar lymph nodes after previous operations.

Methodology Carbon dioxide was insufflated retroperitoneally until a pressure of 14 mm Hg was reached. The first anatomical landmarks were the common iliac artery and the ureter. The dissection was carried out between the fasciae of Toldi and Gerota. Further, the ureter is separated from the surrounding tissues. The duodenum is retracted. The left renal vein is exposed. Lymphadenectomy begins. At the same time, there are no anatomically significant formations on the lateral side. On the medial side, damage to the lumbar vessels that depart from the aorta is dangerous.

Results Currently, 10 such operations have been performed in our team. The lengthening of the operating time up to 240–360 minutes was recorded in comparison with the laparoscopic retroperitoneal approach (180–300 minutes). Complications did not occur, blood loss was minimal. At the same time, better visualization in the robotic group and comfortable surgical conditions made it possible for surgeons to be less tired in terms of subjective sensations.

Conclusion Perhaps with the subsequent use of this access, the operation time will decrease, which will allow you to continue to perform these operations no less carefully, but more quickly. And the fatigue of the surgical team is an important factor in the safety of the workflow, which can be improved through robotic surgery.

#1047 VNOTES APPROACH FOR ONCOLOGICAL SURGERY: A REVIEW OF ONE CENTRE

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Introduction/Background Since multiport laparoscopy replaced open surgery, surgeons started looking for ways to innovate. As a result, laparoendoscopic single-site surgery (LESS) emerged. MIS in endometrial and cervical cancer has been associated with improved quality of life, less blood loss, and similar cancer-related outcomes. To further reduce the morbidity and scarring related to laparoscopic surgery, and improve visualization, closure, and healing, the transvaginal natural orifice transluminal endoscopic surgery (vNOTES), was developed. A series of studies demonstrating the feasibility of vNOTES were conducted in benign gynecologic diseases but have not been confirmed in operations involving malignant tumors. The aim of this study was to evaluate the feasibility of vNOTES surgery for endometrial and cervical cancer, including SLN assessment. The secondary objective was to

determine the intraoperative and postoperative surgical complications.

Methodology This is a retrospective and observational study of 2022, including 27 patients with early stages of endometrial/cervical malignancy and premalignancy (endometrial complex atypical hyperplasia, Lynch syndrome, BRCA mutations). They all underwent surgery via vNOTES, 10 of them including SLN assessment.

Results 10 patients underwent bilateral SLNB followed by total hysterectomy and bilateral salpingo-oophorectomy. The median operative time was 120min and the estimated blood loss 50mL. No intraoperative complications occurred and none of the patients required blood transfusions. Moreover, all surgeries were completed without conversion to laparoscopy. The median postoperative stay was one night, without postoperative complications.

Conclusion Our study suggests that vNOTES could be a safe and feasible approach to perform oncological procedures in early stage cervical and endometrial cancer, including the SNLB assessment. However, prospective studies with longer follow-up periods are needed to demonstrate the benefits and oncological outcomes.

#1067 BLADDER INJURY IN LYMPH NODE STRATIFICATION SURGERY OF A STAGE II ENDOMETRIAL CANCER

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Introduction/Background Bladder injury is widely described in laparoscopic gynaecology surgeries such as hysterectomies or lymphadenectomies, especially if the patient needs to receive multiple surgeries. Nevertheless, usually it can be easily repaired and urinary functions can be quickly recovered.

Results A 69-year-old woman attends her gynaecologist for pink vaginal discharge and a thigh endometrium is seen in the vaginal ultrasound. An endometrial Cornier sampling is made and reveals endometrioid adenocarcinoma with mucinous differentiation, histological grade I. MRI is performed and informs of a 1b endometrial neoplasia. A hysterectomy with double adnexectomy, bilateral sentinel lymph node biopsy, and a left pelvic lymphadenectomy is undertaken. The histological examination reveals endometrioid adenocarcinoma with extensive mucinous differentiation (>50%) and focal squamous differentiation, grade 2, with >50% myometrial invasion but no serous infiltration, affection of the low uterine segment and invasion of the cervical stroma, with negative lymph nodes. On the tumour board, it is decided to perform an additional pelvic and paraaortic lymphadenectomy. On a second surgery, doctors find several intestinal adhesions and a widely fibrosed peritoneal tissue. When getting into the left paravesical space, after identification of both the external iliac artery and vein, as the lymph node sampling has started, a lesion on the left anterolateral bladder wall is suddenly discovered. The surgeons perform a Vicryl 3/0 continuous suture and call the urologist. A cystoscopy is carried out, with catheterisation of the left ureter and a check of its integrity. After a fast look at the right paravesical space, which is found to be also largely fibrosed, it is decided to end up the surgery. The patient needs an indwelling urinary catheter for 14 days, without other further urinary complications. Finally, she receives