**ROBOTIC RETROPERITONEAL LUMBAL LIMPHADENECTOMY**

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10.1136/ijgc-2023-ESGO.78

**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.
adjuvant pelvic radiotherapy and posterior radiotherapy on vaginal cupula.

**Conclusion** Very good outcomes can be achieved if early intervention is performed in bladder injuries.

**Disclosures** The author or authors declare that they have no conflict of interest with respect to the author or publication of this article.

**Introduction/Background** Damage of obturator nerve during laparoscopic pelvic lymphadenectomy may be a surgical complication and it is well described in literature. To keep attentive, make the diagnosis and repair the damage all at one time can be decisive to avoid severe mobility complications.

**Results** A 79-year-old woman attends the emergency room for vaginal bleeding. Corner biopsy reveals a high-grade endometrioid adenocarcinoma. MRI is performed and informs of a 1b endometrial neoplasia, with a possible affection of the cervix. The woman undertakes a hysterectomy with double trioid adenocarcinoma. MRI is performed and informs of a grade 3 neoplasia with 50% infiltration of the myometrium. A PET-TC shows pulmonary nodules, and the surgery must be followed with chemotherapy. Attending to the obturator lesion, the patient has some difficulties in the recovery of the walking capacity and the ability to go up and down stairs, but there isn’t any sensitivity loss. It is catalogued as a good prognosis lesion.

**Conclusion** Minimum or very few consequences can be found after a complete section of the obturator nerve if it is well sutured in the same surgical procedure. To keep trained and to be able to diagnose that lesion can save us from further complications.

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### NEAR-INFRARED FLUORESCENCE ASSESSMENT OF MYOCUTANEOUS FLAP MICROPERFUSION FOR GYNECOLOGIC RECONSTRUCTION (FOREFRONT): A PROSPECTIVE, NON-RANDOMIZED TRIAL (NCT05071976)


**Introduction/Background** Flap-based reconstruction following pelvic exenteration is associated with high rates of wound complications, partly due to impaired perfusion.

**Methodology** In this prospective, non-randomized trial (NCT05071976), we evaluated the use of near-infrared (NIR) angiography in pedicled flap-based reconstruction following pelvic exenteration. The primary endpoint was percentage of cases in which intraoperative NIR angiography led to a change in flap reconstruction management, calculated assuming binomial proportions, with a change in ≥13.3% of cases indicating the technology was worthy of additional investigation. A secondary endpoint was 30-day postoperative outcomes.

**Results** Fourteen patients were enrolled.

Median age was 56 years (range, 29–74). Patients underwent exenteration for cervical (n=8, 57%), rectal (n=3, 22%), vulvar (n=2, 14%), or endometrial (n=1, 7%) cancer. Seven patients (50%) were White non-Hispanic, 4 (29%) were White Hispanic, 2 (14%) were Black non-Hispanic, and 1 (7%) (n=1) was Asian. Median body mass index was 27.8 kg/m2 (range, 16.6–36.1). Three patients (22%) had a smoking history. All patients received prior chemotherapy and radiation.

Nine patients (64%) underwent total, 3 (22%) underwent posterior, and 2 (14%) underwent anterior pelvic exenteration. All patients underwent reconstruction with a vertical rectus abdominis myocutaneous flap. NIR angiography led to a change in intraoperative flap reconstruction management in 7 patients (50%), including trimming poorly perfused areas identified by NIR angiography in 6 patients and abandoning the pedicled flap in 1 patient after poor perfusion was identified by NIR angiography. Only 1 patient (7%) experienced a wound complication—a grade 2 complication of necrosis requiring bedside debridement and oral antibiotics.

**Conclusion** This prospective, non-randomized surgical trial demonstrated NIR angiography led to altered intraoperative flap reconstruction management in 50% of patients, meeting the study’s primary endpoint. Our findings can inform future randomized controlled trials investigating if this technology improves postoperative outcomes.

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### CHALLENGING PARAORTIC AND PRECAVAL BULKY LYMPH NODES

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**Introduction/Background** Lymphadenectomy is part of surgical staging in gynecologic oncology practice. Occasionally, the size of these lymph nodes dictates the resectability and surgical approach.

Minimally invasive surgery has been known to be as safe and feasible as traditional open surgery. However, both laparoscopic lymphadenectomy and removal of isolated bulky lymph nodes are more difficult to perform due to limited surgical space and associated technical problems, especially in the para-aortic lymphadenectomy procedure.

**Methodology** This video describes step-by-step the surgical technique and strategy for the complete removal of two bulky para-aortic and precaval lymph nodes, from two different clinical cases, using a laparoscopic extraperitoneal approach.