

#972 ROBOTIC RETROPERITONEAL LUMBAL LIMPHADENECTOMY

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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 de 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

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.

#1068 OBTURATOR NERVE SECTION IN LAPAROSCOPIC PELVIC LYMPHADENECTOMY PERFORMED IN GRADE 3 ENDOMETRIOID ADENOCARCINOMA

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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. Cornier 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 adnexectomy and pelvic lymphadenectomy. During the surgery, a complete section of the left obturator nerve is made with Ligasure® and it is repaired in the same surgical act with Vicryl 2/0 terminal-terminal suture. The histological examination reveals a grade 3 neoplasia with 40–50% 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.

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

05. Miscellaneous

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

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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 $\geq 13.3\%$ 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.

#347 CHALLENGING PARAAORTIC 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.