

Results The first case involves a 54-year-old woman diagnosed with locally advanced squamous cell carcinoma of the cervix, presenting bilateral iliac lymph node infiltration and a 30x14mm precaval node. The second case involves an 86-year-old woman with a multilocular-solid cyst in the left ovary, and a suspicious node situated below the left renal vein observed in the imaging tests. It presents the anatomical peculiarity of a circumaortic left renal vein and a polar artery, with a bulky node described in between.

In both cases, para-aortic lymphadenectomy and resection of the bulky nodes were performed, highlighting the particularities of dissection in these cases, which represent a surgical challenge.

This video explains the technique of para-aortic lymphadenectomy in complex situations, emphasizing the importance of knowing the anatomy perfectly and the possible anatomical variations, as well as the relevance of tissue manipulation to avoid complications.

Conclusion Despite surgical removal of large pathological para-aortic nodes before definitive CTRT is not routinely recommended, laparoscopic approach is feasible and safe in cases of bulky nodes in gynecological oncology. In order to perform a proper surgery and avoid complications, a deep knowledge of the anatomy is necessary, as well as a previous review of the complementary imaging tests.

#455

RADICAL HYSTERECTOMY, SEGMENTAL BOWEL RESECTION AND NEPHRECTOMY WITH PROTECTIVE TRANSVERSOTOMY IN A CASE OF ADVANCED DEEP INFILTRATED ENDOMETRIOSIS – PRESENTATION OF THE SURGICAL TECHNIQUE

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10.1136/ijgc-2023-ESGO.84

Introduction/Background Patient of 30 years old with the story of chronic pain of pelvis and acute lumbar pain was sent to consultation of oncological gynecologist.

Methodology Left hydronephrosis with atrophy of kidney big nodule of parametrium and paracervix with involvement of bowel wall and adenomyosis of uterus was diagnosed. ON RMI the 6 cm nodule of the cervix and left parametrium up to obturator fossa, with involvement of huge part of rectum with the down limit of 66 mm from Z line and part of the sigmoid (12 cm in length together) was diagnosed.

Scintigraphy of the kidneys revealed: 89% activity of right side and 11% of the left kidney. Based on this findings, after consultation of urologist she was qualified to radical pelvic surgery with left nephrectomy with NOTES technique.

Results The segmental resection of rectum and sigmoid colon with end to end recto-sigmoid anastomosis, resection of posterior wall of the rectum and left part of muscles of the pelvis, resection of left parametrium with part of left levator ani muscle and obturator muscle and radical hysterectomy with both parametria left D type, right B type, and left nephrectomy was done. Due to multiorgan surgery with big risk of leakage complication loop protective stomy on descendent colon was created which was closed 3 months later.

The patient is free from previous syndromes and quality of life estimate as 9/10 due to hypotonic bladder.

Conclusion Laparoscopy is a perfect method for even very extensive surgery. Using the NOTES technique reduce the extent of perioperative trauma. The ICG technique and using the fibrin glue reduce the risk of anastomotic leakage and risk of fistula. The oncological knowledge of anatomy and technique make possible to perform very complicated surgery by the experienced team with the lower risk of complications.

#456

SEGMENTAL RESECTION OF THE BOWEL IN MULTIFOCAL DEEP INFILTRATIVE ENDOMETRIOSIS WITH THE GHOST ILEOSTOMY DUE TO UNCERTAIN VASCULARITY OF THE BOWEL IN THE ICG TEST – PRESENTATION OF THE TECHNIQUE

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10.1136/ijgc-2023-ESGO.85

Introduction/Background 50 years old patient with the story of chronic pelvic pain and dychezia 9/10 was sent to consultation of oncological gynecologistadenomiosis of the uterus, and probable infiltration by the endometriotic nodule of the rectum and sigmoid colon on the length of 130 mm, with the down margin localised 110 mm from the anal canal were diagnosed in the patient . The striction of the lumen of colon measured 70% on RMI scan was detected. Patient was qualified to modified posterior exenteration.

Methodology The presented film is the presentation of the surgical technique with the Ghost stomy usage.

Results The adhesiolysis of the pelvis with segmental resection of rectum and sigmoid colon with end to end recto-sigmoid anastomosis with the usage of ICG test, extended radical hysterectomy type B, separation of the vagina and rectum with the flap of omentum, protection of anastomosis and closure of the vaginal with the fibrin glue and Ghost stomy due to uncertain vascularity detected in ICG test were done.

The Ghost stomy was release on 6 th day after surgery.

Quality of life 3 months after surgery estimated for 10/10.

Conclusion Ghost stomy is one of the option to protect the anastomotic leakage in the cases when the protective ileostomy seems to be overtreatment but the risk of leakage, in our opinion, is a little bigger then average

#474

MANAGEMENT OF IATROGENIC VENA CAVA INFERIOR INJURY DURING LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY

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10.1136/ijgc-2023-ESGO.86

Introduction/Background Iatrogenic major vascular injury during laparoscopic gynecologic surgery is a rare but potentially fatal complication. Major vascular injury has been reported in less than 1% of cases, however, this injury can be fatal. Injuries to the aorta, vena cava inferior (VCI), external, and internal iliac arteries, and veins are the most common sites of major vascular damage during gynecologic surgery.

Results A 66-year-old female patient was diagnosed with endometrioid type grade 2 endometrial cancer. MRI confirmed

more than 50% of myometrial invasion, and no presence of suspicious lymph nodes or cervical involvement was observed. Laparoscopic staging surgery was planned for the patient with a BMI of 31 and no additional comorbidities. During para-aortic lymphadenectomy, we encountered VCI injury causing massive bleeding at the level of the aortic bifurcation. This video presentation demonstrates the laparoscopic repair of a VCI injury that resulted in the loss of approximately three units of blood pack. We repaired the hole on VCI with 5/0 prolene sutures and did not convert to laparotomy. Pre-operative hemoglobin level was 13.9 mg/dl. The patient tolerated the bleeding well during surgery and we completed the surgery successfully, post-operative hemoglobin level was 9.1 gr/dl and the patient was discharged on day 3 with oral Fe+2 uneventfully.

Conclusion VCI is most commonly injured during a right para-aortic lymphadenectomy. In such a situation, applying pressure to the bleeding point must be the first and immediate intervention. Following cessation of massive bleeding, the surgeon should evaluate the laparoscopic reparability of the vascular injury. Small injuries may be easily controlled and resolved with pressure. However, large defects may bleed massively. In these circumstances, Allis clamps, Statinskiy vascular clamps, and Bulldog clamps might be potentially helpful. After the visualization of the hole, it should be repaired with sutures.

Disclosures we declare that we have no conflict of interest

#552

STEPS TO PERFORM INTRAOPERATIVE TRANSURETERIC STENTING : PART AND PARCEL OF GYNAEC ONCOLOGIST'S ARMAMENTARIUM

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10.1136/ijgc-2023-ESGO.87

Introduction/Background Oncological surgery involving extensive intraperitoneal or retroperitoneal disease often carries risk of urological injury or devascularization from extensive ureterolysis.

Prophylactic stents may help visualize ureters, but evidence also suggests it reduces natural pliability of ureter thereby increasing the risk of injury.

Moreover, preoperative need is not always apparent. The art of trans-ureteric insertion of silastic double 'J' stents can easily be practiced by gynaecologist independent of specialist urology.

Methodology This video systematically illustrates simplified steps to perform open intraoperative trans ureteric repair. We report a case of this repair performed for inadvertent partial transection of ureter while dissecting out large cervical mass.

- BOTH PROXIMAL AND DISTAL ENDS OF URETER MOBILISED TO ENSURE TENSION FREE REPAIR
- SPATULATION OF BOTH ENDS TO INCREASE SURFACE AREA AT ANASTOMOSES
- DOUBLE J STENT INSERTION
- PERIURETERAL DRAIN PLACEMENT
- WATER-TIGHT TRANSVERSE CLOSURE WITH INTERRUPTED 4-0 PROLENE
- CT UROGRAM AFTER 3 WEEKS TO ENSURE INTEGRITY
- CYSTOSCOPIC DJ STENT REMOVAL AFTER 8 WEEKS

Results Cystoscopic removal of DJ stent was done 2 months later and patient is doing well on follow-up after 18 months. Strategies for intra-operative stent insertion and managing urological complications are imperative skills to be developed by gyne-oncologists.

Conclusion This study has demonstrated that trans-ureteric stenting by a gyne-oncologist is feasible, without needing a specialist urologist and cystoscopic equipment. The critical point is, such training of gynecological oncologists early in their career, will provide confidence to ensure maximal surgical effort in complex cases.

#1093

TECHNIQUE TO AVOID SPILLAGE IN A LARGE OVARIAN MASS

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10.1136/ijgc-2023-ESGO.88

Introduction/Background AIM: This video highlights a safe technique to drain and remove a large ovarian mass.

Methodology Case report.

Results CASE REPORT: 86 years old woman who received treatment in Covid19 circumstances. She presented with abdominal distension and symptoms related to intraabdominal pressure for 6 months. The estimated glomerular filtration rate was 38. Ca125 was 124. Her World Health Organisation performance status was 0/1. The computer tomography demonstrated a large abdominopelvic mass.

A 10 cm midline laparotomy was performed. The technique of draining the cyst is demonstrated. Ten litres of fluid were aspirated, and an approximately 40x20 cm cyst was removed. It contained further 4 litres of bloodstained fluid.

Conclusion We recommend this technique because it is easy to perform, straightforward, and very simple in case of fluid filled enlarged ovarian cysts. The incision is small and there is a safe aspiration of the cyst contents. Patient's recovery is fast.

This technique can be used for benign cysts, for known malignant cysts, where the dissemination is not of a concern, and also in palliative cases where the performance status does not allow a more complex operation.

06. Ovarian cancer

#83

BAT- SHAPED EN-BLOC TOTAL PERITONECTOMY AND TOTAL HYSTERECTOMY SALPINGO-OOPHORECTOMY WITH OR WITHOUT RECTOSIGMOID RESECTION (SARTABAT APPROACH)

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10.1136/ijgc-2023-ESGO.89

Introduction/Background We have developed a systematic surgical approach of a bat-shaped en-bloc total peritonectomy-total hysterectomy-salpingo-oophorectomy with or without rectosigmoid resection. In this video presentation we aimed to demonstrate the technique.

Methodology Methodology: Fifteen steps were identified in the Sarta-bat surgical approach. 1. Diagnostic-exploratory laparoscopy 2. Median incision from xiphoid to pubis 3.