Exploration and ascites drainage. Retroperitoneal carbon dioxide insufflation. Dissection of both costal arch peritoneum and placement of the automatic retractors. Incision of the superior part of faliform ligament. Demarcation of the diaphragmatic peritoneum from the hepatic veins. Complete liver mobilization. Dissection of the peritoneum of right diaphragm, Morisson, right abdominal wall and gutter. Stripping of the left diaphragm, abdominal wall and gutter peritoneum. Ligation and cutting of the IP ligaments after designation and segregation of the ureters. Pelvic and bladder peritoneum dissection and transection of the round ligaments. Bladder and ureter mobilization. Total hysterectomy-salpingo-oophorectomy with retrograde Douglas and visceral peritoneum ± resection. Suturing of the vaginal cuff ± colorectal anastomosis. The technique with detailed steps will be demonstrated as video presentation.

Results Sarta-Bat approach was performed as en-bloc total peritonectomy, total hysterectomy bilateral salpingo-oophorectomy with or without resection. Final surgery resulted in high rate of complete cytoreduction (no macroscopic residual) with acceptable morbidity rates. Conclusion Sarta-Bat approach is a feasible and convenient technique for cytoreductive surgery of advanced ovarian cancer with disseminated peritoneal metastases.

Unresected tumor of porta hepatis may cause pain, obstructive jaundice and bowel obstruction.

Conclusion Surgical expertise in upper abdominal debulking techniques increase the optimal cytoreduction rate in ovarian cancer.

Managing porta hepatis debulking procedures increase our chances of accomplishing no gross residual disease, therefore, disease-free survival and overall survival of our patients may increase.

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