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 falciform 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 ± rectosigmoid 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 peritoneectomy, total hysterectomy bilateral salpingo-oophorectomy with or without rectosigmoid 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.

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Abstracts

PORTA HEPATIS DISEASE IN OVARIAN CANCER. WHEN CYTOREDUCTION IS POSSIBLE

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Introduction/Background The main surgical goal in ovarian cancer is achieving an optimal cytoreduction with no gross disease.

Upper abdominal debulking procedures demand higher surgical effort, several studies described up to 40% of improvement in optimal cytoreduction rate. Besides, it is recognized that complete cytoreduction is related with higher survival rates.

The dissection of the porta hepatis region is challenging, due to the risk of injury of the portal vein, the hepatic artery and the common bile duct.

Methodology We want to show how to perform a successful porta hepatis tumor resection. We will show anatomical marks, anatomical images and a step by step procedure, correlating the tumor load with MRI pictures of the patient.


Results Traditionally porta hepatis disease was related with non-resectability.

Tumor debulking at porta hepatis region is feasible for some patients with low morbidity.

Anatomical knowledge and meticulous surgical technique should be mandatory.

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.
the colon, splenectomy, cholecystectomy and segmental hepatectomy due to intraparenchymal metastatic invasion in IV segment and tumor invasion of the gallbladder.

The techniques and maneuvers performed are detailed in the video.

Results With an overall mean follow-up of 42 months. 47 women (PDS) and 28 (IDS) women were included.

Rates of complete resection (R0) were 72.3% of patients after PDS and 57.2% of patients after IDS (p=0.217). Postoperative rates of adverse effects and mortality were slightly higher after PDS than after IDS (p=0.793).

Median progression-free survival was 60 months in the PDS group and 52 months in the IDS group (p=0.04). Factors in multivariable analysis associated with increased risk of recurrence included residual tumor >1cm (HR: 2.72, 95% CI 1.06–6.98, p=0.037) and stable/progression in response to chemotherapy (HR 8.85, 95% CI 1.76–44.45, p=0.008).

Median overall survival was not reached for the PDS group and 78 months for the IDS group (HR: 1.63, 95% CI 0.72–3.65, p=0.235) and 28 months for the ChT group (HR: 2.47, 95% CI 1.13–5.39, p=0.022).

Conclusion Higher complete cytoreduction rate indicates that the correct patients have been selected and those that benefit the most.

Disclosures Complete resection of all macroscopic disease (at primary or interval surgery) was the strongest independent variable in predicting overall survival (HR: 4.52, 95% CI 1.86–11.02, p=0.001).

#730 HEPATIC HILIUM CYTOREDUCTIVE SURGERY FOR OVARIAN CANCER RELAPSE
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Introduction/Background Ovarian cancer relapse is a challenge situation, that requires the evaluation of many clinical aspects with a multidisciplinary approach.

A recent randomized trial showed that cytoreductive surgery followed by chemotherapy in women with recurrent ovarian cancer, resulted in longer overall survival than chemotherapy alone.

Methodology The video shows step by step the technique of cytoreductive surgery in a patient with an ovarian cancer tumoral relapse at the level of the hepatic hilum.

The surgery has being performed by General surgeons and Gynecological Oncological surgeons at La Paz University Hospital, Madrid, Spain.

Results 53 years old patient who was diagnosed in February 2022 of endometrioid ovarian carcinoma G2. The patient was proposed for primary cytoreductive surgery. After complete cytoresection, the final stage of the disease was IIIC stage.

Adjuvant treatment was administered based on a combination chemotherapy with paclitaxel plus carboplatin (6 cycles).

In February 2023 a recurrence was confirmed through PET-CT scan that showed a peritoneal nodule adjacent to hepatic hilum suggestive of tumoral tissue.

A complete cytoreductive surgery was performed:

The first step was the common hepatic artery dissection, followed by the common bile duct dissection as the second step. The third step was the portal vein dissection. After identification and dissection of all the hilum hepatic structures; the resection and removal of the tumoral relapsed was performed.

Conclusion Complete secondary cytoreduction surgery in relapsed ovarian cancer at hepatic hilum is feasible in selected patients with a multidisciplinary approach.