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 \(>1\) cm (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, \(p=0.001\)).

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 cytoreduction 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 IIIIC stage.

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

In February 2023 a recurrence was confirmed through computerized tomography scan, a 13 cm mass with prominent solid components in the left ovary, retroperitoneal lymphadenopathy, and peritoneal carcinomatosis were detected.

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 hilium is feasible in selected patients with a multidisciplinary approach.
LAPAROSCOPIC INTERVAL DEBULKING SURGERY: WHERE DO WE STAND AND WHERE DO WE NEED TO GO?

Introduction/Background Retrospective evidences claiming both surgical and oncological adequacy of the minimally invasive (MIS) approach at the time of interval debulking surgery, led to the design of an ongoing prospective randomized controlled trial (LANCE trial) with the primary aim to investigate whether MIS is non-inferior to laparotomy in terms of disease free survival. In selected patients with a good clinical, biochemical and radiological response to neoadjuvant chemotherapy (NACT), the laparoscopic approach could be potentially beneficial in terms of perioperative and cosmetic outcomes.

Methodology We present the case of a 46 years old woman diagnosed with a FIGO stage IIIC high grade serous ovarian carcinoma who underwent IV cycles of NACT with a partial response according to RECIST criteria, negative Ca125 and a ‘favourable’ KELIM score (1.01). The patient was BRCA1mut and HRD positive.

Results The IDS was successfully completed with a complete gross resection after the full exposure of all abdominal quadrants. The surgical complexity was high due to residual disease after chemotherapy, requiring a complete diaphragmatic stripping, a vascular-sparing radical omentectomy and a meso-rectal-sparing posterior pelvic exenteration with a totally intracorporeal colorectal anastomosis. Surgery lasted 4 hours and 24 minutes with an estimated blood loss of 300cc. No intraoperative or postoperative complications occurred and the patient was discharged on postoperative day four. The chemotherapy response score was 2 and the time to chemotherapy 31 days.

Conclusion Currently, complete cytoreduction is described as no visual disease at the end of surgery. The definition ‘no visual disease’ should be carefully interpreted. ‘No visual no palpable disease’ could be a more precise description.

#1033

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USE OF FASCIOCUTANEOUS FLAP TECHNIQUE FOR VAGINAL RECONSTRUCTION AND VESICO-VAGINAL FISTULA CORRECTION: A CASE REPORT

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Introduction/Background A 37-YEAR-OLD PATIENT UNDERWENT, IN 2019, TO CONCURRENT PLATINUM-BASED CHEMORADIATION DUE TO SQUAMOUS CELL CERVICAL CARCINOMA, CLINICAL STAGE FIGO IVA PRESENTED SEVERE VAGINAL STENOSIS AND A VESICOVAGINAL FISTULA. DECREASED QUALITY OF LIFE OCCURS DUE TO SENSITIVE URINE LOSS AND LOSS OF THE ABILITY TO HAVE SEXUAL INTERCOURSE.

Methodology The procedure began with perineal assessment to vaginal reconstruction and vesicovaginal fistula repair. A fasciocutaneous flap was used to reconstruct the vaginal tube and protect the fistulous defect. The bladder face of the fistula was sutured to repair the fistulous conduct, and a bilateral ureteral reimplantation was done.

The vagina was dilated until 8 cm in length using the index finger. Schuchardt’s incision was made bilaterally to optimize surgical access and to plan the fasciocutaneous flap.

The vaginal mucosa was dissected cranially up to 2.0cm higher to the fistulous tract. While the fistulous tract was resected, the vaginal defect was repaired using an inguinocutaneous fascio-cutaneous fold.

The flap was dissected until the cribriform fascia was identified. Then, the flap is mobilized, and a tunnel through the subcutaneous tissue created anteriorly to the bulbocavernosus muscle. The flap was rotated through the tunnel and sutured to the distal part of the vagina simultaneously, the robotic approach was made, taking off the bowell adhesions, and the vertical bladder incision was done. The

10. Quality of life after treatment

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