LAPAROSCOPIC INTERVAL DEBULKING SURGERY: USE OF FASCIO-CUTANEOUS FLAP TECHNIQUE FOR RECTAL-SAVING POSTERIOR PELVIC EXENTERATION WITH A TOTALLY FASCIO-CUTANEOUS FLAP.

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Abstracts

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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 resection after the full exposure of all abdominal quadrants, and rectosigmoid resection during this procedure an uncontrolled bleeding was emerged and managed with direct finger press and grasping with clamp. After comprehensive control of the related area and vessels clips were placed. Additionally, totally omentectomy, retroperitoneal lymphadenectomies, liver umbilical fissure excision, segment 6–7 Glissonectomy and subcapsular metastatectomy, appendectomy, and side to end colorectal anastomosis were performed and complete cytoreduction was achieved.

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.

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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 VESICO-VAGINAL 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.

SCHUSCHARDT’S INCISION WAS MADE BILATERALLY TO OPTIMIZE SURGICAL ACCESS AND TO PLAN THE FASCIOTUNICAL 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 A INGUINOCUTANEOUS FLAP.
