LAPAROSCOPIC INTERVAL DEBULKING SURGERY: USE OF FASCIO-CUTANEOUS FLAP TECHNIQUE FOR RECTAL-SAVING POSTERIOR PELVIC EXENTERATION WITH A TOTALLY STRIPPING, A VASCULAR-SAVING RADICAL OMENTECTOMY AND A MESO-RANTS. The surgical complexity was high due to residual disease after the full exposure of all abdominal quadrants, retroperitoneal lymphadenectomies, liver, and vessel involvement.

Methodology Video presentation

Results Primary cytoreductive surgery was performed.

Total peritonectomy, total abdominal hysterectomy bilateral salpingo-oophorectomy, and rectosigmoid resection were carried out with SARTA-BAT approach. Nonvisual disease at the right portal hilum covered by the gallbladder was palpated. Therefore, cholecystectomy was performed. After Cholecystectomy, the tumoral implants on the posterior and right portal hilar area were clearly seen. Firstly, portal vein was identified and dissected from the tumor. Then, tumoral clearance continued above the left portal vein and left hepatic artery and their branches. 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, total omentectomy, retroperitoneal lymphadenectomies, liver, umbilical fissure excision, segment 6–7 Glissonectomy and subcapsular metastasectomy, 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.
13. Vaginal and vulvar cancer

**PUBOLABIAL FLAP FOR ANTERIOR VULVAL RECONSTRUCTION- A HANDY TECHNIQUE FOR BEGINNERS**

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**Introduction/Background** Selection of appropriate flap for vulval reconstruction after radical vulvectomy is a vital part of surgical armamentarium of any young gynaecological oncologist. Flap enables a tension free closure of the vulval skin which as tension on the suture line is associated with delayed healing. We describe a case of anterior hemivulvectomy for anteriorly situated lesion, closed with Pubolabial V-Y advancement flap.

**Methodology** Results 65 year old postmenopausal lady presented with 3x2 cm right vulval lesion within 2 cm from clitoris. Biopsy revealed the lesion to be HPV independent squamous cell carcinoma. Patient was planned for Modified Radical Vulvectomy and bilateral inguinofemoral lymphadenectomy. Anterior hemivulvectomy was done, and a defect of approximately 5 cm was present. The defect was closed using a pubolabial V-Y advancement flap. Postoperative period was uneventful. The patient received Adjuvant radiation, and is presently doing well with good quality of life.

**Conclusion** Pubolabial flap is an easy to learn advancement flap for beginners, especially useful in preventing urinary voiding symptoms which may be seen with anterior vulvectomy. Its use, however is limited to smaller defect size.

**SURGICAL TREATMENT OF THE COMPLICATION OF WOUND AND LYMHPHOCELE AFTER RADICAL VULVECTOMY + BILATERAL IINGUINO FEMORAL LYMPHADENECTOMY INCISION**

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**Introduction/Background** The patient is 54 years old. Radical vulvectomy and bilateral inguinofemoral lymphadenectomy was performed because of 30x25 mm Stage II tumor on the 1/3 upper part of the right side of the vulva.

During the postoperative 2 weeks, approximately 50 cc of lymphatic fluid leakage was observed daily from the inguinofemoral incision line of the wound.

**Results** Since necrosis was seen on the wound edges, the wound was debrided again. The area of lymphadenectomy was cleaned with curetage, the subcutaneous tissue was freed from the underlying tissues the dermal edges was brought together and closed. Bilateral closed drainage system was applied. A thromboembolic prophylaxis Enoksaparin sodium 0,4 ml/day, third generation cephalosporin 2 mg/day, anti