FISTULOUS TRACT WAS OBSERVED IN THE MUCOSA LAYER OF THE BLADDER. SPECIAL ATTENTION IS GIVEN TO THE URETERS ROUTE CLOSEST TO THE FISTULA. THE FISTULOUS DEFECT WAS SUTURED WITH A CONTINUOUS BARBED SUTURE.

Results THE FISTULOUS DEFECT WAS SURGICALLY CORRECTED. THE FINAL ASPECT OF THE FLAP SHOWS A VAGINAL TUBE MEASURING 7.0 CM IN LENGTH.

Conclusion THE USE OF A FASCIOUSCUTANEOUS FLAP FOR VAGINAL RECONSTRUCTION IS A LOW COST SURGICAL OPTION, WITH MINIMUM ASSOCIATED RISK

13. Vaginal and vulvar cancer

#138 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 lymphadnectomy. 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.

#148 TOTAL COLPECTOMY IN A PRIMARY MALIGNANT MELANOMA OF THE VAGINA: A LAPAROSCOPIC AND VAGINAL COMBINED APPROACH

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Introduction/Background Primary vaginal malignant melanoma is an extremely rare and very aggressive tumor with a 5-year survival rate of 5%-25%. The approach to this disease is a challenge, since staging and treatment data is limited, and the prognosis is poor. Lymph node status and mitotic rate should be assessed as they are the most important predictors of survival.

Methodology We report the case of a 53-year-old woman, subtotal hysterectomized, diagnosed with a primary malignant melanoma of the vagina. On physical examination we can see a hard, cerebroid, non-melanic, pedicled tumour of about 5 cm that depends on the external third of the right lateral face of the vagina.

MRI and PET-CT were performed to plan the surgery.

There was no evidence of extension of the disease to adjacent or distant structures by imaging tests.

A total colpectomy was proposed, and we combined a laparoscopic and vaginal approach to completely remove the tumour

First, a sentinel lymph node biopsy was performed using a hybrid tracer with ICG and Tc99 to detect one inguinal sentinel node bilaterally.

Next, laparoscopic surgery was performed to remove the cervical remanent and to dissect the upper two thirds of the vagina.

Afterwards, the approach to the lower third of the vagina was finished vaginally. We dissected the vagina at the level of the introitus and closure of both sides with Chrobak forceps. Paracolpos was cut and the piece was extracted through the vagina.

Finally, we closed the perineal muscles by planes and performed vaginal cleisis.

Results Despite total vaginectomy, one of the inguinal lymph nodes was affected, which is why the patient has been proposed to complete treatment with immunotherapy. However, the expected outcomes are poor.

Conclusion This video shows the feasibility of performing a complete vaginectomy with a minimally invasive technique by combining a laparoscopic and vaginal approach.

Disclosures There is no standardized therapy for primary melanoma of the vagina but surgical excision either by local wide excision or radical surgery with colpectomy with/without exenteration is the mainstay of treatment.

#301 SURGICAL TREATMENT OF THE COMPLICATION OF WOUND AND LYMPHOCELE 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 subcutenous 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 o,4 ml/day, third generation cephalosporin 2 mg/day, anti