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 fasciocutaneous flap for vaginal reconstruction is a low cost surgical option, with minimum associated risk.

13. Vaginal and vulvar cancer

**#138 PUBLOLABIAL FLAP FOR ANTERIOR VULVAL RECONSTRUCTION- A HANDY TECHNIQUE FOR BEGINNERS**

*Debabrata Barmon, Eshwarya J Kaur*, Upasana Baruah, Dimpy Begum, Sopouassi V Nicholas King, Apocrita Tal, Aparajita Aparajita, Mahendra Kumar, Karthik C Bassetty, Dr B Borooah Cancer Institute, Guwahati, Guwahati, India; John F Kennedy Memorial Hospital, Monrovia, Liberia

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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 bilateralinguinosofemoral 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.

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

*Kadir Güzin, Alp Koray Kinter, Hüseyin Hüsnü Gökaslan*, Ahmet Çelebi. Hisar Hospital, Istanbul, Turkey; KSU Tip Fakültesi, Kahramanmaras, Turkey; Acıbadem Hospital, Istanbul, Turkey

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Introduction/Background The patient is 54 years old. Radical vulvectomy and bilateralinguinosofemoral 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 lymph node bilaterally.

Results 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 remnant 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.

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 standardised 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.
thrombotic stockings for both legs with keeping the wound clean and dry were the principal measures taken. Besides early mobilization of the patient was recommended. Approximately 10 days later, 3/0 prolene sutures were removed. The treatment was proved successful at the end of the procedure.

Conclusion In 60% of patients who underwent en bloc radical vulvectomy, a wound dehiscence occurs due to potential infection and tissue necrosis. The most common complications in the early post-operative period are thromboembolic events and lymphedema in the lower extremities.

Additionally since these patients are old in age, myocardial infarction and the risk of cerebrovascular events were highly expected. If this type of complication occurs in these patients in the wound immediate intervention with exploration and drainage may be life saving preventing infection as well.

#604 LAPAROSCOPIC POSTERIOR PELVIC EXENTERATION WITH VAGINAL RECONSTRUCTION FOR LOCALLY ADVANCED VULVAR CANCER

In Sun Hwang*, Sejin Kim, Keun Ho Lee. Seoul St. Mary’s hospital, College of Medicine, The Catholic University of Korea, Seoul, South Korea

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Introduction/Background Staging for vulvar cancer requires primary tumor resection. When the disease involves the anus, rectum, rectovaginal septum, posterior pelvic exenteration with permanent colostomy may be required. Laparoscopic posterior exenteration is a complex and rarely done procedure. We suggest the surgical procedure for laparoscopic posterior pelvic exenteration with vulvar reconstruction for locally advanced vulvar cancer.

Methodology This is a step-by-step video presentation of laparoscopic posterior pelvic exenteration with primary direct appositional vaginal repair. The patient was a 63-year-old woman (body mass index 25.1 kg/m²) with locally advanced clear cell adenocarcinoma. The preoperative magnetic resonance imaging/positron emission tomography showed suspicious lesion to anal interspincteric space. The surgery was performed including laparoscopic total hysterectomy with both salpingo-oophorectomy, laparoscopic abdominoperineal resection of rectum, colostomy, and total vaginectomy. Vulvar reconstruction with bilateral V-Y advancement flap coverage was performed.

Results The operation was performed successfully with no intra-operative or postoperative complications. Total duration of surgery was 450 minutes. The estimated blood loss was 200 mL. The patient was discharged on day 10. The pathology report was clear cell carcinoma. The tumor size was 2.7×2.5×1.3 cm without other organ involvement. The International Federation of Gynecology and Obstetrics stage IB. No residual lesion was found at the surgical margin. Radiation treatment was performed as adjuvant therapy following initial surgery. The patient is alive without recurrence 13 months after the initial treatment.

Conclusion This is a case of locally advanced vulvar cancer for which complete response was achieved by laparoscopic posterior resection and vulvar reconstruction, without severe adverse effects and with no observed recurrence 13 months after the surgery.

Disclosures We have no conflicts of interest to disclose.

#691 DOUBLE TRACER SENTINEL LYMPH NODE BIOPSY TECHNIQUE IN EARLY-STAGE VULVAR CANCER

Maria Alonso-Espia*, Virginia Garcia-Pineda, Myriam Gracia, Maria Dolores Diestro, Jaime Siegrist, Alicia Hernandez, Ignacio Zapardiel. La Paz University Hospital, Madrid, Spain

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Introduction/Background Sentinel lymph node biopsy (SLNB) is an alternative to inguinofemoral lymphadenectomy for selected patients with stage I or II vulvar carcinoma without palpable inguinal lymph nodes. It is a precise and safe technique that does not increase groin recurrence or worsen survival rates. In addition, it significantly reduces the morbidity and side effects of lymphadenectomy such as wound dehiscence or infection, lymphedema or lymphocysts. To date, the use a radioactive tracer like technetium 99 (99mTc) is mandatory, and it can be combined with a colorant tracer being blue dye the most used one. However, the near-infrared (NIR) fluorescence tracer indocyanine green (ICG) is an alternative technique with some advantages derived from its characteristics such as a higher tissue penetration and better intraoperative identification compared to blue dye.

Methodology In this video we explain step by step the surgical technique of SLNB using ICG in a patient with an unifocal 1 cm left-sided squamous cell carcinoma.

To carry out the procedure, the day before surgery 2mCi of Tc99 nanocolloid is injected peritumoral in four quadrants (0.1 ml in each quadrant) followed by Single Photon Emission Computed Tomography (SPECT) scan. Intraoperatively, 4 ml of ICG is injected 2 cm paraclitoral bilaterally (2 ml on each side). Intraoperative pathological assessment was performed.

Results Bilateral SLN was detected and both were intraoperatively reported as negative. Additionally, radical excision of the vulvar lesion was performed. The patient was discharged the day after surgery without postoperative complications. No metastases were found in the ultrastaging exam of the SLN.

Conclusion ICG is a safe technique for SLN detection in early-stage vulvar cancer combined with 99mTc TRACER. Due to its high tissue penetration, a deeper and earlier visualization of signal is possible, making its detection easier compared to blue dye.

Disclosures The authors have no conflicts of interest.

#839 LAPAROSCOPIC INRALEVATORAL TOTAL PELVIC EXENTERATION

Mehmet Faruk Köse, Edis Kahraman, Mustafa Deveci*. Acibadem University Atakent Hospital, Istanbul, Turkey

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Introduction/Background Pelvic exenteration is highly morbidity surgery. Most important part of the surgery is patient selection and explanation of post-surgery life changes to the patient. Since first described by Brunshwig (1948), many modification has been made in procedure. Today’s technology and surgical experience allow us to perform this brutal surgery in minimal invasive ways.

Methodology 72 years of woman had vaginal mucosal malign melanoma. After careful examination, we decided to perform infrapelvral total laparoscopic pelvic exenteration. We aimed to show the video of the procedure.

Results Tips of laparoscopic pelvic exenteration