thrombotic stockings for both legs with keeping the wound clean and dry were the principal measures taken. Besides early mobilization of the patient was recomended. 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

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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 25.1kg/m^2) with locally advanced clear cell adenocarcinoma. The preoperative magnetic resonance imaging/positron emission tomography showed suspicious lesion to anal intersphincteric 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 200mL. The patient was discharged on day 10. The pathology report was clear cell carcinoma. The tumor size was 2.7*2.5*1.3cm 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 13months 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 13months 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

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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 1cm left-sided squamous cell carcinoma.

To carry out the procedure, the day before surgery 2mCi of Tc99 nanocolloid is injected peritumoral in four quadrants (0.1ml in each quadrant) followed by Single Photon Emission Computed Tomography (SPECT) scan. Intraoperatively, 4ml of ICG is injected 2cm paraclitoroidal bilaterally (2ml 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 LAPAROSKOPIC INFRALEVATORAL TOTAL PELVIC EXENTERATION

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Introduction/Background Pelvic exenteration is highly morbid surgery. Most important part of the surgery is patient selection and explanation of post-surgery life changes to the patient. Since first discribed by Brunschwig(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 infralevatoral total laparoscopic pelvic exenteration. We aimed to show the video of the procedure.

Results Tips of laparoscopic pelvic exenteration

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