

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

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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<sup>2</sup>) 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 inguofemoral 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 a 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 LAPAROSCOPIC INFRALEATORAL 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 described 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 infraleatoral total laparoscopic pelvic exenteration. We aimed to show the video of the procedure.

**Results** Tips of laparoscopic pelvic exenteration

**Conclusion** we aimed to discuss tips of laparoscopic pelvic exenteration.

**Disclosures** we aimed to discuss tips of laparoscopic pelvic exenteration.

#856

#### ROB-GND: SURGICAL TIPS AND MODIFICATIONS IN TECHNIQUE TO IMPROVE PROBLEMS ENCOUNTERED DURING THE LEARNING CURVE FOR ROBOTIC INGUINOFEMORAL GROIN NODE DISSECTION FOR EARLY STAGE VULVAR CANCER

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**Introduction/Background** Modifications in Techniques to identify thigh muscles accurately during surgery to improve problems encountered during robotic groin node dissection (Rob-GND)

**Methodology** Identification of muscles in the anterior upper half of the thigh is of paramount importance for approaching femoral triangle. In open surgery, the incision and landmarks for identifying sartorius are fairly easy in upper third of thigh. Traditional port placement during Rob-GND described so far and practiced is at the junction of middle and lower third of thigh. However Sartorius and Vastus medialis are almost in the same spot in the middle third of the thigh leading to potential muscle miss. Problems encountered in the initial learning curve of Rob-GND with regards to anatomical muscle miss was addressed by rearranging the position of the ports and bringing them higher up around one index finger length below the apex of the femoral triangle. The initial port placement is done with blunt dissection of the space with index finger reaching the apex of the triangle, then the rest of the ports are introduced. So, the dissection starts from apex which helps in identifying sartorius accurately all the time. A 30 degree telescope helps in visualising the apex of the triangle better to remove the nodal tissue enbloc at completion of surgery as the camera is too close to the apex with this technique.

**Results** Improved techniques led to easy identification of sartorius and standardization of the procedure.

**Conclusion** Rob-GND is still a novel technique and is being evaluated. Adjustments and improvements in surgical techniques further will help in standardising the procedure for all surgeons in the learning curve.

**Disclosures** This surgical video was presented at IGCS Conference 2019

#860

#### LAPAROSCOPIC ASSISTED INFRALEVATOR POSTERIOR EXENTERATION WITH VULVOVAGINAL RECONSTRUCTION

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**Introduction/Background** Recurrent cervical cancer following surgery and pelvic radiotherapy is a complex disease to treat. It is also difficult to differentiate field change cancers of the lower genital tract from recurrent cervical cancer. Exenterative

surgery is commonly indicated for central recurrences with no involvement of pelvic side wall structures or lymph nodes as complete resection is feasible with better oncological outcomes. We present a surgical film of a unique case who developed disease (? recurrent/field change cancer) on the vulva with extension to posterior vagina and anal mucosa.

**Methodology** A 50 year old lady presented with a malignant growth on the vulva extending to lower vagina and anal canal. She did not have lateral side wall disease or lymph nodal involvement or distant metastasis. She had undergone non radical hysterectomy for an undiagnosed cervical cancer and had received adjuvant pelvic radiation elsewhere 12 months prior to referral to our hospital. We performed Laparoscopic Assisted Infralevator Posterior Exenteration with Vulvovaginal Reconstruction using gluteal V-Y advancement flaps.

**Results** Her postoperative recovery was uneventful.

Histopathology confirmed squamous cell cancer and margins of resection were free of tumor. Two suspicious sub-centimeter nodules in the pelvic peritoneum was positive for tumor for which she received adjuvant chemotherapy.

**Conclusion** Laparoscopic Assisted Infralevator Posterior Exenteration with Vulvovaginal reconstruction even though a complex procedure facilitates early postoperative recovery and timely administration of adjuvant therapy when indicated.

**Disclosures** This surgical video was presented at IGCS Conference 2020

#1000

#### VIDEO-ENDOSCOPIC INGUINAL SENTINEL LYMPH NODE BIOPSY WITH INDOCYANINE GREEN IN VULVAR CANCER

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**Introduction/Background** The standard surgical treatment of vulvar carcinoma < 4 cm in size without clinical or radiological suspicion of lymph node metastases consists of resection of the vulvar tumor with negative margins with mono- or bilateral sentinel lymph node biopsy performed by inguinal incision. The inguinal approach to inguinal lymph node staging is associated with a high rate of post-operative complications such as wound dehiscence, lymphocele, lymphedema, infections, and psychosexual impairment.

**Methodology** In this video, we present the case of an 83 years-old patient with 2 cm central anterior vulvar squamous carcinoma and in which inguinal sentinel lymph node biopsy was performed with an innovative video-endoscopic approach using indocyanine green. The surgery was carried out in an Italian Comprehensive Cancer Center.

**Results** The vulvar-vaginal examination under general anaesthesia reported an central anterior vulvar lesion of 2 cm. Indocyanine green (2.5 mg) was injected all around the tumor mass. After placement of a 15mm main trocar distal to the apex of the femoral triangle and two accessory trocars, the procedure began developing the anterior working space. Then, we performed a blunt dissection developed up to the inguinal ligament. The lymphatic tissue was identified from the fascia lata with a combination of blunt and sharp dissection up to