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 INGUINOFEOMRAL 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 pelvis radiation elsewhere 12 months prior to referral to our hospital. We performed Laparoscopic Assisted Infralevator Posterior Exenteration with Vulvovaginal Reconstruction using glutal 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