

be made to perform US guidance during all IC BT applications in definitive/palliative RT of cervical and uterine carcinomas.

**Disclosures** The authors disclose no conflict of interest.

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#### PELVIC EXENTERATION IN GYNECOLOGIC CANCER: COMPLICATIONS AND ONCOLOGICAL OUTCOME

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**Introduction/Background** Total pelvic exenteration (PE) is a radical operation, involving en bloc resection of pelvic organs, including reproductive structures, bladder, and rectosigmoid. PE is indicated in cases of unresponsive, recurrent pelvic cancer or for palliative intent. Careful patient selection and counseling are of paramount importance when considering someone for PE.

**Methodology** Between January 2011 and June 2022, 21 women underwent radical pelvic surgery (Exenteration) at Gyn-Oncological Department St. Luke's Hospital in Thessaloniki, Greece. Data related to surgery, complications and outcomes were recorded.

**Results** Fifteen (15) patients underwent supra-levator anterior exenteration and 2 patients had combined LEER. Two (2) patients had supra-levator posterior exenteration and 4 patients infra-levator total exenteration. The 5 years Overall Survival was 52% (11 pts).

**Conclusion** PE is an alternative treatment in carefully selected cases with good oncological outcomes. It is crucial though to be performed in well-organized Oncological centers, by experienced and well trained surgeons.

**Disclosures** All authors declare no conflict of interest

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#### SINGLE PORT ACCESS (SPA) ROBOT ASSISTED RADICAL TRACHELECTOMY FOR PATIENTS WITH EARLY STAGE UTERINE CERVICAL STUMP CANCER: FARFGALY'S TECHNIQUE

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**Introduction/Background** Cervical stump cancer occurs after 2 years or longer of subtotal hysterectomy that was performed for benign gynecologic diseases (including uterine myoma, endometriosis, pelvic inflammatory diseases, ovarian cyst), obstetric diseases (rupture of the uterus, severe postpartum hemorrhage).

**Methodology** The procedure is performed under general anesthesia. A Vcare uterine manipulator is placed vaginally. a veress needle is placed in the umbilicus for peritoneal insufflation. A 2 cm incision over the lower rim of the umbilicus was performed. The patient was placed in the Trendelenburg position, and the DaVinci SP robotic surgical system is side-docked parallel to the right side of the patient. Pelvic lymphadenectomy was performed. Dissection boundaries: The lateral bound is the medial bound of the psoas major muscle, the medial bound is the terminal branch of the internal iliac artery, the upper bound is 3 cm above the common iliac

artery, the lower bound is deep inguinal lymph nodes, and the bottom bound is obturator nerve. Radical trachelectomy. Type B1 of radical hysterectomy was performed. The procedure lasted for 180 minutes, and blood loss during the operation was 50 milliliters. Abdominal incisions are closed with O vicryl suture.

**Results** The patient had an uneventful post-operative recovery. The operating time was maintained at 180 minutes, and the console time was 130 minutes. The estimated blood loss was 50 ml. The patient was discharged home 2 days after surgery.

**Conclusion** Robot-assisted surgery has the advantages of the three-dimensional view, wrist system, and tremor filtration, reducing the scale of movements, improving ergonomics, and allowing more flexible joint activities and a higher degree of freedom, thus more precise operations can be performed. Farghaly's technique of robot-assisted trachelectomy for early-stage uterine cervical cancer stump is feasible and has the advantage of decreasing morbidity, reducing the risk of dissemination, and short hospital stay.

**Disclosures** None.

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#### PERIPARTUM RADICAL HYSTERECTOMY IN THE SETTING OF CERVICAL SQUAMOUS CELL CARCINOMA

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**Introduction/Background** Cervical cancer during pregnancy is rare, with an incidence rate of 0.1–12.0 per 10,000 pregnancies. Although the incidence of peripartum hysterectomy is increasing due to placenta accreta spectrum, peripartum radical hysterectomy remains an infrequently performed procedure.

**Methodology** A retrospective review of peripartum hysterectomies that occurred in a tertiary unit from 2011–2021. Patients who had a peripartum radical hysterectomy were included.

**Results** In total, 23 peripartum hysterectomies were performed (incidence of 0.8 hysterectomies per 1000 deliveries). Of these, 2 (8.7%) were radical hysterectomies for cervical squamous cell carcinoma (SCC).

Patient one is a 37-year-old woman diagnosed with cervical SCC at 29 weeks gestation in 2015. MRI demonstrated a 1.6cm cervical lesion, without parametrial involvement. A radical hysterectomy and pelvic lymph node dissection was performed at 35+6 weeks gestation, with 800ml blood loss. Post-operative course was complicated by vault dehiscence requiring re-suturing. This was FIGO stage 1B2 with positive lymph nodes and the patient received adjuvant chemoradiotherapy.

Patient two is a 35-year-old woman diagnosed with cervical SCC at 29 weeks gestation in 2017. MRI revealed a 4cm cervical lesion with an indeterminate left pelvic sidewall node. A radical hysterectomy and pelvic lymph node dissection was performed at 36+1 weeks gestation, with 400mls blood loss. Post-operative course was uncomplicated. This was FIGO stage 1B2 with LVSI and the patient received adjuvant chemoradiotherapy.

Both women had healthy babies and neither have had disease recurrence. Long term, patient one has had issues with lymphoedema and the second has had issues secondary to pelvic radiation.