

## AS04. Endometrial/Uterine corpus cancers

FF002/#801

**SUCCESSFUL LAPAROSCOPIC PROCEDURE INVOLVING THE PRIMARY REPAIR OF A PERFORATION IN THE DUODENUM SUBSEQUENT TO A LAPAROSCOPIC PARA-AORTIC LYMPHADENECTOMY**

Seongsil Cho\*, Jeong Min Eom, Joong Sub Choi. *Hanyang College of Medicine, Obstetrics and Gynecology, Seongdong-gu, Korea, Republic of*

10.1136/ijgc-2023-IGCS.487

**Introduction** To present of laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy for the patient with endometrial carcinoma.

**Description** A 78-year-old Korean woman with postmenopausal bleeding and thickened endometrium presented to our department. The histopathology of biopsied endometrium revealed grade 1 endometrioid adenocarcinoma. The preoperative MRI shows an about 5 cm sized tumor within the endometrial cavity suspicious myometrial invasion. We perform the laparoscopic staging surgery. No intraoperative complications were recognized. However, on postoperative day 1, the color of intra-abdominal drainage change from serosanguinous to dark green. We strongly suspected small bowel perforation and perform secondary laparoscopic surgery immediately. Peritoneum and prior operative site were tinged with bile. We scrutinized the small bowel and finally found the perforation site on duodenum. The perforation occurred at the horizontal part of duodenum ventrally vena cava. We carried out laparoscopic primary repair with 3–0 vicryl. Double layer closure was done by interrupted suture in first layer and Lambert suture for second layer. Then, we placed drainage into the duodenal repair site and traced the small bowel meticulously. We reviewed the video of primary surgery. But there was no definitive procedure related with duodenal perforation. We thought that the thermal injury was occurred by ultrasonic cutting and coagulating device during the lymphadenectomy in pre-caval area just below duodenum or mechanical micro-perforation is made during lifting the duodenum by dissecting forcep.

**Conclusion/Implications** Immediate laparoscopic primary repair of duodenal perforation after laparoscopic para-aortic lymphadenectomy is safe and feasible.

FF003/#250

**ROBOTIC RESECTION OF BULKY VAGINAL CUFF ENDOMETRIAL CANCER RECURRENCE WITH BLADDER INVOLVEMENT**

<sup>1</sup>Esra Demirel, <sup>2</sup>Farr Nezhat\*, <sup>3</sup>Anthony Corcoran. <sup>1</sup>*NYU Langone Hospital Long Island, Minimally Invasive Gynecologic Surgery, Mineola, USA;* <sup>2</sup>*Nezhat Surgery for Gynecology/Oncology, Gynecologic Oncology, New York, USA;* <sup>3</sup>*NYU Langone Hospital Long Island, Urologic Oncology, New York, USA*

10.1136/ijgc-2023-IGCS.488

**Introduction** In this surgical film, we present a robot-assisted upper vaginectomy and partial cystectomy for resection of endometrial cancer recurrence at the vaginal cuff involving the bladder. We highlight the use of indocyanine green dye

guidance to avoid ureteral injury and review techniques to prevent fistula formation.

**Description** The patient was taken to the operating room for robot-assisted resection of vaginal cuff tumor. Cystoscopy was performed and revealed no mucosal invasion of the bladder. Bilateral ureteral stents were placed without difficulty and injected with indocyanine green dye for identification of the ureters during dissection. Exploratory laparoscopy revealed no gross carcinomatosis or distant metastasis. The vaginal cuff tumor was noted to be invading into the bladder muscularis posteriorly and partial cystectomy was performed to resect the mass margins in this area. Once the tumor was completely mobilized off the bladder anteriorly and rectum posteriorly, upper vaginectomy was performed with adequate margins. The cystotomy was repaired with a running 3.0 absorbable barbed suture horizontally and the vagina was closed with a running absorbable barbed suture vertically to avoid parallel friction with the cystotomy repair for prevention of fistula formation. A piece of omentum was mobilized and sutured over the vaginal closure as an additional step to prevent future fistula formation.

**Conclusion/Implications** Locally recurrent vaginal cuff tumors can be safely resected with adequate margins robotically under indocyanine green dye guidance to avoid ureteral injury. Techniques to prevent future fistula formation include avoiding parallel suture friction between bladder, vagina or rectum and using omentum as a friction barrier.

## AS18. Surgical techniques and perioperative management

FF004/#554

**VIDEO DEMONSTRATION OF ROBOTIC ASSISTED TYPE II RADICAL HYSTERECTOMY FOR EARLY CERVICAL CANCER WITH VAGINAL CUFF CLOSURE USING ENDOSCOPIC STAPLER BEFORE COLPOTOMY**

Shree Bharathi\*, Rohit Ranade, Shruthi Dhevi, G Abhirami, Monica Saraswat. *Narayana Health City, Gynaecological Oncology, Bengaluru, India*

10.1136/ijgc-2023-IGCS.489

**Introduction** Minimally invasive surgery decreases postoperative morbidity after radical hysterectomy (RH) for early-stage cervical cancer. However, studies reported lower survival and higher recurrence rates as compared to open surgery, which maybe due to tumour spillage into the abdominal cavity during vaginal colpotomy or use of a uterine manipulator. This surgical film aims to present a methodical step-by-step approach for robotic radical hysterectomy with added steps for preventing tumour spillage.

**Description** A 48-year-old multiparous lady underwent loop electrosurgical excision procedure (LEEP) for CIN III (Cervical Intraepithelial Neoplasia) which was reported as well differentiated squamous cell carcinoma. There was no visible lesion on clinical examination or imaging. Here is an account of the steps of surgery- Creation of retroperitoneal spaces Ureterolysis Transection of right uterine artery Transection of right infundibulopelvic and round ligaments Bladder mobilization Similar steps on opposite side Development of Rectovaginal