spared radical hysterectomy (C-RRH) and total mesometrial resection method of robot radical hysterectomy (TMMR-RRH)

**Description**
TMMR can be standardized for all patients with locally defined tumors and appears to reduce morbidity, improve outcome and can potentially eliminate the need for adjuvant chemotherapy. It removes the complete Müllerian compartment except its distal part to preserve a functional vaginal vault. The identification of developmentally dedicated pelvic visceroptarial compartments serves as a template for the lymph node basins to be cleared.

**Conclusion/Implications**
The propensity score matched cohort of 66 patients in each group showed the overall survival rate was 89% in the C-RRH and 95% in the TMMR-RRH group (p=0.728) (HR 0.77; 95% CI 0.18–3.27) and disease-free survival rate was 83% in the C-RRH and 83% in the TMMR-RRH group (p=0.949). (HR 1.03; 95% CI 0.45–3.27) (106 vs 39 months median follow up). The recurrence pattern was significantly different in both groups (p=0.034) and was not significantly median time to recurrence (11 vs 18 months, p=0.271). In univariable and multivariable analysis with OS, involvement of resection margin (p=0.000) were found as independent significant risk factors and in regard to DFS involvement of resection margin (p=0.000) and deep stromal invasion (HR 3.84; 95% CI, 1.20–12.26, p=0.023) was found as independent significant risk factors. The present study found that TMMR-RRH provides the benefits of higher number of retrieved LNs, shorter operation times, however more blood loss and no disease free and overall survival benefit.

**SF006/#457**
**LAPAROSCOPIC SINGLE PORT RADICAL Hysterectomy with total mesometrial resection as part of surgical procedures in cases of cervical cancer**

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**Introduction**
The video is about **single port radical hysterectomy with total mesometrial resection** as part of surgical procedures in cases of cervical cancer. A 48-year-old patient with FIGO stage ib1 squamous cell cancer is shown

**Description**
In single port surgery, the operator provides traction or countertraction, and a hanging over or attraction suture through the abdomen is needed. The most important anatomic landmark for total mesometrial resection is superior hypogastric nerve and both hypogastric nerves and inferior hypogastric plexus. To identify these nerves following procedures are necessary. After extended lymphadenectomy, the pelvic anatomy could be examined more clearly including the superior hypogastric nerve promontory lower part of the aorta common iliac hypogastric vessels hypogastric nerve communicating with parasympathetic nerves and vesicle branches of the inferior hypogastric plexus. Cardinal ligament dissection is as follows. Opening of para vesical and par rectal spaces vessels in the cardinal ligament were selectively separated. Only superficial and deep uterine vein were coagulated with bipolar forceps or ligature and cut but the neutral part was preserved, located at dorsal medial part of cardinal ligament.

**Conclusion/Implications**
Even though laparoscopic single port radical hysterectomy is difficult, but total mesometrial resection techniques is more difficult. It took a long time 203 minutes and blood loss was 100 ml. 7 days later she can do self-voiding without catheterization. choice between these techniques should be based on surgeon preference and experience, patient anatomy, and other clinical factors. The identification of independent risk factors for survival outcomes may help guide clinical decision-making and improve patient outcomes.

**SF007/#740**
**FLUORESCENT-IMAGE-GUIDED PELVIC LYMPH NODE DISSECTION WITH RADICAL HYSTERECTOMY IN SINGLE-PORT LAPAROSCOPY**

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**Introduction**
The aim of this article is to demonstrate the feasibility and efficacy of fluorescent-image-guided pelvic lymph node dissection with radical hysterectomy in cervical cancer patients

**Description**
A 43-year-old woman was diagnosed with cervix cancer by punch biopsy. Pelvic MRI showed a 2.0×1.5 cm sized cervical mass and enlarged external iliac lymph node, and lymphovascular invasion with invasive squamous cell carcinoma was pathologically confirmed. The tentative FIGO stage
was Cervix cancer IB. At the beginning of the operation, indocyanine green (ICG) 2cc was injected into the 3 O’clock and 9 O’clock of the cervix. After ICG injection, a single umbilicus incision was made, and pelvic lymph node dissection was performed guided by a florescent image colored by ICG. Contrary to sentinel lymph node biopsy, we selectively removed all the ICG-stained lymph nodes and lymphatic channels around the parametrium. After complete removal of lymph nodes and lymphatic channels, type C1 radical hysterectomy, paraaortic LN dissection, and left ovarian transposition were conducted. The greatest dimension of the residual tumor was 21 mm, involving a deep one-third of the stroma invasion. There was no parametrial invasion or node metastasis except diffuse lymphovascular invasion. The patient was discharged on the 6th postoperative day without any surgical complications, including lymphocele or lymphedema. Currently, there is no recurrence; progression-free interval is 76 months.

Conclusion/Implications Florescent-image-guided pelvic lymph node dissection with radical hysterectomy is the best method for pelvic lymph node dissection in terms of making it easy to operate, reducing complications associated with lymph node dissection, and reducing locoregional metastasis.

AS04. Endometrial/Uterine corpus cancers

SF009/#744  SINGLE PORT ASSISTED LAPAROSCOPIC DEBULKING SURGERY FOR ENDOMETRIAL CANCER WITH BULKY LYMPH NODE LESION

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Introduction The purpose of this article is to demonstrate the possibility of single port assisted laparoscopic debulking surgery for endometrial cancer patients with bulky lymph node metastasis.

Description A 36-year-old married woman with abnormal vaginal bleeding was diagnosed with grade 3 endometrioid endometrial cancer. Pelvic and abdominal MRI revealed endometrial lesions invading more than half of the myometrium. In addition, multiple enlarged lymph nodes suggestive of metastasis were shown in both iliac chains, paraaortic, and retroperitoneal area. The largest paraaortic lymph node is about 4 cm in size. The patient underwent a single-port approach laparoscopic debulking. After indocyanine green injection onto the cervix, we performed pelvic and paraaortic lymph node dissection. The largest lymph node, about 40 mm, is noted on the L3L, severely adhered to vessels and soft tissues. Single-port approach laparoscopic debulking including hysterectomy with bilateral salpingo-oophorectomy, bilateral pelvic and paraaortic lymph node dissection and pelvic peritoneectomy was done. We achieved complete resection without complications. The total operating time was 7 hours. According to the final pathological reports, the patient was diagnosed with endometrial cancer stage IVB. 12 of 29 lymph nodes were contained with metastasis, and extrapelvic peritoneal metastasis was noted. The patient was discharged on the 3rd postoperative day without any surgical complications such as lymphocele and treated with systemic chemotherapy after the operation. There was no recurrence or complications. The progression-free interval was 14 months.

Conclusion/Implications Single port assisted laparoscopic debulking operation is feasible for endometrial cancer with bulky lymph node lesions.

AS11. Ovarian cancer

SF011/#797  SECONDARY LAPAROSCOPIC CYTOREDUCTION FOR RECURRENT OVARIAN CANCER FOLLOWING LAPAROSCOPIC PRIMARY DEBULKING SURGERY

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Introduction Background and Aims: To investigate the feasibility of laparoscopic secondary cytoreduction in patients with recurrent ovarian cancer with previous laparoscopic primary debulking surgery.

Description Methods: Design: Case study. Patients: A 52-year-old Korean woman underwent laparoscopic secondary