

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 6<sup>th</sup> 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.

SF008/#125

#### WHOLE COURSE TUMOR FREE LAPAROSCOPIC RADICAL HYSTERECTOMY ON CERVICAL CANCER

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**Introduction** Because of the concern of the tumor exposure during the classical LRH procedure for cervical cancer, we designed and implemented a surgical approach that ensure no tumor exposure throughout the procedure.

**Description** 1. The first step of the surgery is determining the lower border of the anterior and posterior vaginal walls which are intended to be excised. Then suture them together to seal the cervical cancer, so as to ensure no tumor exposure throughout LRH surgery. 2. 40 ml saline is injected into the vesicovaginal and rectovaginal spaces respectively to facilitate separation of the anterior and posterior spaces. 3. The anterior and posterior vaginal walls are cut to expose vesicovaginal space and rectovaginal space by monopolar electrocautery. Fingers are used to further separate the anterior and posterior spaces to reach the anterior and posterior reflection peritoneum. 4. A gauze is plugged into the two spaces respectively for support and as a marker. 5. After completing the pelvic lymphadenectomy, the operator cut the uterorectal and uterovesical reflection peritoneum to expose the gauze in above two spaces that have already been separated transvaginally. 6. After above procedures, the dissection of ureteral tunnel, and the cut of cardinal ligament, sacral ligament, and paravaginal tissues become simple. Finally, the LRH surgery is completed easily and safely, and no tumor exposure throughout the surgery.

**Conclusion/Implications** This surgical method can not only ensure no tumor exposure in the whole course of LRH surgery on cervical cancer, but also make the LRH surgery simple and safe.

## 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 into 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 peritonectomy 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 3<sup>rd</sup> 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