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 parametral invasion or node metastasis except diffuse lymphovascular invasion. The patient was discharged on the 6\textsuperscript{th} 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

**SFO09/#744** SINGLE PORT ASSISTED LAPAROSCOPIC DEBULキング SURGERY FOR ENDOMETRIAL CANCER WITH BULKY LYMPH NODE LESION

Young Joo Lee*, Sang Wun Kim. Institute of Women’s Life Medical Science, Yonsei University College of Medicine, Obstetrics and Gynecology, Seoul, Korea, Republic of

10.1136/ijgc-2023-IGCS.500

Introduction The purpose of this article is to demonstrate the possibility of single port assisted laparoscopic debulキング 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 debulキング. 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 debulキング 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 3\textsuperscript{rd} 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 debulキング operation is feasible for endometrial cancer with bulky lymph node lesions.

AS11. Ovarian cancer

**SFO11/#797** SECONDARY LAPAROSCOPIC CYTOREDUCTION FOR RECURRENT OVARIAN CANCER FOLLOWING LAPAROSCOPIC PRIMARY DEBULキング SURGERY

1Bo Seul Jegal*, 2Joong Sub Choi, 3Jeong Min Eom. 1Hanyang University Medical Center, Obstetrics and Gynecology, Seongdong-gu, Korea, Republic of; 2Hanyang College of Medicine, Obstetrics and Gynecology, Seongdong-gu, Korea, Republic of

10.1136/ijgc-2023-IGCS.501

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

Description Methods: Design: Case study. Patients: A 52-year-old Korean woman underwent laparoscopic secondary
NON-ANATOMIC LIVER RESECTION IN A CASE OF SOLITARY LIVER METASTASIS

1Shalini Rajaram*, 1Ayush Heda, 2Nirjhar Raj, 2Neeraj Yadav, 1Lakhwinder Singh, 2Nilotpal Chowdhury, 2Dipendra Sharma, 3Samiksha Thapa. 1All India Institute of Medical Sciences, Rishikesh, Surgical Gastroenterology, Rishikesh, India; 2All India Institute of Medical Sciences, Rishikesh, Gynaecological Oncology (Obstetrics and Gynecology), Rishikesh, India; 3All India Institute of Medical Sciences, Rishikesh, Department of Obstetrics and Gynecology, Rishikesh, India

Introduction Ovarian cancer is diagnosed at an advanced stage (FIGO stage IIC-IV) in approximately 60-80% of cases and aggressive, complex surgical procedures are often needed to achieve an optimal cytoreduction. Liver metastasis is one of the most common organs for metastasis portending a poor prognosis. We present a surgical video of non-anatomical liver resection (wedge resection) for oligometastatic disease in a case of high-grade serous carcinoma ovary during interval cytoreductive surgery.

Description 34-year P2L2A2 with high-grade serous carcinoma right ovary post right salpingo-oophorectomy with persistent solitary liver metastasis after 4 cycles of neoadjuvant chemotherapy for liver resection is presented. Intra-operatively, peritoneal washings, total abdominal hysterectomy, left salpingo-oophorectomy, retroperitoneal lymph node sampling, para-aortic omentectomy and excision of 2×2 cm peritoneal deposit adjacent to segment VI of liver was done. Intra-operative USG was used to localize the intraparenchymal lesion in segment IV/V of liver which measured 2.5×2 cm. Non-anatomical liver resection was done with adequate resection margins after ligation of distal middle hepatic vein. Post-operative course was uneventful and final histopathology reported the lesion and peritoneal deposit to be positive for metastatic carcinoma.

Conclusion/Implications Non-anatomical liver resection should become part of cytoreductive surgery, especially in surgically approachable oligometastatic disease. Feasibility of liver resection has recently been reported in a systematic review. However further studies are needed to address the prognostic impact of liver resections.