

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

cytoreduction for recurrent ovarian cancer and previous laparoscopic primary debulking surgery. Interventions: Laparoscopy Results: A 52-year-old Korean woman had a laparoscopic primary optimal debulking surgery on September 22, 2015. The FIGO stage IIIC was confirmed and she received 12 cycles of paclitaxel/carboplatin chemotherapy. Since then, it had been checked as NED state for 6 months. During follow up, lab results showed elevation of CA125, and recurrence was confirmed by PET-CT imaging. We performed LAVH with BSO, CDS mass excision, pelvic and paralympadenectomy during primary debulking surgery. In addition, diaphragm and omentectomy were performed. She received adjuvant chemotherapy with paclitaxel/carboplatin for 12 cycles. We performed the laparoscopic secondary cytoreductive surgery. Peritoneal cavity and diaphragm were clear and showed no metastatic nodule. Metastatic lymph nodes were confirmed along the left iliac vessels like seen in the previous PET-CT imaging and we resected them. What was seen as recurrence around right para-colic gutter area were metastatic nodule on the cecum surface. We removed the nodules and repaired the bowel serosa. She is receiving chemotherapy with stable disease at this time.

**Conclusion/Implications** Conclusions: Our experience indicate that laparoscopy is a feasible and safe approach to optimal cytoreduction for patients with recurrent ovarian cancer in case of laparoscopic primary debulking surgery.

SF012/#265

#### NON-ANATOMICAL LIVER RESECTION IN A CASE OF SOLITARY LIVER METASTASIS

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**Introduction** Ovarian cancer is diagnosed at an advanced stage (FIGO stage IIIC-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, supracolic 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.

SF014/#578

#### EXTENSIVE PERITONECTOMY OF OVARIAN CANCER BY REGION PARTITIONING ALGORITHM UNDER THE GUIDANCE OF MEMBRANE ANATOMY

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**Introduction** To show extensive peritonectomy of ovarian cancer by region partitioning algorithm under the guidance of membrane anatomy.

**Description** The theory of membrane anatomy is based on the premise that cell lineages of different organs do not mix at the boundary during embryonic development, the surface of each organ is covered by an envelope like structure. The key to success is to correctly identify the envelope of organs, find the white filaments (also called angel hair) in the membrane space and enter the right anatomical interface between organs. The scope of extensive peritonectomy includes the resection of all parietal peritoneum, part of visceral peritoneum, some mesentery and ligaments. The region partitioning algorithm was used to divide the whole abdominopelvic cavity into three parts by taking two lines, one was the upper edge of true pelvis, the other was the lowest margin of costal arch on both sides. Peeling the peritoneum by antagonistic drawing from the median abdominal incision to both sides of the lateral peritoneum by the way of envelopment from the periphery to the center.

**Conclusion/Implications** The implementation of extensive peritonectomy by region partitioning algorithm under the guidance of membrane anatomy marked R0 cytoreductive surgery for ovarian cancer changed from the removal of scattered lesions or organs to a set of orderly and complete narrative surgical march, which can not only improved the thoroughness and safety of the operation, but also avoided omitting the invisible peritoneal metastasis to the naked eye, helped surgeons to clarify technique routes, and reached the realm of nature.

#### AS15. Rare tumors

SF015/#414

#### METASTATIC MESONEPHRIC-LIKE UTERINE CARCINOMA: ROBOTIC ASSISTED TUMOR DEBULKING

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**Introduction** Mesonephric-like adenocarcinoma (MLA) of the uterine corpus is a rare and distinct gynecological malignancy. MLA has a similar appearance to mesonephric adenocarcinoma of the uterine cervix or vagina, which originates from mesonephric remnants. Despite presenting with symptoms and signs