similar to more common types of endometrial carcinoma, MLA tends to behave more aggressively, with advanced-stage disease at diagnosis, rapid progression, frequent recurrence, distant metastases, and poor prognosis.

Description This video showcases a case of robotic-assisted tumor debulking in a 60-year-old patient with metastatic mesonephric-like uterine carcinoma. The patient had a past medical history of fibroid uterus and endometriosis and presented with pelvic pain and postmenopausal bleeding. Imaging showed a dominant intramural uterine fibroid that had significantly increased in size, right pelvic sidewall and external iliac lymphadenopathy, and associated peritoneal thickening. CT imaging showed intense hypermetabolic activity in the uterus consistent with malignancy and hypermetabolic pelvic lymph nodes. At the time of the procedure, the patient was found to have extensive peritoneal carcinomatosis, bulky lymph nodes, and a tumor on the ureter, with distorted anatomy due to a large multi-fibroid uterus and dense adhesive disease on the vesico-uterine space. This video aims to review the surgical techniques used in complex minimally invasive debulking procedures. By the end of the procedure, all visible cancer was removed. The procedure was uncomplicated, and the patient was discharged on postoperative day 0.

Conclusion/Implications Our video provides valuable insights into the surgical techniques used to achieve complete tumor resection in complex cases with aggressive uterine tumors.

AS18. Surgical techniques and perioperative management

**SF017/#575** SURGICAL PROCEDURES OF SINGLE PORT ROBOTIC PARAAORTIC LYMPHADENECTOMY

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**Introduction** Single port robotic paraaortic lymphadenectomy is challenging surgical procedures. We are to demonstrate the surgical procedures of transperitoneal paraaortic lymphadenectomy.

**Description** Using bipolar and monopolar instrument of DaVinci SP robotic system, lymph nodes can be removed. With strength of articulating third arm, counter-traction of peritoneum made a clear view of retroperitoneal anatomy. In this video, DaVinci SP robotic paraaortic lymphadenectomy took 48 minutes and removed 15 paraaortic nodes. She discharged home on the next day of surgery without any events.

**Conclusion/Implications** Left and right infra-mesenteric or infra-renal paraaortic lymphadenectomy can be safely done by SP robotic system in endometrioid endometrial cancer patients.

**SF018/#987** GASTRIC RESECTIONS DURING UPPER ABDOMINAL CYTREDUCTIVE SURGERY IN OVARIAN CANCER

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**Introduction** Ovarian cancer is one of the most common gynecologic cancers and ranks eighth in mortality among women. More than 60% are detected in FIGO2018 stages III and IV. A complete cytoreduction is a significant prognostic factor. Eventual resection of gastric implants becomes an essential knowledge for the surgical treatment of ovarian cancer.

**Description** This video demonstrates surgical techniques using current surgical equipment for the correct resection of stomach lesions in ovarian debulking. It’s advise the introduction of a nasogastric tube to help mobilize the stomach. Initially demonstrated the resection of a lesion in the lesser omentum, which can be challenging due to rich vascularization and difficult access. The lesion is demarcated for its resection, and its dissection is started, paying attention to the preservation of the vascularization of the lesser curvature. Afterwards, we demonstrate a large lesion located on the posterior wall of the stomach. Starts performing the release of the transverse mesocolon of the lesion, taking care not to damage the vascularization of the colon. After shaving the stomach, hemostasis is performed with bipolar forceps and hemostatic suture. At the end, resection of the lesion in the gastric anterior wall was demonstrated. After its correct resection, a suture was performed to approximate the gastric serosa.

**Conclusion/Implications** This video demonstrates reproducible standardized surgical techniques with simple materials for gastric resections during ovarian cancer upper abdominal cytoreduction.
SURGICAL APPROACH TO CERVICAL CANCER AND CONSIDERATIONS FOR NERVE SPARING RADICAL Hysterectomy

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Introduction In this surgical film, our objective is to review the surgical approach to cervical cancer with a focus on nerve sparing radical hysterectomies. It is important to note that performing a nerve sparing radical hysterectomy does not detract from the radicality of the procedure, but rather describes the technique employed to carefully dissect and preserve the autonomic nerves of the pelvis. Radicallity, rather, is determined by the resection of ventral, dorsal, and lateral parametrium. This surgical film will outline the surgical techniques of nerve sparing radical hysterectomy and considerations for abdominal and minimally invasive routes of surgery. Footage is obtained from various cases.

Conclusion/Implications Radical hysterectomy is not just one type of surgery, but rather includes a spectrum of types of resections that balance curative effect with adverse postoperative consequences. Considerations for radical hysterectomy include review of the updated radical hysterectomy system, dissection and identification of key artificial spaces of the pelvis, and use of a laparoscopic vessel sealing device for abdominal surgeries. Importantly, sentinel lymph node mapping can be utilized in early stage cervical cancer with side specific pelvic lymph node dissection performed for unsuccessful mapping. Lastly, use of a Wertheim clamp or minimally invasive stapling device to prevent spill of cervical cancer cells intra-peritoneally is crucial in this oncologic procedure.

ROBOTIC-ASSISTED LAPAROSCOPIC TECHNIQUE FOR SPLENECTOMY AND PERICOLONIC TUMOR REMOVAL IN A PATIENT WITH RECURRENT OVARIAN CANCER

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Introduction The patient is a 64 year-old individual with germline BRCA status and recurrent ovarian cancer status post second-line treatment. She presented with increasing growths in her spleen and along the descending colon. We outline a robotic-assisted laparoscopic splenectomy and tumor implant removal performed by a multidisciplinary team of gynecologic oncologists and surgical oncologists.

Description Laparoscopic access was acquired using 12-mm AirSeal device followed by four 8-mm robotic trocars. The surgical field of view of interest was achieved by placing the patient in reverse Trendelenburg with a partial right lateral decubitus position. Due to the patient’s prior omentectomy, there was optimal visualization of the splenic ligaments and vascularization. Hem-a-lock clips were applied on the splenic vessels upon skeletonization, which were sealed and divided with the robotic vessel sealer. The pericolonic tumor had dense adhesions to the mesentery of the descending colon which disallowed its complete removal. This did not affect the patient’s disease course due to existing abdominal miliary disease. There were no intraoperative or postoperative complications, and the patient was discharged on postoperative day 1. Her pathology returned with metastatic carcinoma consistent with her primary diagnosis.

Conclusion/Implications This video shows the feasibility of a robotic-assisted laparoscopic splenectomy with tumor implant removal in recurrent ovarian carcinoma. A multi-disciplinary approach with surgical colleagues may offer improved patient benefit.

ROBOTIC-ASSISTED LAPAROSCOPIC SURGERY FOR EARLY-STAGE ENDOMETRIAL CANCER WITH SENTINEL LYMPH NODE BIOPSY USING INDOCYANINE GREEN AND NEAR-INFRARED IMAGING IN A PATIENT WITH MORBID OBESITY

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