#1109 ROBOTIC RETROPERITONEAL DEBULKING – CASE REPORT WITH TIPS AND TRICKS FOR A SAFE PROCEDURE

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Introduction/Background Lymph node metastasis significantly impairs the prognosis in cervical cancer. Patients with nodal metastases have a 3-year survival rate of 64%, compared to 94% in nodal-negative patients. It is postulated that bulky lymph node metastases are at a substantial risk of treatment failure due to the inverse relationship between tissue radiosensitivity and tumor deposit volume. Therefore, it is rational to hypothesize that pre-treatment lymph node debulking may optimize the response to radiotherapy, provided that the procedure is safe and does not delay the main treatment.
Methodology The illustrative case is of a 29-year-old patient with squamous cell carcinoma of the cervix stage T2bN1M0, treated with upfront chemoradiotherapy and brachytherapy, achieving a complete clinical response but experiencing retroperitoneal lymph node recurrence after a 8-month disease-free interval. Intraoperative evaluation identified para-aortic, intercaval, retro, and paracaval lymph node conglomerates measuring up to 5.0 cm.

The robotic surgical technique and tactics used for retroperitoneal lymph node debulking are described for didactics to perform it safely and effectively.
Results After accessing the retroperitoneal space, surgical thread is used to traction the peritoneal fold anteriorly. The acquisition of the surgical field provides wider freedom of movement for robotic forceps. Sharp dissection of great vessels allows the safety and radicality needed. The use of metal clips helps define the anatomical limits and the radiotherapy field, and prevents lymphorrhea. Surgical gauzes could be used as landmarks while lateralizing and protecting the ureters. The vessel-loop promotes the lateral and anterior vena cava mobilization during retrocaval space dissection, exposing the lumbar vessels.
Conclusion The benefits of this procedure are unproven and should not delay the sequential radiotherapy and systemic treatment. This video shows the strategies to achieve the desired success and avoid intraoperative complications. The standardized surgical steps and adequate training could make this complex surgical procedure easier and lead to satisfactory results.

03. Endometrial cancer

#133 DISSECTION OF AN EXTRAORDINARY LOCATION OF SENTINEL LYMPH NODES AND HYSTERECTOMY WITHOUT MANIPULATOR IN A PATIENT WITH ENDOMETRIAL CANCER

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Introduction/Background Endometrial cancer (EC) is the most common gynecological malignancy throughout the world. Sentinel lymph node biopsy with indocyanine green (ICG) has become more widely used and has been featured in recently published guidelines for EC.
Methodology A 45-year-old female with gravidity 0, parity 0, and body mass index 23.4 kg/m2 presented with complaints of abnormal uterine bleeding (spotting). Increased endometrial thickness was detected on transvaginal ultrasound (10 mm) in the postmenstrual period. Endometrioid type endometrial adenocancer with focal squamous differentiation International Federation of Gynecology and Obstetrics (FIGO) grade 1 was detected on endometrial biopsy.

Laparoscopic bilateral sentinel lymph node dissection with indocyanine green (ICG), hysterectomy (without uterine manipulator) + bilateral salpingo-oophorectomy were performed (video).
Results The patient stayed in hospital for 1 day. The final pathology result showed a FIGO grade 1, endometrioid type endometrial adenocancer with focal squamous differentiation, as a 1.5x 1 cm tumorous mass invading less than one-half of the myometrium. Neither lymphovascular invasion nor sentinel lymph node metastasis was detected.
Conclusion This video article is the first video demonstration of bilateral isolated high pelvic, para-aortic sentinel lymph node dissection in endometrial cancer.
Disclosures No major complications occurred during or after the surgery.

#167 SLN – MAPPING IN ENDOMETRIAL CANCER USING IMAGE1 S™ RUBINA – K. STORZ (ICG/NIR TECHNOLOGY)

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Introduction/Background The sentinel lymph node (SLN) mapping may have particular value in endometrial cancer (EC) because a therapeutic effect of lymphadenectomy per se is still unproven.
Methodology From March 2017 through December 2022, 114 women with apparently early stage EC underwent laparoscopic hysterectomy including ICG fluorescence SLN mapping. In all of the cases we use the IMAGE1 S™ Rubina – K. STORZ.
Results In all patients more than $\geq$1 SLNs was identified. In 94 (84.2%) patients bilaterally and in 20 (14.8%) patients unilaterally. All SLN-positive patients had pelvic SLNs. Lymph node metastases were detected in 6 patients (5.2%).
Conclusion With the standardization of the technique we managed to reproduce the high total and bilateral SLN mapping using cervical ICG injection and NIR fluorescence.

#378 THE CASE OF THE (NOT) MISSING SENTINEL LYMPH NODE

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