ISP-1-1  Primary invasive carcinoma of the vagina after partial colposcisis for stage IV pelvic organ prolapse: a case report

Department of Obstetrics and Gynecology, Chonnam National University Medical School, Gwangju, Korea
Chul Hong Kim, Moon Kyoung Cho, Woo Dae Kang, Jong Woon Kim, Seok Mo Kim, Yoon Ha Kim

We present here the case report of a postmenopausal woman who complained of recurrent pus-like vaginal discharge and perianal pain 1 year after Le Fort colposis, which was subsequently identified as a primary invasive carcinoma of the vagina. Biopsy confirmed a squamous cell carcinoma in the vagina, and the disease was classified as stage III according to FIGO staging. The patient received pelvic radiotherapy. This case emphasizes that differential diagnosis of recurrent vaginal discharge that presents remote from obliterate procedure for pelvic organ prolapse should consider not only pyometra, but also other causes.

ISP-1-2  Video endoscopic inguinal lymphadenectomy via the hypogastric subcutaneous approach (VEIL-H): our initial experience

Department of Obstetrics and Gynecology, Zhujiang Hospital, Nanfang Medical University, P.R. China, Department of Obstetrics and Gynecology, the Third Affiliated Hospital of Guangzhou Medical College, P.R. China
Yifeng Wang, Gaowen Chen, Huinan Weng, Xiujie Sheng, Ying Tan

Objectives: To develop a novel minimally invasive procedure, video endoscopic inguinal lymphadenectomy (VEIL-H), for inguinal lymphadenectomy in the patients with genital cancer, and to explore the feasibility to perform laparoscopic pelvic procedure (LPP) with the same working ports while VEIL-H is done.

Methods: From January 2010 to October 2011, six women with vulvar cancer and one with median vaginal cancer underwent VEIL-H. The procedures were performed using four working ports: the visual port was made at the umbilicus or at the midpoint between the umbilicus and xyphoid process for the laparoscope. Three 5-mm working ports were made at the sites 10 mm medially to the bilateral anterosuperior iliac spines and the midpoint between the umbilicus and pubic symphysis, respectively. The boundaries of inguinal dissection were same as those of open inguinal lymphadenectomy. The study was conducted with the approval of IRB.

Results: Of the 7 patients, four patients underwent bilateral VEIL-H only, and 3 patients underwent both VEIL-H and LPP using the same working ports. The average operative time for superficial and deep inguinal lymphadenectomy was 84 and 57.4 minutes respectively. No intra-operative complications were observed. The postoperative period was uneventful in 4 cases while 3 cases demonstrated mild complications like local erythema and lymphocyst. The average drainage duration was 10 days and hospital stay was 12 days. There was no recurrence after a mean of 10.5-month follow-up.

Conclusions: Our study demonstrated that VEIL-H could be an alternative to the open and conventional VEIL for the treatment of genitalrinary malignancies. It may have the advantage of being able to perform a less invasive LPP even in the cases with inguinal lymph node metastasis. However, further study with more cases and longer follow-up is needed to evaluate the long-term clinical outcome of this novel technique.

ISP-1-3  Two-port access staging laparoscopy including pelvic peritoneocmy

Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, Women's Cancer Clinic, Yonsei University College of Medicine, Seoul, Korea
Yoo Jin Lee, Hyun Jong Nam, Korea Lee, Eun Ji Nam, Sang Wun Kim, Sunghoon Kim, Young Tae Kim

Objectives: To demonstrate a two-port access laparoscopic maximal cytoreduction surgery in patient with suspected ovarian cancer.

Methods: A 35-year old woman with suspected ovarian cancer with multiple peritoneal seeding was performed a two-port access staging laparoscopy including pelvic peritonectomy at Yonsei University Health System in July 2011. Patient demographics and operative outcomes were prospectively collected.

Results: About a 10 x 8 cm sized multilobulated pelvic mass adhered to the right adnexa and the small bowel, about 6 x 6 cm sized left ovarian tumor and multiple tumor nodules on pelvic peritoneum, posterior cul-de-sac, rectal serosa and bladder serosa were noted. Staging laparoscopy including pelvic peritonectomy was successfully performed with no gross residual tumor. Resection of main mass adhered to small bowel was performed by general surgery department. The total operation time was 363 min and blood loss was about 250cc. On the final pathology report, diagnosis was given as gastrointestinal stromal tumor. The patient was discharged after conservative management of partial bowel obstruction.

Conclusion: A two-port access staging laparoscopy with pelvic peritonectomy as maximal cytoreduction surgery could be applied in selected patients.