Surgical film

Surgical Film (F1)

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Removal of metastatic nodes para-aortic area

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US guideline for cervical cancer recommends CCRT + brachytherapy for IB2 IVA disease if pelvic or para-aortic nodes are positive by radiological imaging or surgical staging. There is no description of lymphadenectomy. ESGO guideline describes that para-aortic lymphadenectomy may be considered in locally advanced cervical cancer with negative paraaortic lymph nodes on imaging for staging purposes and that debulking of suspicious pelvic nodes may be also considered. There is a big difference between the treatment policies for metastatic nodes for cervical cancer. LION trial for advanced ovarian cancer (AOC) concluded systematic pelvic and para-aortic lymphadenectomy, in patients with AOC who had undergone intraabdominal macroscopically complete resection and had normal lymph nodes both before and during surgery, was not associated with longer overall or progression free survival than no lymphadenectomy, and was associated with a higher incidence of postoperative complications. Two randomized controlled trials did not show a survival benefit of lymphadenectomy for patients with low-risk endometrial carcinoma. For patients with intermediate risk, data also has not shown a survival benefit. However, in Japan, Dr. Todo reported from retrospective cohort analysis that combined pelvic and para-aortic lymphadenectomy should be recommended as treatment for patients with endometrial carcinoma of intermediate or high risk of recurrence (Lancet 2010). As described above, especially therapeutic significance of systemic lymphadenectomy is still controversial in gynecological malignancies. What do you think about removing bulky nodes after completing the resection of primary tumor or optimal surgery? In this video, I am going to focus on Bulky nodes, which means clearly identified metastatic nodes. We will try to show you the “meticulous” and “awesome” lymph node dissection by our original video.

Surgical Film (F2)

Endometrial Hyperplasia, Endometrial Intra-epithelial Neoplasia, and Endometrial Cancer

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Laparoscopic para-aortic lymphadenectomy in endometrial cancer

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A 46-year-old female underwent total abdominal hysterectomy with right salpingo-oophorectomy and left salpingectomy for her provisionally diagnosed myoma uteri. The pathology report revealed myoma uteri with grade 1 endometrioid carcinoma of endometrium. Myometrial invasion was less than half of the thickness. However, the left fallopian tube had mucosal invasion of cancer. She was referred to our hospital. Six weeks after first operation, she underwent laparoscopic left oophorectomy, pelvic and para-aortic lymphadenectomy. The camera port was set at Li-Huang point with 3 ancillary diamond shaped ports. The procedure started with lysis adhesion and bilateral lymphadenectomy. Para-aortic lymphadenectomy began with opening the peritoneum covering right ureter along common iliac artery and aorta to the level of third part of duodenum. Both sides of peritoneum were sutured with vicryl no 0, hanging with abdominal wall at camera port level. The para-aortic lymph node (LN) was dissected in 4 groups; right below inferior mesenteric artery (IMA), right above IMA, left below IMA and left above IMA, respectively. The postoperative period was uneventful. The patient can be discharged in 2 days. The final pathology was negative of carcinoma in all specimens (0/17 right pelvic LN, 0/30 left pelvic LN, 0/12 right para-aortic below IMA, 0/6 right para-aortic above IMA, 0/11 left para-aortic below IMA and 0/10 left para-aortic above IMA). The pelvic and para-aortic lymphadenectomy in endometrial cancer patient can be achieved. However, this procedure takes times and complication such as; vascular injury, ureteric injury, lymphocyst and lymphedema. We conduct the sentinel LN biopsy study to detect the false negative rate compared to full lymphadenectomy. If this false negative rate is acceptable, we will not do the full lymphadenectomy anymore.

Surgical Film (F3)

Surgical Techniques & perioperative Management

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Robotic radical hysterectomy without uterine manipulator or vaginal tube
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The purpose of this study is to introduce robotic radical hysterectomy with tagged uterine suture instead of using a uterine manipulator or vaginal tube. A total of 4 ports were used; first