

Conclusion Based on the sample population, the cut-off values of Huang et al. (2019) of 475 for the SII, 2.4 for NLR, 118 for PLR and 0.26 for MLR were not found to be associated with cervical recurrence by multivariate analysis. Our results support the report of Holub & Biete (2019). Larger, local prospective studies is recommended.

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RECONSTRUCTIVE PLASTIC SURGERY USING FASCIOTANEOUS FLAPS IN THE SURGICAL TREATMENT OF VULVAR CANCER (193 CASES WITHIN THE 1995-2015 TIME PERIOD)

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Introduction Vulvar cancer is one of the rare malignancies in women, with surgical treatment showing the highest effectiveness. Extensive wound defects are difficult to close by stitching the edges of the wound. Tissue tension causes altered blood supply, which leads to suppuration of the wound, healing by secondary intention, and scarring. Delayed complications may be avoided using reconstructive plastic surgery. We aimed to show the advantages of reconstructive plastic surgery while treating vulvar cancer.

Methods We analyzed the outcomes of surgical treatment among 202 patients. Patients were grouped, depending on the method of closing the wound defect after radical vulvectomy: I - suturing the edges of the wound (n=110); II - using fasciocutaneous flaps from the posterior thighs (n=42); III - stitching the vaginal wall and flaps with intradermal suture (n=50).

Results Suppuration and secondary healing were less common in Group II, compared with Group I (19.0% vs. 50.9%, respectively). In group III they were even further reduced down to 2.44%. A decrease in the frequency of delayed complications (dysuria, vaginal stenosis) and improved quality of life was also noted in Group III. The rate of local cancer recurrence did not exceed 10% in group II and III, while it equaled 24.6% in group I.



Abstract 122 Figure 1 The wound defect is closed with fasciocutaneous flaps from the back of the thighs



Abstract 122 Figure 2 Two years after radical vulvectomy and plastic surgery with fasciocutaneous flaps

Conclusions Reconstructive plastic surgery after vulvectomy allows wide excision of perineal tissue while simultaneously improving the treatment results.

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MINIMALLY INVASIVE SURGERY VERSUS LAPAROTOMY IN HGS EOC PATIENTS IN A TEACHING REFERRAL CENTER

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Introduction Complete cytoreduction represents a significant impact in OS for EOC patients. A large longitudinal incision is the standard access to achieve this goal. The aim of this study is to evaluate the role of MIS in interval debulking at a teaching institution.

Methods 126 HGS EOC patients referred for primary treatment in a referral cancer center, from 2014 and 2018, were included. Almost all patients underwent a laparoscopic diagnostic and peritoneal carcinomatosis index evaluation (PCI) before therapy. PS>2, PCI>20 and ASA>3 were indicators for neoadjuvant therapy.

Results 16 MIS and 79 laparoscopic debulking procedures were identified. Interval debulking was proposed in 9 (23.6%) MIS and 29 (76.4%). Most patients were stage III and IV. A

Abstract 123 Table 1 Câncer stage x surgery interval cytoreduction

	MIS	Laparotomy
2b	0	1
3a	0	1
3b	0	1
3c	5 (55,5%)	16 (55,1%)
4a	1 (11,1%)	6 (20,6%)
4b	3 (33,3%)	4 (13,7%)