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LONG TERM FOLLOW UP AFTER DIAGNOSIS OF GESTATIONAL TROPHOBLASTIC DISEASE

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Introduction/Background The spectrum of Gestational trophoblastic disease (GTD) ranges from pre-malignant conditions of complete (CHM) and partial (PHM) hydatidiform moles to the malignant invasive mole, choriocarcinoma (CC) and very rare placental site trophoblastic tumour/epithelioid trophoblastic tumour (PSTT/ETT). Gestational trophoblastic neoplasia (GTN) are highly responsive to chemotherapy (CT) and with appropriate diagnosis and management a high cure rate (>90%) is observed. In this study we reviewed the outcomes of long term follow up for GTN patients (pts) treated in our centre.

Methodology Update of outcomes (clinical records and phone contacts) of patients with GTN tumours treated in our centre between January 2005-December 2014.

Results Twenty three GTD pts between 2005–2014: 2 PHM (9%) and 9 CHM (39%), 8 CC (35%), 2 ETT (9%) and 2 PSTT (9%). Median age at diagnosis: 37 years (20–53). Staging: 12 stage I (52%), 9 stage III (39%) and 2 stage IV (9%). Most patients received CT as first treatment (20; 87%), according to prognostic risk score: 10 with methotrexate (MTX) monotherapy (50%) and 10 with EMA-CO (50%). Resistance to first line CT was observed in 5 patients (22%), 2 after MTX monotherapy and 3 after EMA-CO. For those pts, 2nd line CT was as follows: 1- ACT-D; 1 -EMA-CO (after MTX monotherapy) and 3-EMA-EP (after EMA-CO). Surgery was performed in 9 pts: 6 because of residual disease after CT and in 3 cases as the only treatment (1 patient with ETT and 2 patients with PSTT). One patient without criteria for treatment underwent clinical surveillance. Treatment related adverse reactions- Significant CT toxicity was observed in 2 pts (1-pneumonitis, 1- sarcoidosis), both with clinical resolution after specific care. One pt complained of late surgical sequelae (adhesions) and still hasn't recovered. After a median follow up of 69 months, 2 patients died: 1 due to a second malignancy (glioblastoma), 1- due to acute respiratory failure (extensive lung metastasis in previous chronic lung disease). Five patients maintain FU at our centre and 17 were either referred to their primary care physician (9) or were lost to follow up (7). Second neoplasia was observed in 3 pts: 1-glioblastoma, 1- thyroid papillary carcinoma, and 1- gallbladder polyps.

Conclusion GTD is a rare diagnosis and duration of follow is controversial. Our data suggests that prompt management of serious CT adverse reactions is important to prevent the late term impact of CT toxicities. Second neoplasia in survivors of GTD deserve further study.

Disclosures No disclosures to report.

Vaginal and vulvar cancer

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CONTRALATERAL NON-SENTINEL NODE METASTASIS IN EARLY PRIMARY VULVAR CANCER WOMEN WITH POSITIVE UNILATERAL SENTINEL NODE

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Introduction/Background Since the introduction of the S2K AWMF guideline-based sentinel node biopsy technique in unifocal vulvar cancer (diameter of <4 cm) and unsuspecting groin lymph nodes, the morbidity rate of patients has significantly decreased in Germany. The groin recurrence rate after IFL is vary from 0% to 5.8%, in contrast to 2.3% (95% CI, 0.6% to 5%) in unifocal vulvar cancer vs 3% (95% CI, 1% to 6%) in multifocal vulvar cancer after SLNB only, as suggested in the GRoningen INternational Study on Sentinel node in Vulvar cancer (GROINSS-V-I) in 2008. Current guidelines suggest that in cases of metastasis of unilateral sentinel lymph node (SLN) biopsy (B), groin node dissection, namely inguinofemoral lymphadenectomy (IFL), should be performed bilaterally. However, a publication by Woelber et al. in Germany and Nica et al. in Canada contradicted the current guideline indication for bilateral IFL in case of unilateral SLNB metastasis.

Methodology Our research study consisted of a single-center analysis from the Department of Obstetrics and Gynecology in the University Hospital of Dusseldorf, evaluating vulvar cancer patients treated with SLNB retrospectively from 2002 to 2018.

Results

1. Twelve women (n=12/30; 40%) had ipsilateral IFL only, in accordance with patient desire to avoid morbidity and/or old age. Only one woman was diagnosed having positive metastatic IFL and 11 women were negative IFL
2. Eighteen women (n=18/30; 60%) who received complete bilateral IFL were further divided into three subgroups:
 - A. Thirteen women (n=13/30; 43.4%) had negative IFL results in both groins.
 - B. One woman (n=1/30; 3.3%) had ipsilateral IFL metastasis.
 - C. Four women (n=4/30; 13.3%) had contralateral IFL groin metastasis after unilateral SLNB metastasis initially.

Conclusion The depth of tumor cells infiltration is a significant factor in the prediction of contralateral metastasis (p=0.0038). According to our study results, radical bilateral IFL should be offered in treatment management of early primary vulvar cancer with anterior midline lesion and unilateral SLNB metastasis. However, the need for radical bilateral IFL in cases of lateralized tumor with positive ipsilateral SLNB should be further evaluated.

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3D-PRINTED MULTI-CHANNEL VAGINAL APPLICATOR FOR BRACHYTHERAPY IN GYNECOLOGICAL CANCER

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Introduction/Background Despite modern techniques in external beam radiotherapy (EBRT), intensity modulated radiation therapy (IMRT) and stereotactic radiotherapy (SRT), brachytherapy (BT) remains one of the most important modalities for the treatment of advanced gynaecological cancer. In some special cases commercially available applicators for MRI-guided intracavitary/interstitial (IC/IS) BT do not offer proper target