terms of the number of patients, our results show the efficacy of vaginectomy in recurrent gynecological cancer.

2022-RA-1211-ESGO VULVAR ECTOPIC LOCALIZATION OF BREAST CANCER

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Introduction/Background To report the case of a patient diagnosed withectopic pagetoide vulvar lesion in the vulva with breast cancer and to conduct a literature review of the diagnosis, treatmentand prognosis in that location.

Methodology A 60-year-old patient who presented a pagetoide vulvar lesionwith breast cancer to CPMC, Algiers, Algeria. The lesionwas assessed on MRI and then surgically excised; histopathology showed Invasive carcinoma of no special type (NST) after a mastectomy for the initial breast cancer We reviewed PubMed for our search, all dates using the terms: breast cancer recurrence, breast cancer metastasis, vulva and breast cancer, metastatic vulvar cancer and vulvar cancer, ectopic localisation

Results Including our case, a total of 21 publications were listed including 9 cases of IDC, 5 cases of ILC, 2 cases of undifferentiated carcinomas, 2 cases not clinically described, 1 case of comedocarcinoma and 1 case of cystosarcomaphyllodes .The time interval between the initial diagnosis of breast cancer and the secondary vulvar localization, ranges from 4 months to 255 months.

Conclusion Hartung, in 1872, first reported a fully formedmammary gland in the left labium majus of a 30-year-old womanEven the ectopic breast tissue occurs along the milklines, extending bilaterally from the mid-axillae through the normal breasts and then inferiorly to the medial groins. In women, the inferior extensions of the milk lines transverse the vulva bilaterallyIn this case; Is it a secondary localization or an ectopic localization of an infiltrating breast carcinoma? Due to the rarity of this diagnosis, there are no establishedguidelines for the treatment of the patient. The appropriatetreatment for a primary orthotopic breast cancer of a similarstage is recommended. Our patient was treated with local excision of the vulva and adjuvant.

2022-RA-1268-ESGO SURGERY AFTER PRIMARY CHEMO/RADIATION IN LOCALLY ADVANCED VULVAR CANCER: ANALYSIS OF SURGICAL OUTCOMES AND SURVIVAL

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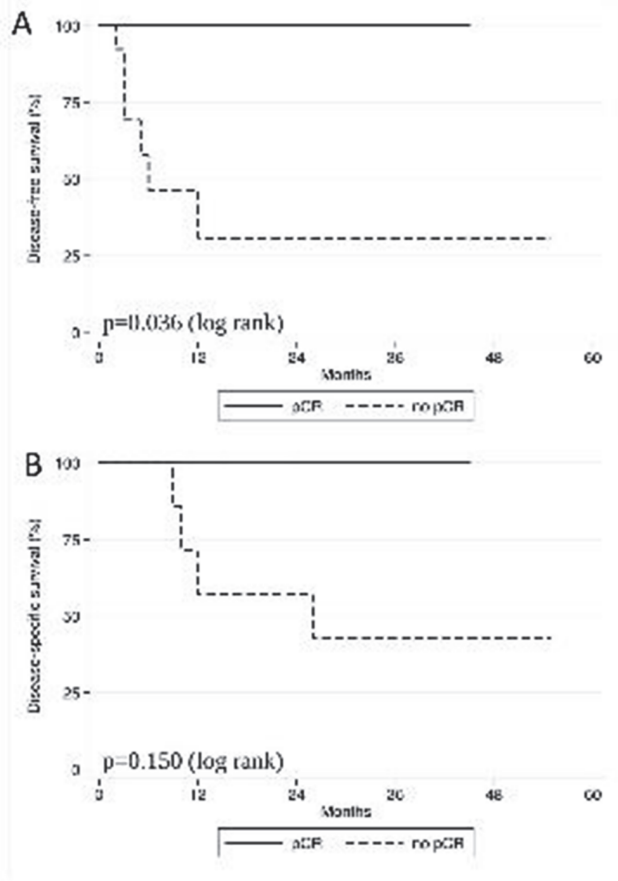
Introduction/Background More than 30% of vulvar cancer new cases are locally advanced (LAVC). The treatment of LAVC consists of primary radiotherapy, +/- chemotherapy – (CT)RT. Surgery is scheduled after neoadjuvant treatment or added to exclusive (CT)RT to debulk residual disease. Our aim was to assess survival and surgical complications in this setting.

Methodology Patients with squamous LAVC submitted to (CT)RT and surgery at our Institution between January 2016 and December 2021 were retrospectively evaluated.

Results 51 patients were submitted to primary (CT)RT: 40 (78,4%) had a clinical response (complete in 18 and partial in 22 cases), 1 (2%) stable and 10 (19.6%) progression disease. Overall, 19/51 (37.2%) patients underwent surgery. Regarding baseline nodal involvement of surgically treated patients, the work up showed 6 (31,6%) clinically negative, 3 (15,8%) clinically positive inguinal nodes and 10 (52,6%) pelvic nodal disease. Surgeries were classified as radical [vulvar and/or inguinal surgery, n=5 (26.3%)] and ultra-radical [requiring plastic reconstruction and/or pelvic surgery (visceral or lymph-nodal), n=14 (73.7%)]. Overall, 17 patients (89,4%) experienced a post operative complication with a Clavien-Dindo grade ≤2 in 58,8% of cases (17,6% after radical and 41,2% after ultra-radical surgery) (Table 1).Five (26.3%) patients showed pathological complete response (pCR), while 14 (73.7%) had residual tumor [7 (36.8%) vulvar-site, 1 (5.3%) LN-site and both-sites in 6 (31.6%) cases].The 3-years disease-free survival was 100% in case of pCR and 30.8% for residual tumor, (p=0.036) (Figure 1).



Abstract 2022-RA-1268-ESGO Figure 1

Abstract 2022-RA-1268-ESGO Table 1

	Radical surgery (n=5)	Ultra-radical surgery (n=14)
Patient experiencing any complication, n (%)	5 (100)	12 (85.7)
Patient experiencing grade ≥ 3 complications, n (%)	2 (40)	5 (35.7)
Patients experiencing more than one complication, n (%)	1 (20)	7 (50)
Details of surgical complications	**All (6)**	**All (20)**
Grade 1		
Vulvar wound dehiscence	1	4
Lymphocele	1	3
Grade 2		
Vulvar wound dehiscence	1	1
Groin wound dehiscence	1	2
Reconstruction flap necrosis	-	1
Atrial fibrillation	-	1
Grade 3a		
Lymphocele	-	1
Groin wound infection	1	-
Abdominal abscess	-	1
Grade 3b		
Vulvar wound dehiscence	1	4
Groin wound dehiscence	-	1
Grade 4a		
Pneumonia	-	1

Conclusion A high rate of clinical responses (complete/partial) to (CT)RT was registered. Post-operative complications resulted acceptable compared to literature data. pCR is associated with excellent survival also in these tumors as demonstrated in other neoplasms. The multidisciplinary approach is crucial to complete the combined treatment planned [(CT)RT+/- surgery]. In the future, predictive models could allow to select patients on the basis of their foreseen response.

2022-VA-1275-ESGO AGRESSIVE ANGIOMYXOMA OF THE PELVIS AND VAGINA: A ROBOTIC AND VAGINAL COMBINED APPROACH

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Introduction/Background Aggressive angiomyxoma (AA) is a rare mesenchymal tumor, typically arising in the soft tissue of the pelvis and perineum[1], with local aggressive behavior and frequent local recurrence. Surgical excision is the standard treatment[2].

Methodology We report the case of a 47-year old woman diagnosed with a pelvis and perineum AA. Magnetic resonance imaging revealed a 9cm infiltrative mass at the level of the lateral wall of the left introitus, extending to the left infravesical space, lateral wall of the vagina and anal sphincter, infiltrating the left levator ani muscle and ischiorectal fossa. A surgical treatment was performed.

Results First, a robotic approach with standard five-port placement configuration was used. Surgical strategy initially consisted in the development of the lateral avascular spaces of the left pelvis: lateral and medial paravesical spaces, lateral pararectal space and left obturator fossa. The first maneuver consisted in the detachment of the tumor from the obturator fossa and left lateral wall of the bladder. Then, development of the Retzius space up to the bladder neck was realized to identify the pre-vesical portion of the tumor. The use of intravenous ICG helped to identify the anatomical plane for the detachment of the tumor from the bladder. A technical difficulty for the excision of the AA is its soft consistency, making it easy to confuse with soft fatty tissues of the pelvis and making it difficult to obtain negative pathologic margins. Next, a vaginal approach with a longitudinal incision was performed, enabling the identification of the ischiatic tuberosity, ischiocavernosus, bulbocavernosus, and perineum transversus muscles. Ischiorectal fossa was developed and the tumor exteriorized. Detachment of the AA from the lateral wall of the vagina and rectum enabled the excision of the surgical specimen.

Conclusion The pathologic analysis revealed positive margins. The patient was discharged four days later.

2022-RA-1299-ESGO HOW TO PREDICT PREOPERATIVE RISK OF LYMPH NODE METASTASIS IN VULVAR CANCER PATIENTS THE MORPHONODE PREDICTIVE MODEL

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Introduction/Background Preoperative evaluation of inguinal lymph nodes in vulvar cancer patients is still a challenge. Our aim was to build a robust, multi-modular ultrasound model based on artificial intelligence.

Methodology From March 2017 to April 2020, 127 women were included at our center and 237 inguinal regions were studied before surgery by ultrasound experienced examiners. Ultrasound features defined in previous studies were prospectively collected. Histopathology was considered the reference standard. Fourteen informative features were used to train and test the machine, in order to obtain a diagnostic model. The following data classifiers were integrated into the predictive model: 1) random forest classifiers (RCF); 2) decisional tree (DT); 3) regression binomial model (RBM); 4) similarity profiling (SP). A predictive tool was implemented in the open-source R package, available on line as 'Morphonode Predictive Model' at https://github.com/Morphonodepredictivemodel.

Results The tool provides four output modules: 1) the binary malignancy prediction (Morphonode-RFC), distinguishing between malignant and benign lymph nodes with an accuracy of 93.3% and a negative predictive value of 97.1% (95%CI 83.8–100.0); 2) the risk signature (Morphonode-DT), identifying 4 specific signatures correlated with the risk of metastases: metastatic signature (MET), high metastatic risk (HMR), moderate metastatic risk (MMR) and low metastatic risk (LMR); the point risk of metastasis for each signature is 100%, 81%, 16% and 4% respectively; MET signature correlates with higher risk for multiple metastatic nodes (frequency of 45.7%); 3) the point malignancy risk, providing a point risk estimate in each specific lymph node described (Morphonode-RBM); 4) a selection of the top- 5 similar profiles in the