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LONG TERM FOLLOW UP AFTER DIAGNOSIS OF GESTATIONAL TROPHOBLASTIC DISEASE

Pedro Corvelo Freitas, Beatriz Mira, António Guimarães, Ana Opinião, Hugo Nunes, Ana Francisca Jorge, Fátima Vaz, António Moreira. *Instituto Português de Oncologia de Lisboa Francisco Gentil*

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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

Andreas Suhartoyo Winarno. *University Hospital of Dusseldorf, Obstetrics and Gynecology*

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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

- 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
- Eighteen women (n=18/30; 60%) who received complete bilateral IFL were further divided into three subgroups:
 - Thirteen women (n=13/30; 43.4%) had negative IFL results in both groins.
 - One woman (n=1/30; 3.3%) had ipsilateral IFL metastasis.
 - 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

Helena Logar, Robert Hudej, Manja Kobav. *Institute of Oncology Ljubljana*

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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

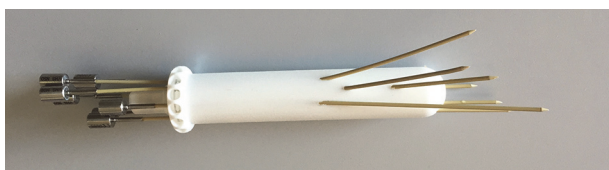
coverage. With the help of additive technologies, 3D-printed applicators can be tailored to the patient's tumour and anatomy.

Methodology In this report two cases of gynaecological cancer, one vaginal and one recurrent endometrial cancer are presented. The design of the applicator was based on MRI images of the patient with the standard Varian vaginal cylinder inserted. Parallel and oblique needles were virtually added to the planning system to get the best possible coverage of the tumour while respecting the dose constraints to the organs at risk (OARs). Individual applicators were made from biocompatible polyamide PA 12 with selective laser sintering (SLS) technology (figure 1). The next BT was performed with an individual applicator in situ. Rectal ultrasound was used for needle guidance. The dose-volume histogram (DVH) parameters for each patient were compared according to the planning aims. The planning aim for D90 high-risk clinical target volume (CTV-THR) was to reach physical dose > 20.5 Gy per one BT fraction delivered in 24 pulses of pulsed dose rate (PDR) BT.

Results The DVH parameters for both cases per one BT fraction are presented in table 1. The procedure and the implantation of the needles was performed without complications in regional anaesthesia. The applicator was well tolerated, no adverse effect was reported during the treatment or removal of the applicator.

Conclusion The advantages of using an individually-designed multi-channel vaginal applicator are:

- better target coverage in advanced tumours extended in the vagina
- can be used in a narrow vagina
- implantation guidance of several oblique and parallel needles can be performed with minimized trauma to the surrounding tissue
- allows for the treatment of several tumour locations in the same BT fraction



Abstract 86 Figure 1 Multi-channel vaginal applicator with oblique and parallel needles

Abstract 86 Table 1 The dose-volume histogram parameters for both cases per one pulse-dose rate brachytherapy fraction

| DVH parameter | Patient 1 | Patient 2 | Planning aims* |
|--------------------------------------|-----------|-----------|----------------|
| CTV-T _{HR} D98 | 18.7 Gy | 17.4 Gy | > 14.8 Gy |
| CTV-T _{HR} D90 | 23.4 Gy | 21.5 Gy | > 20.5 Gy |
| CTV-T _{HR} V100 | 19.3 Gy | 18.9 Gy | > 18.0 Gy |
| Bladder D _{2cm³} | 13.3 Gy | 12.5 Gy | 14.6 Gy |
| Rectum D _{2cm³} | 9.5 Gy | 10.8 Gy | 11.2 Gy |
| Sigmoid D _{2cm³} | 5.7 Gy | 5.7 Gy | 13.0 Gy |
| Bowel D _{2cm³} | 5.6 Gy | 9.5 Gy | 13.0 Gy |

*The planning aims are physical doses calculated per one BT fraction according to Embrace II study.

BT fraction was delivered in 24 pulses using pulsed dose rate BT, one pulse per hour, repair half time 1.5 hour, a/b = 10 for tumour and a/b = 3 for OARs

Disclosures Helena Barbara Zobec Logar, Robert Hudej and Manja Kobav have nothing to disclose.

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PROGNOSTIC FACTORS RELATED TO RECURRENCE AND SURVIVAL OF EARLY STAGE VULVAR SQUAMOUS CELL CARCINOMA

¹Yun Wang, ²Kristina Lindemann, ³Kjersti Bruheim, ³Anne Barrameda, ⁴Ben Davidson, ³Tone Skeie-Jensen. ¹Department of Gynecologic Oncology, Oslo University Hospital-Radium Hospital, Oslo, Norway; ²Department of Gynecologic Oncology, Oslo University Hospital-Radium Hospital, Oslo, Norway; Faculty of Medicine, Institute of Clinical Medicine, University of Oslo, Oslo, Norway; ³Department of Oncology, Oslo University Hospital-Radium Hospital, Oslo, Norway; ⁴Department of Pathology, Oslo University Hospital-Radium Hospital, Oslo, Norway; Faculty of Medicine, Institute of Clinical Medicine, University of Oslo, Oslo, Norway

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Introduction/Background In patients treated for clinical early stage vulvar squamous cell carcinoma (VSCC), recurrence rate is reported to be up to 37%. Identification of prognostic factors related to recurrence and survival will help to tailor surgical treatment and follow-up with the aim to prevent recurrence and prolong survival. The aim of the study is to evaluate prognostic factors for recurrence and survival among patients with early stage VSCC.

Methodology This is a retrospective study of patients with early stage VSCC who were treated at Oslo University Hospital – Radium hospital between 01.01.2006 and 31.12.2016. Clinicopathological characteristics, treatment and follow-up were extracted from the medical records. Univariate analysis and multivariate logistic regression and Cox proportional hazard regression analysis were used to identify prognostic factors for recurrence, time to recurrence (TTR) and overall survival (OS). A p-value of <0.05 was considered to be statistically significant.

Results 133 patients with clinical stage I VSCC were included. All patients underwent primary vulva surgery and evaluation of groin lymph node status. The median age was 64 years (range 29–93 years), and groin lymph node metastases were identified in 22.6% of patients. The median follow-up time was 67 months (range 5–165). The 5-year recurrence and survival rates were 23.3% (31 of 133) and 72.2% (96 of 133), respectively. In multivariate analysis, the presence of lichen sclerosus and groin lymph node metastasis were independent significant prognostic factors for recurrence and TTR, with an odds ratio (OR) (95% CI) of 5.37 (2.13–13.53) and 2.8 (1.17–6.72), respectively, for recurrence, and a HR (95% CI) of 2.6 (1.35–5.19) and 2.2 (1.13–4.26) for TTR, respectively. Age >70 years and a history of recurrence were independent prognostic factors for OS, with an HR (95% CI) of 3.0 (1.58–5.65) and 2.1 (1.57–6.15), respectively. Pathological tumor-free margin distance was not an independent prognostic factor for recurrence, TTR or OS, neither using a cutoff of 8 millimeters, nor as a continuous variable.

Conclusion Patients with lichen sclerosus and groin lymph node metastasis have a higher risk for recurrence and shorter TTR. Patients with age >70 years and a history of recurrence have significantly poorer OS. Pathological tumor-free margin distance was not an independent prognostic factor for recurrence and survival.

Disclosures All authors declare no conflict of interest.