Results We presented two types of vulvar reconstructions at the time of primary treatment, using different types of flaps: medial thigh flap and rectus abdominal muscle flap. The histological types of tumors were vulvar squamous cell carcinoma and lymphangiosarcoma. The operation time was 320 and 420 minutes, the blood loss – 200 ml and 350 ml, the length of hospitalization was 12 and 14 days respectively. Both of patients suffered pain before surgery, and were relived after. There were no postoperative complications. None of patients had flap loss.
Conclusion The use of skin flap for reconstruction in treatment of advanced vulvar cancer can improve functional status. It is associated with the low rate of postoperative complications and decreasing pain, which significantly better the women's quality of life.
Disclosures Authors declare no disclosures.

475 VULVAR CANCER: 20 YEAR OF EXPERIENCE FROM A REFERRAL CENTER IN MEXICO

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Introduction/Background Vulvar cancer is one of the less frequent gynecological tumors, with only 4% occurrence in patients, with a mean age at diagnosis of 68 years. In Mexico, it represents 0.22% of all tumors, however, its incidence in the last few years has been rising in hand with human papillomavirus infection and smoking. The most common symptoms are pruritus, ulcers, vaginal discharge, or pain.

Squamous cell carcinoma is the most common histology (75%), followed by melanoma, basal cell carcinoma, and adenocarcinoma. At diagnosis, 59% are in early stages, 30% involve locoregional and 6% distant metastases, with an overall 5-year survival of 72%.
Methodology Retrospective analysis of the database of Centro Universitario Contra el Cáncer from 1999 to 2019.
Results We identified 61 patients with diagnosis of vulvar cancer, with a median age of 68 years (27 – 95), 20% history of diabetes mellitus, 80% overweight or obesity, 10% positive smoking, 85% postmenopausal, 46% had more than 3 children, 85% status performance 0 – 1 and incidence of 4 cases/year.

In relation to the disease characteristics, the median size of the tumor was 48 mm. The most common histological subtype was squamous cell carcinoma, 85% with invasive component, 78% moderately differentiated, 50% lymphovascular invasion and 8% perineural invasion present; 46% had negative nodes, 38% N1 and 16% N2.

The most frequent clinical stage at diagnosis was III and only 3 patients presented distant disease (lung, bone, and rectum). Initial treatment was surgical in 60%, with radical vulvectomy in 43%, 22% unilateral lymphadenectomy, and 13% bilateral, with positive margins in 32% of cases. 30% received radiotherapy as initial treatment (dose of 30Gy/10 Fx - 50Gy/25 Fx), 10% concurrent weekly cisplatin with RT 45-60Gy and 20% adjuvant RT with complete response rates 25% of cases.

Only 10% of the cohort received initial chemotherapy (carboplatin or carboplatin/paclitaxel) in unresectable disease or not suitable for concurrent treatment, with a mean of 4 cycles.

From those patients that received any treatment, 40% presented recurrence or progression disease, with disease-free survival of 10.8 months and progression-free survival of 13.5 months.

Of the 61 patients, only 4 patients are alive disease-free and 3 patients with active disease at the time of analysis.
Conclusion Vulvar cancer has a higher prevalence and incidence in developing countries in comparison to developed countries, with the diagnosis of the disease in more advanced stages, as observed in our study of 60% stages III-IV vs 36% reported form the USA and early stages 10% vs 59% respectively.

About treatment, 2/3 underwent initial surgical treatment, nevertheless, one of every 3 patients ended with positive margins, regardless of more radical surgery, which did not translate in better oncologic outcomes but major psychosexual sequels and related morbidities.

Vulvar cancer incidence was significative higher in postmenopausal and multiparous women. For better oncological outcomes on this rare gynecologic tumor, a multidisciplinary approach must be assessed.
Disclosures No disclosures.

484 RESULTS OF SURGICAL TREATMENT OF VULVAR CANCER USING RECONSTRUCTIVE PLASTIC SURGERY

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Introduction/Background The most effective treatment of vulvar cancer is surgery. The results of treatment are influenced by the volume of tissues removed during the operation. Radial excision of tumors is associated with the formation of extensive wound defects. In most cases, traditional suturing of the wound edges after radical vulvectomy leads to postoperative complications. The use of displaced fascial skin flaps on the pedicle for the closure of wound defects can reduce the number of postoperative complications, improve oncological results and the quality of life of patients.
Methodology A retrospective analysis of the results of surgical treatment of patients with malignant neoplasms of the vulva (n = 202) was carried out. First group (n = 92) included the patients with displaced fascial skin flaps used in covering of perineal wound defect. The second group (2) included patients, with suturing the wound edges (n = 110). The patients in the groups were identical by age (median 68 years old), stage of the disease. Predominant stages were II and III: 35.7% and 33.3% (in the 1st group), 37.3% and 31.8% (in the 2nd group). There were no differences between the groups in number of inguinal-femoral lymphadenectomy. Patients in the 1st group were significantly more likely to undergo surgical interventions with resection of the urethra (23.8% vs 3.1% in the 2nd group), which was associated with the localization of the primary tumor.

The observation time ranged from 2 to 20 years. The analysis of postoperative complications, disease-free and overall survival in each was carried out for the period from 1995 to 2015.
Results Significantly less number of postoperative complications (suppuration, rough healing of postoperative wounds, rough scars, vaginal stenosis) were registered in the 1st group: 4.8%

vs 44.6% in the 2nd group. The hospital stay was significantly less: in the 1st group: 18.8 ± 1.4 days vs 26.9 ± 4.6 days in the 2nd group. The recurrence rate in the 1st group was 9.53% vs 24.6% in the 2nd group, which is probably due to wider excision of the perineal tissue using reconstructive plastic surgery. Five-year survival was 76.5% in the 1st vs 56% in the 2nd group.

Conclusion The use of reconstructive plastic surgery for closing of wound defects after radical vulvectomy reduces the incidence of postoperative complications and improves oncological treatment results.

Disclosures None.

513 IMPACT OF TUMOUR-FREE MARGIN AND LYMPH NODE RATIO ON ONCOLOGIC OUTCOMES IN VULVAR CANCER- A SINGLE INSTITUTE EXPERIENCE

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Introduction/Background Vulvar cancers accounts for 3–5% of all gynaecological malignancies. Inguinal lymph node involvement and tumour-free margin are considered as significant prognostic factors for survival in patients with vulvar cancer. Surgery is the cornerstone of treatment. Lymph node ratio (LNR) is the ratio of the number of positive lymph nodes (LN) to the number of removed LN. This parameter incorporates not only the burden of nodal disease and cancer spread but also the extent and quality of surgical staging. Current data in the literature regarding a minimum oncologically safe tumour-free margin distance are contradictory. The objective of this study was to evaluate the association of tumour-free margin and LNR with oncologic outcomes in vulvar cancer.

Methodology Retrospective analysis evaluating 21 patients of vulvar squamous cell cancer who underwent primary surgery at our institution from January 2013 to December 2018. Patients were stratified into three risk groups according to tumour-free margin (<5 mm, ≥5 mm - <8 mm and ≥8 mm) and LNR (0%, >0–20% and >20%) to compare oncologic outcomes. Follow up was done till August 2019. Qualitative variables were correlated using Chi-Square test/Fisher's exact test. Overall survival (OS), disease free survival (DFS) and recurrence rate (RR) were estimated by Kaplan-Meier method. Log rank test was used for comparison among the groups.

Results Median age was 67 years. Median DFS and OS were 17.4 months and 27.7 months respectively. 11 patients (52.4%) developed recurrence of which 8 had local recurrence. RR in tumour-free margin <5 mm group was high (100%) as compared to ≥5 mm - <8 mm (50%) and ≥8 mm (30%) groups (p=0.037). DFS rates at the end of the study were increasing from 0.0% (in <5 mm group) to 66.7% (in ≥8 mm group) and as well OS rates also (50% to 65.6%). At the end of the study DFS rates in patients with LNR 0%, >0-<20% and ≥20% were 57.1%, 22.5% and 0.0% respectively (p=0.047). On applying Log rank test no significant difference was seen in the OS between the different groups of LNR.

Conclusion Prognosis of vulvar cancer patient is affected by tumour-free margin and high LNR in our study. DFS is significantly reduced in patients with tumour-free margin <5 mm even in the absence of LN metastasis. High LNR is associated with unfavourable DFS. Tumour-free margin ≥8 mm is a good prognostic factor in patients of vulvar carcinoma.

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530 RISK FACTORS AFFECTING ONCOLOGICAL OUTCOMES IN VULVAR CANCER UNDERGOING PRIMARY SURGERY: CASE SERIES FROM A TERTIARY CANCER CENTRE

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Introduction/Background To evaluate risk factors associated with adverse oncological outcomes in women undergoing primary surgery for vulvar cancer.

Methodology Eighty-one patients who underwent primary surgery for SCC vulva and were registered at tertiary cancer hospital between January 2011- December 2018 were analysed retrospectively. Adverse risk factors such as age, stage, tumour free margins (TFM), depth of stromal invasion (DSI) and lymph node status were analysed using univariate analysis and survival was calculated using Kaplan-Meir curves.

Results Median age was 55 years. All patients underwent either wide radical excision/radical vulvectomy. Groins were addressed in 63 patients. Median follow up was 42 months. Overall survival and DFS at 3 years were 82% and 69% respectively. On univariate analysis of 81 patients, DSI, TFM (<10 mm) and stage III> had statistically significant effect on DFS, whereas DSI and stage III> had statistically significant effect on overall survival. Age >60 years did not have significant effect on oncological outcomes.

Following surgery, based on final histology report, 63 patients remained within stage I/II, whereas 18 patients were upstaged to Stage III & above (Stage III>). Stage migration was mainly due to lymph node positivity on histology.

On subgroup analysis of 63 patients in good prognostic group (stage 1/II), DFS and TFM had statistically significant adverse effects on DFS and OS. Overall survival at 3 years was 86% and DFS 78% in this subgroup.

Of 18 patients in poor prognostic subgroup (post-surgical stage III and above), 1 in 3 developed recurrence and 1 in 2 died of disease.

Conclusion There is a positive correlation of DSI and lymph-node metastasis, hence lymphadenectomy is proposed based on DSI subcategory in FIGO stage I. Our study found DSI as an independent risk factor which affects both DFS and overall survival in early stage vulvar cancer with negative lymph nodes.

Disclosures None.