

patients gynecologic examination revealed pigmented lesion from which a biopsy was taken. Histologic examination indicated the diagnose of a melanoma. The mean tumor's size was 3.5 ± 2.1 cm with clinically negative nodes and a mean Breslow depth 11.2 ± 8.7 mm. PET-CT was solicited as pre-surgical imaging workup.

According to the AJCC Cancer Staging Manual, 3/7 (42.8%) of patients were diagnosed at IIC stage, 1/7 (14.3%) at IIIB stage, 2/7 (28.6%) at IIIC stage and 1/7 (14.3%) at IV stage. The treatment was surgery: 3/7 (42.8%) of patients underwent wide local excision and 4/7 (57.2%) of patients underwent hemivulvectomy. Negative margins were obtained in 4/7 (57.2%) of surgeries. Sentinel lymph node (SLN) biopsy was performed in 5/7 (71.4%) of patients and SLN confirmed nodal metastases in 4/5 (80%) of patients. Immunotherapy was the adjuvant treatment for patients with \geq IIIB stage (4/7), one of them combined with radiotherapy.

During the follow up, 5/7 (71.4%) of patients relapsed. The mean time to relapsed was 5.5 ± 2.3 months. The treatment for the recurrences was 3/5 (60%) cytoreductive surgery combined with immunotherapy in two patients. One woman (20%) received a combination of radiotherapy and immunotherapy and other woman (20%) received palliative treatment. At the time of last follow up, 4/7 (57.2%) women died because of melanoma, 2/7 (28.6%) was tumor free and 1/7 (14.3%) was alive with the disease.

Conclusion* As reported in literature, primary vulvar melanomas have biologically aggressive characteristics. The treatment consists of a surgery with appropriate free surgical margins. However, early recognition is what brings the maximal benefit to survival.

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V-Y FLAP RECONSTRUCTION FOR VULVAR CANCER RECURRENCE AFTER PRIMARY RADIOTHERAPY

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Introduction/Background* Vulvar cancer is a rare disease specially in young women. When a large tumour is diagnosed, reconstruction flap should be considered in order to achieve the best cosmetic and functional result.

Methodology This surgical video shows the excision of a perianal recurrence secondary to a vulvar cancer after primary radiotherapy. Rectal amputation and terminal colostomy were performed through a laparoscopic approach. A bilateral V-Y flap was designed for perineal reconstruction. This procedure was recorded step by step.

Result(s)* A 47 years old woman was diagnosed with perianal VIN III. It measured 25mm and had no extraperineal disease. Primary radiotherapy was indicated due to the invasion of anal mucosa. After 6 months of treatment, perianal recurrence of scamous vulvar carcinoma was diagnosed. Consequently, wide surgical excision, anal amputation, bilateral V-Y flap reconstruction and terminal colostomy were performed under lithotomy position and general anaesthesia. Despite surgical wound infection by pseudomonas and partial dehiscence, very good cosmetic and functional results were achieved.



Abstract 1021 Figure 1

Conclusion* V-Y flap reconstruction may be a good option for the treatment of perineal defects that are too large for primary intention wound closure.

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TRANSINGUINAL PELVIC LYMPHADENECTOMY IN VULVAR CANCER PATIENTS (TRIPLE STUDY): A SINGLE-INSTITUTION, PROSPECTIVE, PILOT STUDY

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Introduction/Background* Vulvar cancer (VC) is a lymphotropic disease. The preferred lymphatic pathway involves the inguino-femoral lymph nodes (IFLNs), followed by the pelvic lymph nodes (PLNs). In selected cases, surgical approach to PLNs may be the first choice when histologic confirmation is required for suspicious involvement on imaging or when radiation therapy is out of indication (e.g., in cases of previous radiation therapy or in specific histotypes).

Given the anatomic continuity between the inguinal and pelvic sites, a novel retrograde trans-inguinal pelvic access was explored to provide concomitant lymphadenectomy, with a single skin incision and no change in surgical position or instruments.

Our objective was to evaluate the feasibility and safety of the extraperitoneal trans-inguinal novel approach to pelvic lymphadenectomy (TRIPLE).

Methodology All consecutive patients referred to our Institution in the last 18 months, affected by primary/recurrent VC, candidate to concomitant groin and pelvic lymph node surgery were included. After conventional IFLN dissection, ipsilateral extraperitoneal trans-inguinal pelvic lymphadenectomy (TRIPLE) was performed. Clinical data, type of treatment,

perioperative complications and follow-up have been evaluated.

Result(s)* Thirteen patients (8 primary, 4 recurrent VC) underwent 15 TRIPLE procedures (11 monolateral, 2 bilateral). Patients' median age was 68 (range: 58-93); Eight of them had relevant comorbidities (61.5%). Up front locoregional radiotherapy was previously performed in three cases (23.1%). Pathology report showed: metastatic lymph nodes were found in 14 (66.7%) groins and 11 (73.3%) pelvic sites; the mean number of removed and metastatic PLNs was 13.5 (range: 5-33) and 3.2 (range: 1-18), respectively. No specific intraoperative complications occurred. One (6.7%) postoperative site-specific complication was reported (pelvic abscess, grade 2), completely restored by antibiotics. One patient died due to concomitant pneumonia. No PLN recurrence occurred during follow-up (median 9 months). Three patients (23.1%) had distant site progression (median PFS 9 months).

Conclusion* TRIPLE seems to be a feasible and safe technique, providing adequate lymph node dissection. Despite high-risk and fragile population, morbidity was similar to previously data reported for conventional mini-invasive approaches. Prospective larger comparative series are necessary.

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ABSTRACT WITHDRAWN

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PELVIC EXENTERATION FOR VULVAR CANCER: POSTOPERATIVE MORBIDITY AND ONCOLOGIC OUTCOME – A SINGLE CENTER RETROSPECTIVE STUDY

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Introduction/Background* Pelvic exenteration may be necessary for some patients with primary locally advanced or recurrent vulvar cancer. The procedure is associated with significant morbidity and mortality and requires highly specialized surgical skills as well as careful patient selection. In Norway, the procedure is largely centralized to Oslo University Hospital (OUH). Few case series have been published to date.

Methodology This single center retrospective study included patients treated with pelvic exenteration for primary locally advanced or recurrent vulvar cancer between 1995 and 2019 at OUH, Norway. Complications were coded according to the contracted Accordion classification. Descriptive statistics were used. Follow up time was calculated with the Inverse Kaplan Meyer method. Progression free survival (PFS) and overall survival (OS) were estimated with the Kaplan Meyer method.

Result(s)* 31 patients were followed for a median of 4.94 years (95%CI: 3.37-NR). 55% were exenterated for a primary vulvar cancer, and 45% had recurrent vulvar cancer. 19% underwent anterior, 19% posterior, 32% modified posterior and 29% total exenteration. Histopathological free margins were achieved in 28 (90%) of the patients. Four (13%) patients received adjuvant treatment due to lymph node metastasis at the time of exenteration. The 90 days morbidity for grade 3 complications was 61%, while 10% had no

complications. The 90 days mortality rate was 3%. 16 patients (52%) relapsed, and more than half of the recurrences were localized in the pelvis (4 of 17 patients with primary vulvar cancer; 6 of 14 patients with relapsed vulvar cancer). During follow up, 18 (58%) patients died, 11 of those from vulvar cancer. Median PFS and OS were 3.12 years (95% CI: 1.19-NR) and 4.87 years (95%CI: 1.74-9.00) respectively. Three-year PFS and OS were 50% (95% CI 31-67%) and 60% (95%CI: 40-75%), respectively.

Conclusion* Acceptable oncologic outcomes after pelvic exenteration for primary and recurrent vulvar cancer can be achieved if surgery is centralized. Still, the procedure is associated with considerable morbidity and high risk of relapse. Despite the exceptionally high rate of free margins, the majority of relapses were localized to the pelvis, in particular among patients with relapsed disease. Improved outcomes may be achieved with incorporation of biomarkers beyond clinical characteristics for selection, as well as consideration of multimodal treatment.

Abstract 1050 Table 1 Patient characteristics and oncologic outcome (N=31)

Variable	Mean	Range
Age (years)	64	33-80
Body mass index	26	17-38
	N	%
Histology	30	96.8
Squamous cell carcinoma	1	3.2
Malignant melanoma		
Reason for surgery	17	54.8
Primary disease	14	45.2
Recurrent disease		
Type of Exenteration	9	29.0
Total	6	19.4
Anterior	6	19.4
Posterior	10	32.3
Modified posterior		
Margins	28	90.3
Negative	3	9.7
Positive		
Pelvic lymph nodes	5	16.1
Positive	13	41.9
Negative	13	41.9
Not assessed		
90 days morbidity (Accordion)*	3	9.7
No complications	24	77.4
Any Grade 2	19	61.3
Any Grade 3	1	3.2
Any Grade 4 (mortality)		
Relapse	16	51.6
Site of relapse	10	32.3
Central/pelvic	2	6.5
Pelvic lymph nodes	2	6.5
Distant metastasis	1	3.2
Central and distant metastasis	1	3.2
Pelvic lymph nodes and distant metastasis		

*Overlap. 16 of the patients with Grade 3 or Grade 4 complications also had Grade 2 complications.