

Abstract 1103 Table 1 Study population

Age	Median 71.5 (range 17-90)
Surgery	
- Radical vulvectomy	104 (57.5%)
- Partial vulvectomy	69 (38.1%)
- Vulvectomy	3 (1.66%)
- Local Excision	4 (2.2%)
- Plastic surgery	1 (0.6%)
Staging	
- pT1a	15 (8.3%)
- pT1b	137 (75.7%)
- pT2	27 (14.9%)
- pT3 - pNx	2 (1.1%) 19 (10.5%)
- pN0	45 (24.9%)
- pN+	117 (64.6%)
Maximal tumor diameter	
- >4cm	107 (59.1%)
- <4cm	74 (40.9%)
Grading	
- G1	17 (9.4%)
- G2	113 (62.4%)
- G3	47 (26.0%)
- NA	4 (2.2%)
Histology	
- Squamous cell carcinoma	176 (97.2%)
- Other	5 (2.8%)
Radiotherapy prescription:	
- Dose on the surgical bed	45-70 Gy (1.8-2 Gy/die)
- Dose on the residual tumor (if any)	50-70 Gy (1.8-2 Gy/die)
- Dose on the lymph nodes (if prescribed)	45-70.4 Gy (1.8-2 Gy/die)
Concomitant chemotherapy	
- Yes	61 (33.7%)
- No	120 (66.3%)
Toxicity G3-4	
- Acute skin	40 (22.1%)
- Chronic skin	4 (2.2%)
- Acute lymphoedema	0 (0%)
- Chronic lymphoedema	2 (1.1%)
- Vaginal stenosis	1 (0.6%)
NA: not available	

1112

A NATIONAL RETROSPECTIVE STUDY ON EFFICACY OF EXCLUSIVE (CHEMO)RADIOTHERAPY FOR VULVAR CANCER

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10.1136/ijgc-2021-ESGO.636

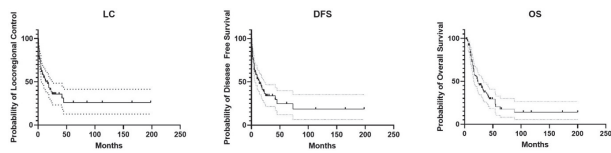
Introduction/Background* Vulvar cancer (VC) is a rare gynaecologic cancer with poor outcomes in locally advanced disease. This study aims to evaluate in a retrospective, multicentred, real-world dataset of patients affected by VC efficacy and safety of exclusive (chemo)radiotherapy (eRT), focusing especially to the treatment prescription among participant centers joining the Observational itaLian stuDY on vuLvar cAnCer radical raDiotherapY (OLDLADY) project endorsed by the GYN study group of the AIRO (Italian Association of Radiotherapy and Clinical Oncology).

Methodology Patients affected by VC and treated by eRT from January 2010 to December 2018 in Seven Italian radiotherapy centers were retrospectively included and clinical data were collected, analysing tumour staging, treatment prescription, clinical and toxicity outcomes.

Result(s)* The multicentred retrospective cohort was composed by 90 patients (patient populations shown in table 1), with a median age of 76 years (range 32-92). A considerable heterogeneity was found in the treatment prescription, radiotherapy doses and concomitant chemotherapy schedules. The most relevant acute toxicity revealed for the patient cohort was skin toxicity (26%); instead, the rate of severe skin fibrosis was

Abstract 1112 Table 1 Study population

Age	Median 76 (range 32-92)
Status	
- Primary disease	61 (76.7%)
- Relapse	29 (23.3%)
Staging	
- T1a	3 (3.3%)
- T1b	28 (31.1%)
- T2	44 (48.9%)
- T3 - Nx	15 (16.7%) 4 (4.4%)
- N0	34 (37.8%)
- N+	51 (56.7%)
- NA	1 (1.1%)
Maximal tumor diameter	
- >4cm	54 (60%)
- <4cm	36 (40%)
Grading	
- G1	19 (21.1%)
- G2	52 (57.8%)
- G3	3 (8.9%)
- NA	11 (12.1%)
Histology	
- Squamous cell carcinoma	88 (97.8%)
- Other	2 (2.2%)
Radiotherapy prescription:	
- Dose on the vulva	Dose (dose per fraction)
- Dose on the tumour	45-70.4 Gy (1.8-2 Gy/die)
- Dose on the lymph nodes (if prescribed)	55-70.4 Gy (1.8-2 Gy/die)
- Dose on the lymph nodes (if prescribed)	45-70.4 Gy (1.8-2 Gy/die)
Concomitant chemotherapy	
- Yes	52 (57.8%)
- No	38 (42.2%)
Toxicity G3-4	
- Acute skin	24 (26%)
- Chronic skin	4 (4.4%)
- Acute lymphoedema	1 (1.1%)
- Chronic lymphoedema	0 (0%)
- Vaginal stenosis	1 (1.1%)
NA: not available	



Abstract 1112 Figure 1 Kaplan Meier curves for LC, DFS and OS

4.4%. After a median follow-up of 10 months (range 1-199), the 2-year actuarial local control rate (LC), the 2-year disease free survival rate (DFS) and the overall survival rate (OS) were 42.2%, 40%, and 36.7%, respectively. Kaplan-Meier curves were computed and reported in figure 1.

Conclusion* A diverse spectrum of radiotherapy options to exclusively treat patients affected by VC was reported. Clinical outcomes are still confirmed to be poor. The results suggest the clinical evaluation of the impact of treatment standardisation, in terms of doses and volumes, in a further perspective study.

1115 INGUINFEMORAL LYMPH NODE DISSECTION TECHNIQUE

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10.1136/ijgc-2021-ESGO.637

Introduction/Background* The cornerstone of treatment in early-stage squamous cell carcinoma (SCC) of the vulva is wide local excision with elective uni- or bi-lateral inguofemoral lymphadenectomy.

Methodology Draw a line between the anterior superior iliac spine (ASIS) and pubic tubercle. Measure 3 cm, medial to ASIS to mark the lateral dissection border. Draw a 90-degree line, 6-7 cm down towards the thigh *and* repeat the same step from the pubic tubercle. Join the two-end point to draw the incision for the groin nodes. Dissect gently the subcutaneous until you reach to superficial fascia (Campers fascia). Incise the fascia gently, lift the fascia and dissect parallel to the lower border of the fascia to separate the superficial inguinal nodes from the subcutaneous tissue. Continue with until you reach the inguinal ligament (upper border of the dissection). Dissect the superficial inguinal lymph nodes off the inguinal ligament starting from the upper edge of the ligament down to the femoral triangle. Lateral circumflex vessels are laterally and the superficial epigastric vessels central & cranial. Dissect the lymph-nodes off the sartorius muscle fascia starting from upper down to the lower border of the triangle. Dissect the lymph nodes off the adductor longus muscle (medial border). Be aware of the superficial external pudendal vessels. Once the borders identified proceed with separating the groin nodes off the femoral triangle floor proceeding from lateral to medial. Identify the great saphenous vein and dissect carefully until the point of insertion with the femoral vein. For the dissection of the deep femoral lymph nodes, gently dissect the fatty tissue starting from the point of junction between great saphenous vein and femoral vein. Follow the femoral vein through the length of fossa ovalis (usually 3 cm). Retract the inguinal ligament cephalad to check for Cloquet's node. Place the drain on the pelvic floor, using silk suture to fix the drain.

Result(s)* Using this step by step technique we minimize the possibility of injuries and offer better healing prognosis with less complications.

Conclusion* This is a safe step by step technique minimizing the risks of injuries and complications of inguofemoral lymphadenectomy.

1120 AN UNSUAL PRESENTATION OF A GYNECOLOGICAL TUMOR: EXTRAGONADAL YOLK SAC TUMOR OF THE VULVA

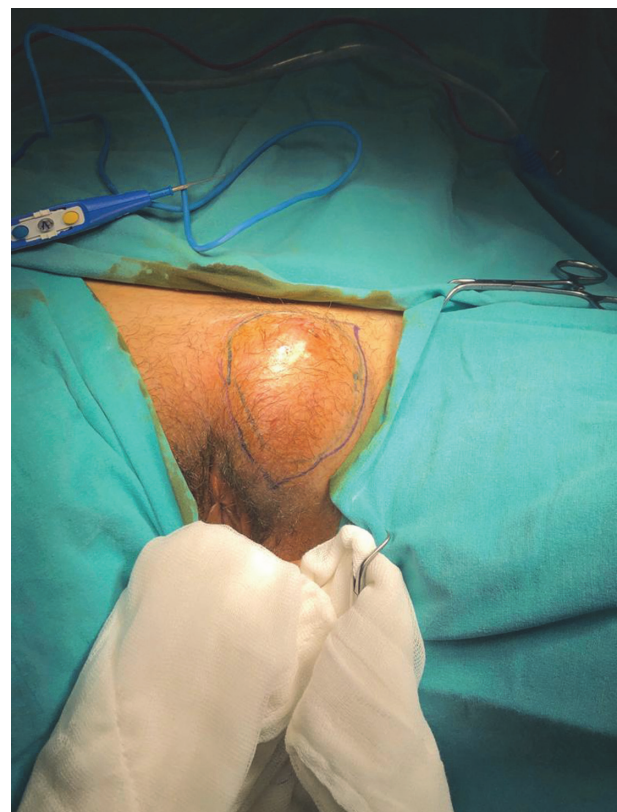
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10.1136/ijgc-2021-ESGO.638

Introduction/Background* Extragenadal yolk sac tumours (YST) of the external genitalia is a rare malignancy. Up to date 15 cases have been reported in the literature. YST are highly aggressive, however with the use of chemotherapy survival has improved. The disease-free survival in vulvar YSTs has been reported as 15-90 months with the use of chemotherapy. We present a case of vulvar YST that has been managed with local excision and adjuvant chemotherapy.

Methodology Case Report

Result(s)* A 34-year-old woman presented to our institution with a left vulvar mass reported as primary adenocarcinoma of the vulva. She had given birth six months ago and noticed the mass in the last four months. During the examination a left, painless, mobile mass of average 7 cm was detected on



Abstract 1120 Figure 1