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

C Pappa*, S Smith, HJ Jiang, M Alazzam. *Gynaecological Oncology, Oxford*

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

¹SA Duru Çötel*, ²G Yeter, ²A Usubütün, ¹N Boran. ¹Etilik Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi, Turkey; ²Hacettepe Üniversitesi Tıp Fakültesi, Turkey

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

Abstract 1120 Figure 2

the left side of vulva, inguinal palpation was normal, and no abnormalities were detected in the internal genitalia (figure 1). In the pelvic MRI a 69*65*55 mm vulvar mass was reported, and this mass showed a FDG uptake of 11.5 SUVmax in the PET- CT. No distant and nodal uptake was detected. Also, upper, and lower gastrointestinal endoscopies were reported normal.

A vulvar mass resection and left superficial inguinal lymphadenectomy was performed. During the operation the mass was mobile and no invasion with other tissues was detected. The final pathology specimen was diagnosed as yolk sac tumour of the vulva, all surgical margins and lymph nodes were negative (figure 2). The patient was given four cycles of Bleomycin, Etoposide and Cisplatin (BEP) chemotherapy. She is being regularly examined every three months and no relapse has been detected in 10 months.

Conclusion* Primary YST of the vulva is extremely rare and this case is the 16. case in the literature. Local excision and adjuvant BEP chemotherapy should be the choice of treatment in these patients.

1161

STEP BY STEP RADICAL VULVECTOMY AND ANATOMICAL BOUNDARIES ON LIVE PATIENT

I Selcuk*, F Kilic, O Ceylan, B Ersak, HR Yalcin. *Ankara Şehir Hastanesi, Turkey*

10.1136/ijgc-2021-ESGO.639

Introduction/Background* To demonstrate the true anatomical boundaries and surgical technique for radical vulvectomy on a live patient.

Methodology This surgical video was recorded at Ankara City Hospital, where is an ESGO Accredited Gynecologic Oncology Center.

Result(s)* • A proper vulvar incision depending on the localization of the tumor with 2cm lateral gross margin if possible is performed (close to the urethra and anus this margin will decrease to 1cm).

• The incision deepens down to the level of perineal membrane (the inferior fascia of the urogenital diaphragm which is superior to the superficial perineal space) by passing through the subcutaneous fatty tissue with creating dissection tunnels.

• At the cranial part of the dissection, the pubic periosteum is found and here, the suspensory ligament of clitoris with the dorsal artery of clitoris should be ligated.

• At the craniolateral part of the vulvar dissection, the adductor fascia is encountered.

• At the caudolateral part of the vulvar dissection, the perineal branches of the internal pudendal artery lie at the 5 and 7 o'clock positions of the vulva.

• At the caudal part of the vulvar dissection, the posterior vulvar tissue is dissected from the perineal body and here, the dissection proceeds over the rectovaginal septum.

• A circumferential vaginal inner incision encircling the vaginal introitus and lying superior to the external urethral meatus is performed, by the way the outer vulvar and inner vaginal incision are bounded. Here, a Foley catheter may secure the urethra.

• After excision of the vulvar tissue; if possible, the wound is closed primarily. First, the deep subcutaneous part is closed and the lateral margin of the vaginal introitus is sutured to the medial edge of the vulvar excision line.

• If it is not possible to close the wound with primary sutures, a flap reconstruction is performed.

Conclusion* The perineal arteries at 5 and 7 o'clock positions should be kept on mind while performing a radical vulvectomy and the deepness of the excision at the base of the tumor should extend to the level of the perineal membrane.

1166

STEP BY STEP INGUINOFEMORAL LYMPHADENECTOMY AND ANATOMICAL BOUNDARIES ON LIVE PATIENT

I Selcuk*, F Kilic, O Ceylan, B Ersak, HR Yalcin. *Ankara Şehir Hastanesi, Turkey*

10.1136/ijgc-2021-ESGO.640

Introduction/Background* To demonstrate the proper anatomical landmarks and surgical technique for inguinofemoral lymphadenectomy on a live patient.

Methodology This surgical video was recorded at Ankara City Hospital, an ESGO Accredited Gynecologic Oncology Center.

Result(s)* 1. The superficial inguinal lymph nodes are located between the Scarpa's fascia and fascia lata. The deep inguinofemoral lymph nodes are located below the fascia lata medial to the femoral vein.

2. After the groin incision, which is 2cm below the inguinal ligament and parallel to it, the Camper's fascia is secured by identifying the Scarpa's fascia.

3. The superficial inguinal lymph nodes are dissected from the craniolateral part to the caudomedial part; between the superficial circumflex iliac vein laterally, superficial external pudendal vein medially, aponeurosis of the external oblique muscle cranially and inferomedial end of the inguinal ligament where it intersects with the adductor longus muscle caudally.