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.

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STEP BY STEP RADICAL VULVECTOMY AND ANATOMICAL BOUNDARIES ON LIVE PATIENT

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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.

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STEP BY STEP INGUINOFEMORAL LYMPHADENECTOMY AND ANATOMICAL BOUNDARIES ON LIVE PATIENT

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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.

4. When the superficial inguinal lymph nodes are retracted over the fascia lata from the craniolateral part, the fossa ovalis is identified at the central part of the incision, which is covered by the cribriform fascia. Besides, during the excision of the superficial nodes at the caudal part of this area, the great saphenous vein passing through the fossa ovalis is identified.

5. After total excision of the superficial inguinal lymph nodes, the cribriform fascia is dissected. The femoral vein is identified below the fascia lata, covered by the femoral sheath between the sartorius muscle laterally and the adductor longus muscle medially. The great saphenous vein drains into the femoral vein, and the deep inguino-femoral lymph nodes, which are located medial to the femoral vein, are dissected. The femoral artery lies at the lateral part of the femoral vein, and the femoral nerve is the most lateral component in the femoral sheath.

6. The deep inguino-femoral lymph nodes cover the base of the great saphenous vein.

7. During excision of the deep inguino-femoral lymph nodes, the deep external pudendal vein should also be kept in mind, which drains into the great saphenous or femoral vein.

Conclusion* The essential anatomy of the superficial inguinal and deep femoral lymph nodes, with Scarpa's fascia, fascia lata of the thigh, and cribriform fascia should be known to perform an inguino-femoral lymphadenectomy.

Late breaking abstracts

Cervical cancer

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KEYNOTE-826: PEMBROLIZUMAB PLUS CHEMOTHERAPY VERSUS PLACEBO PLUS CHEMOTHERAPY FOR PERSISTENT, RECURRENT, OR METASTATIC CERVICAL CANCER

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Introduction/Background* Pembrolizumab has efficacy in previously treated, PD-L1-positive advanced cervical cancer. KEYNOTE-826 (NCT03635567) was a phase 3, randomised, double-blind trial of pembrolizumab or placebo added to chemotherapy ± bevacizumab for first-line treatment of recurrent, persistent, or metastatic cervical cancer.

Methodology Eligible adults had persistent, recurrent, or metastatic cervical cancer not previously treated with systemic chemotherapy and not amenable to curative treatment. Patients were randomised 1:1 to pembrolizumab 200 mg or placebo Q3W for ≤35 cycles added to chemotherapy (paclitaxel plus cisplatin or carboplatin) ± bevacizumab and stratified by metastatic status at diagnosis, planned bevacizumab use, and PD-L1 combined positive score (CPS). Dual primary endpoints were PFS (RECIST v1.1, investigator review) and OS tested sequentially in the CPS ≥1, all-comer, and CPS ≥10 populations.

Result(s)* 617 patients were randomized: 308 to pembrolizumab plus chemotherapy (63.6% with bevacizumab) and 309 to placebo plus chemotherapy (62.5% with bevacizumab); 548 (88.8%) patients had CPS ≥1, 317 (51.4%) had CPS ≥10. At the protocol-specified first interim analysis, pembrolizumab plus chemotherapy ± bevacizumab significantly improved PFS in the CPS ≥1 (median, 10.4 vs 8.2 months; HR, 0.62 [95% CI, 0.50–0.77]; P<0.001), all-comer (10.4 vs 8.2 months; 0.65 [0.53–0.79]; P<0.001), and CPS ≥10 (10.4 vs 8.1 months; 0.58 [0.44–0.77]; P<0.001) populations. OS was also significantly improved in the CPS ≥1 (median, not reached [NR] vs 16.3 months; HR, 0.64 [95% CI, 0.50–0.81]; P<0.001), all-comer (24.4 vs 16.5 months; 0.67 [0.54–0.84]; P<0.001), and CPS ≥10 (NR vs 16.4 months; 0.61 [0.44–0.84]; P=0.001) populations. Benefits were seen in the with and without bevacizumab subgroups. The incidence of grade ≥3 AEs was 81.8% in the pembrolizumab arm and 75.1% in the placebo arm. Anaemia and neutropenia were the most common grade ≥3 AEs (30.3% vs 26.9% and 12.4% vs 9.7%, respectively).

Conclusion* Pembrolizumab plus chemotherapy ± bevacizumab significantly improves OS and PFS in patients with persistent, recurrent, or metastatic cervical cancer. Along with a manageable safety profile, the clinically meaningful survival benefits suggest pembrolizumab plus chemotherapy ± bevacizumab may be a new standard first-line therapy for this population.

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IDENTIFYING PREDICTORS OF LYMPH NODE METASTASES IN EARLY-STAGE CERVICAL CANCER BY TRANSFERRING PREDICTION MODELS ACROSS INTERNATIONAL REGISTRIES

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Introduction/Background* Identifying risk factors for lymph node metastases in early-stage cervical cancer may aid in tailoring treatment. Unfortunately, early-stage cervical cancer research is often hampered by small sample sizes.