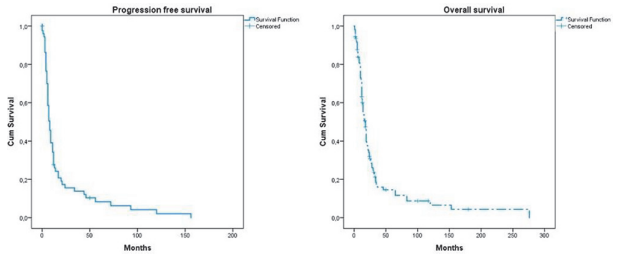
CI 22.8, 49.6). At 5 years only 7% of patients (9/107) were alive. Only 3 patients were free of disease at 5 years.



Abstract 2022-RA-698-ESGO Figure 1

Conclusion Survival outcomes of patient with vaginal melanoma are poor as the disease is associated with short intervals to recurrence and high mortality rates. Various treatment strategies have been published throughout the years with novel targeted therapies achieving the best survival rates.

2022-RA-725-ESGO TREATMENT PATTERNS & OUTCOMES OF PATIENTS WITH LOCALLY ADVANCED VULVAR OR VAGINAL CANCER IN BRITISH COLUMBIA

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10.1136/ijgc-2022-ESGO.927

Introduction/Background As vulvar and vaginal cancers are rare malignancies, treatment is extrapolated from the cervical cancer field, in which concurrent chemoradiation is used. Thus, further studies are necessary to evaluate whether surgery, radiotherapy (RT), or combined chemoradiotherapy (CCRT) will benefit patients the most.

Methodology A retrospective chart review was conducted on patients diagnosed with vulvar or vaginal cancer in 2000–2017. Descriptive statistics were used to compare survival outcomes between surgery, RT only, and CCRT.

Results We included 688 patients with either vulvar (N=560, 81%) or vaginal cancer (N=128, 19%). Median age of diagnosis was 68 (range 27–98) years. In multivariate survival analysis, vulvar cancer was associated with more likelihood of death compared to vaginal cancer (Hazard ratio (HR): 1.50, p=0.042). For patients who received curative RT, median OS (mOS) was 63.8 months with concurrent chemotherapy vs 46.3 months without (p=0.75) for vulvar cancer; for vaginal cancer, mOS was 100.4 months with concurrent chemotherapy vs 66.6 months without (p=0.31). For those who received RT (N=224, 40%; HR: 0.80, p=0.25), adding chemotherapy was not associated with statistically significant improvement in OS for vulvar (N=101, 18%; HR: 0.80, p=0.30) or vaginal (N=51, 40%; HR: 1.31, p=0.41) cancers. Vulvar cancer patients who received ≥5 weeks of chemotherapy had better OS (HR: 0.78, p=0.038) vs <5 weeks of treatment. This effect on OS was not seen in vaginal cancer patients (HR: 0.95, p=0.86). In the 221 (32%) patients who had disease relapse, the most common patterns of relapse were the pelvis without RT (N=96, 43%) and the primary site where radiation was given (N=89, 40%).

Conclusion In this retrospective study, CCRT was not associated with significant improvements in survival for patients with vulvar or vaginal cancer compared to RT only. Future studies investigating novel therapies to treat these cancers are needed to improve patient outcomes.

2022-VA-730-ESGO VULVAR AND CLITORAL RECONSTRUCTION USING BILATERAL SINGAPORE ISLAND PERFORATOR FLAP AFTER ANTERIOR VULVECTOMY

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10.1136/ijgc-2022-ESGO.928

Introduction/Background Surgical treatment of vulvar cancer can lead an important defect to consider a direct skin closure without flap reconstruction.We present a case of a 75-year-old patient diagnosed with squamous cells carcinoma of the vulva localized in the left labium minus, the prepuce of the clitoris, the right labium minus, in contact with urethra and vagina without invasion requiring anterior vulvectomy with bilateral sentinel node.

Methodology Vulvar reconstruction was performed using a perforator-based island pedicle flap, the Singapore flap also called internal pudendal perforator flap, to recreate internal face of labia majora, vestibule and fill the space of the labia minora.At the same time, we performed clitoral reconstruction using Foldès Technique, described to restore the clitoral anatomy in patients who undergone genital mutilation.

Results Post-operative care consisted in 3 days wound drainage and bladder catheterization for 10 days. Patient was discharged at 7th postoperative day without major complication.

Conclusion Bilateral Singapore island perforator flap is a reliable flap who maintain vulvar cosmesis with minimal donor site-mobidity.

2022-VA-742-ESGO BRACHYTHERAPY FOR INOPERABLE VULVAR CANCER: IMPLANT TECHNIQUE

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10.1136/ijgc-2022-ESGO.929

Introduction/Background The standard treatment for locally advanced vulvar cancer is neodjuvant chemoradiation followed by evaluation for surgery. However a vast majority of patients are yet unable to undergo surgery due to proximity of the tumour to eloquent structures as urethra, post forchette, distal vagina or anal sphincter muscles

Methodology In our institution, patients with locally advanced vulva cancer are evaluated by examination under anaesthesia for disease mapping prior to initiating chemoradiation. PETCT and/or MRI is performed for staging and colposcopy is performed to exclude simultaneous malignancy in cervix. After chemoradiation a joint examination under anaesthesia is performed by the surgical and radiation oncology team and when patients are deemed surgically resectable interstitial