and the overall detection rate was 96.9%. Twenty-one patients had SN metastases (stage III A-C) while 79 patients were node negative (stage IB). Median follow up was 20.4 month (range 2–47.8). 73% of patients had more than one and 41% of patients had more than two years follow-up. During follow-up 10 patients developed recurrence (in vulva (n=4), groin (n=1), vulva and groin (n=4) and distant metastases (n=1)). The isolated groin recurrences occurred in one patient with bilaterally SN-negative groins. The two years disease free survival and overall survival was 93.0% and 95.2%, respectively.

Conclusion A combination of fluorescent and radioactive technique using ICG-99mTc-Nanocoll for detection of SN is feasible and a safe treatment option for patients with clinically low stage vulvacean.

**Abstract 2022-RA-824-ESGO Figure 1**

Conclusion The percentage of HPV-positive VSCCs has increased from 1970–75 until 2000–05. The predominant genotypes are HPV 16, 33 and 18 and have not changed during the last decades. HPV-positive tumours were associated with better survival.

**Abstract 2022-RA-868-ESGO**

**Risk for Contralateral Non Sentinel Metastases in Patients with a Unilateral Positive Sentinel Lymph Node in Primary Vulvar Cancer: A Subgroup Analysis of the AGO-VOP.2 QS Vulva Study**

Introduction/Background The need for contralateral full groin dissection after bilateral sentinel node biopsy (SNB) with only unilateral detection of a macrometastasis is unclear. Bilateral inguinofemoral lymphadenectomy (jf- LAE) is recommended by German guidelines to avoid groin recurrences which are associated with high morbidity. Few unicenter, retrospective
analyses have looked at the risk of contralateral non-sentinel (SNL) metastases with conflicting results.

**Methodology**
The AGO VOP.2 QS vulva study is a retrospective, multicenter study. Within the study, therapeutic data from n=306 patients, diagnosed with primary groin node positive vulvar squamous cell carcinoma (VSCC) between 2017–2019 at 33 gynecologic cancer centers in Germany were collected. In the current subgroup analysis, only patients with bilateral SNB and unilateral positive SNL were included.

**Results**
Of 306 documented groin node positive patients, 137 received bilateral SNB. Of these, 98 had unilateral positive SNL. 58/98 (59.18%) received a consecutive bilateral if- LAE. 30/98 (30.61%) underwent unilateral if- LAE and 10/98 (10.2%) had none. Of 98 patients with unilateral positive SNL, two patients (2.04%) showed positive contralateral non-SNL. In the first patient with a midline VSCC a contralateral non-SNL metastasis was detected, despite two negative SNLs in this groin. Bilateral LAE and adjuvant chemoradiation of groins and pelvis were performed and there is no sign of recurrence 18 months after first diagnosis (FD). In the second patient one non-SNL metastasis of 2 mm was detected during LAE after a negative SNL node in the same groin. This patient received radiation to vulva and groins. She suffered from isolated groin recurrence in the groin where the SNL metastasis was initially detected, 11 months after FD.

**Conclusion**
In this large multicentre retrospective trial the risk of contralateral non-SNL metastasis is low. Therefore, morbidity should be carefully balanced against oncologic safety and omission of contralateral LAE should be considered, especially in multimorbid or obese patients.

**USE OF VACUUM-ASSISTED CLOSURE AFTER EXTENSIVE FLAP DEHISCENCE IN VULVECTOMY FOR PAGET’S DISEASE**

Introduction/Background Paget’s disease of the vulva is a rare malignancy for which radical surgical approach such as vulvectomy or wide local excision with adequate surgical margins should be performed. Vulvectomy is complicated by complex wound failure (CWF) in 26–85% of cases. CWF usually occurs 8 to 10 days after surgery. Schimp et al. firstly reported the use of vacuum-assisted closure (VAC) after vulvectomy.

**Methodology**
A 68 years old polymorbid obese patient with recurrent Paget’s disease of the vulva underwent vulvectomy with multiple frozen sections of the edges followed by vulvar reconstruction using suprafascial flap. First signs of CWF could be seen on the 9th day with conventional treatment methods. On the 15th day the 2nd surgery for necrectomy was needed. The primary closure after necrectomy was impossible, CWF area was large so we decided to try VAC although we struggled with air leakage around the vagina introitus. We were not able to maintain an airtight seal so we invented a vaginal phantom made of condom filled with drapes. We used two ports connected to the Y connector applying 125 mmHg continuous pressure. Urine derivation was needed by Foley catheter On the 5th dressing change we started with dynamic sutures. We were concerned about wound infection and blood supply of flaps but VAC did not allow spreading the infection.

**Results**
The VAC treatment lasted for 10 weeks, 14 dressing changes in general anesthesia and last 5 were tolerated without anesthesia.

**Conclusion**
Due to our experience, we can say that VAC can be successfully applied for treatment of CWF in genital area. Urine derivation is needed when an area of external urethral orifice is involved in the wound otherwise urine can disrupt an airtight seal. To prevent air leakage in vagina introitus we successfully inserted the vaginal phantom.