Introduction/Background Pelvic reconstruction after pelvic exenteration is a challenge for gynecologic oncology surgeons. In this vulvar relapse case, a huge defect was left in the perineum after the exenteration. We decided to do a double V-YT flap in order to fill all the defect and a sigmoid neovagina for the sexual reconstruction and to avoid an empty pelvis syndrome.

Methodology Video edited.

Results

Conclusion.
follow-up of 13.5 months, half of the patients had no evidence of disease.

**Conclusion** Our institutional experience comprising intensive clinical and emotional management of vulvar carcinoma radiotherapy provides a proactive approach involving frequent assessment, initiated breaks and emotional support, all facilitating improvement in historically low treatment compliance.

**Methodology** We conducted a retrospective observational study of patients with vulvar cancer, who underwent IFSLNB following radiotracer injection around a tumour or around a scar following previous vulvar excision. IFSLNB detection rates are described per patient and per groin and are compared using chi-square analysis. We performed a Cox regression analysis to assess the association of recurrence and survival with vulvar injection site and recognized pathological variables.

**Results** Data was analyzed for 173 groins in 97 patients. At least one IFSLNB was detected in 94% of groins examined, and IFSLNB detection rate did not differ whether the groin was assessed following tumour injection (n=122, 94%) or scar injection (n=40, 93%; p=0.85). Patients in the scar injection group had less frequent IFLN metastases (p=0.019), smaller tumours (p<0.001) and more superficial invasion (p=0.02). Median overall follow-up from surgery to death or censoring was 34.7 (range 0–108) months. Cox regression analysis demonstrated that scar injection was not an independent predictor of recurrence or death, and depth of invasion was the only independent predictor of disease recurrence (HR 1.14, p=0.029).

**Conclusion** Our observations support the feasibility and safety of scar injection as an alternative to full lymphadenectomy and should be validated in a prospective study with a more robust sample size.

**Introduction/Background** Adenocarcinoma gland Bartholin’s is a very rare tumor accounting for 2–7% of all cancers of the vulva and less than 1% of all female genital malignancies. These tumors’ basic features are slow growth, expanding locally, and sometimes this tumor expanding as metastatic from the other organs like carcinoma mamma. There is no agreement on optimal treatment for this type of carcinoma.

**Methodology** We will show the case 64-year-old woman who came to our hospital because of a tumor mass in the region gland Bartholin’s. She already had the operation because of Carcinoma mamma ten years ago. A gynecological examination can be seen enlarged Bartholin’s gland about 5 cm in diameter to the left side. The other gynecological examination was normal.

**Results** We performed a local-wide removal of the tumor. Histopathology confirmed that this is metastatic Bartholin’s gland adenocarcinoma. The tumor was removed in its entirety with a healthy edge. CT and MRI of the pelvis were normal. We decided to follow up patient but after six months she had recurrences of the disease. We treated her by local irradiation but the patient, unfortunately, died after one year after.

**Conclusion** This case indicates that meta changes could be fined even on unusual localization like in our case. Follow-up patients with carcinoma must include an examination of the whole body and every change should be treated immediately.