Abstract 2022-RA-1268-ESGO Table 1

	Radical surgery (n=5)	Ultra-radical surgery (n=14)
Patient experiencing any complication, n (%)	5 (100)	12 (85.7)
Patient experiencing grade ≥ 3 complications, n (%)	2 (40)	5 (35.7)
Patients experiencing more than one complication, n (%)	1 (20)	7 (50)
Details of surgical complications	**All (6)**	**All (20)**
Grade 1		
Vulvar wound dehiscence	1	4
Lymphocele	1	3
Grade 2		
Vulvar wound dehiscence	1	1
Groin wound dehiscence	1	2
Reconstruction flap necrosis	-	1
Atrial fibrillation	-	1
Grade 3a		
Lymphocele	-	1
Groin wound infection	1	-
Abdominal abscess	-	1
Grade 3b		
Vulvar wound dehiscence	1	4
Groin wound dehiscence	-	1
Grade 4a		
Pneumonia	-	1

Conclusion A high rate of clinical responses (complete/partial) to (CT)RT was registered. Post-operative complications resulted acceptable compared to literature data. pCR is associated with excellent survival also in these tumors as demonstrated in other neoplasms. The multidisciplinary approach is crucial to complete the combined treatment planned [(CT)RT+/- surgery]. In the future, predictive models could allow to select patients on the basis of their foreseen response.

2022-VA-1275-ESGO · **AGRESSIVE ANGIOMYXOMA OF THE PELVIS AND VAGINA: A ROBOTIC AND VAGINAL COMBINED APPROACH**

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Introduction/Background Aggressive angiomyxoma (AA) is a rare mesenchymal tumor, typically arising in the soft tissue of the pelvis and perineum[1], with local aggressive behavior and frequent local recurrence. Surgical excision is the standard treatment[2].

Methodology We report the case of a 47-year old woman diagnosed with a pelvis and perineum AA. Magnetic resonance imaging revealed a 9cm infiltrative mass at the level of the lateral wall of the left introitus, extending to the left infravesical space, lateral wall of the vagina and anal sphincter, infiltrating the left levator ani muscle and ischiorectal fossa. A surgical treatment was performed.

Results First, a robotic approach with standard five-port placement configuration was used. Surgical strategy initially consisted in the development of the lateral avascular spaces of the left pelvis: lateral and medial paravesical spaces, lateral pararectal space and left obturator fossa. The first maneuver consisted in the detachment of the tumor from the obturator fossa and left lateral wall of the bladder. Then, development of the Retzius space up to the bladder neck was realized to identify the pre-vesical portion of the tumor. The use of intravenous ICG helped to identify the anatomical plane for the detachment of the tumor from the bladder. A technical difficulty for the excision of the AA is its soft consistency, making it easy to confuse with soft fatty tissues of the pelvis and making it difficult to obtain negative pathologic margins. Next, a vaginal approach with a longitudinal incision was performed, enabling the identification of the ischiatic tuberosity, ischiocavernosus, bulbocavernosus, and perineum transversus muscles. Ischiorectal fossa was developed and the tumor exteriorized. Detachment of the AA from the lateral wall of the vagina and rectum enabled the excision of the surgical specimen.

Conclusion The pathologic analysis revealed positive margins. The patient was discharged four days later.

2022-RA-1299-ESGO · **HOW TO PREDICT PREOPERATIVE RISK OF LYMPH NODE METASTASIS IN VULVAR CANCER PATIENTS THE MORPHONODE PREDICTIVE MODEL**

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Introduction/Background Preoperative evaluation of inguinal lymph nodes in vulvar cancer patients is still a challenge. Our aim was to build a robust, multi-modular ultrasound model based on artificial intelligence.

Methodology From March 2017 to April 2020, 127 women were included at our center and 237 inguinal regions were studied before surgery by ultrasound experienced examiners. Ultrasound features defined in previous studies were prospectively collected. Histopathology was considered the reference standard. Fourteen informative features were used to train and test the machine, in order to obtain a diagnostic model. The following data classifiers were integrated into the predictive model: 1) random forest classifiers (RCF); 2) decisional tree (DT); 3) regression binomial model (RBM); 4) similarity profiling (SP). A predictive tool was implemented in the open-source R package, available on line as 'Morphonode Predictive Model' at https://github.com/Morphonodepredictivemodel.

Results The tool provides four output modules: 1) the binary malignancy prediction (Morphonode-RFC), distinguishing between malignant and benign lymph nodes with an accuracy of 93.3% and a negative predictive value of 97.1% (95%CI 83.8–100.0); 2) the risk signature (Morphonode-DT), identifying 4 specific signatures correlated with the risk of metastases: metastatic signature (MET), high metastatic risk (HMR), moderate metastatic risk (MMR) and low metastatic risk (LMR); the point risk of metastasis for each signature is 100%, 81%, 16% and 4% respectively; MET signature correlates with higher risk for multiple metastatic nodes (frequency of 45.7%); 3) the point malignancy risk, providing a point risk estimate in each specific lymph node described (Morphonode-RBM); 4) a selection of the top-5 similar profiles in the