

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 $\geq$ 3 complications, n (%)	2 (40)	5 (35.7)
Patients experiencing more than one complication, n (%)	1 (20)	7 (50)
<b>Details of surgical complications</b>		
<b>Grade 1</b>		
Vulvar wound dehiscence	1	4
Lymphocele	1	3
<b>Grade 2</b>		
Vulvar wound dehiscence	1	1
Groin wound dehiscence	1	2
Reconstruction flap necrosis	-	1
Atrial fibrillation	-	1
<b>Grade 3a</b>		
Lymphocele	-	1
Groin wound infection	1	-
Abdominal abscess	-	1
<b>Grade 3b</b>		
Vulvar wound dehiscence	1	4
Groin wound dehiscence	-	1
<b>Grade 4a</b>		
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 AGGRESSIVE ANGIOMYXOMA OF THE PELVIS AND VAGINA: A ROBOTIC AND VAGINAL COMBINED APPROACH

Ana Luzarraga, Asunción Pérez-Benavente, Vicente Bebia Conesa, Silvia Cabrera, Jose Luis Sanchez Iglesias, Natalia Rodriguez Gomez-Hidalgo, Antonio Gil Moreno. *Gynecologic Oncology, Hospital Vall d'Hebron, Barcelona, Spain*

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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<sup>1</sup>, with local aggressive behavior and frequent local recurrence. Surgical excision is the standard treatment<sup>2</sup>.

**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 ischioanal 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 intra-venous 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, ischioanalis, bulbocavernosus, and perineum transversus muscles. Ischioanal 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

<sup>1</sup>Simona Maria Fragomeni, <sup>1</sup>Francesca Moro, <sup>2</sup>Fernando Palluzzi, <sup>1</sup>Alex Federico, <sup>3</sup>Sonia Bove, <sup>1</sup>Floriana Mascilini, <sup>1</sup>Federica Pozzati, <sup>1,4</sup>Giovanni Scambia, <sup>1,4</sup>Antonia Carla Testa, <sup>4,3</sup>Giorgia Garganese. <sup>1</sup>Unità di Ginecologia Oncologica, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; <sup>2</sup>Bioinformatics Facility, Gemelli Science and Technology Park (GSteP), Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; <sup>3</sup>Gynecology and Breast Care Center, Mater Olbia Hospital, Olbia, Italy; <sup>4</sup>Dipartimento Universitario Scienze della Vita e Sanità Pubblica Sezione di Ginecologia ed Ostetricia, Università Cattolica del Sacro Cuore, Rome, Italy

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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 (RFC); 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

study series, supporting the clinician to integrate output analysis (Morphonode-SP).

**Conclusion** Our findings indicate that Morphonode Predictive Model is a simple and observer-independent tool. It could be easily integrated in the clinical routine for preoperative stratification of vulvar cancer patients.

**2022-RA-1300-ESGO** **MULTICENTER EXPERIENCE ON SENTINEL NODE MAPPING IN VULVAR MELANOMA EVALUATION OF CLINICAL IMPACT**

<sup>1</sup>Simona Maria Fragomeni, <sup>2</sup>Angela Collarino, <sup>3</sup>Valentina Fuoco, <sup>4</sup>Fabio Martinelli, <sup>5</sup>Tina Pasciuto, <sup>1</sup>Giacomo Corrado, <sup>4</sup>Francesco Raspagliesi, <sup>2,6</sup>Vittoria Rufini, <sup>3</sup>Marco Maccauro, <sup>1,7</sup>Giovanni Scambia, <sup>7,8</sup>Giorgia Garganese. <sup>1</sup>Unità di Ginecologia Oncologica, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; <sup>2</sup>Nuclear Medicine Unit, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; <sup>3</sup>Department of Nuclear Medicine, Fondazione IRCCS Istituto Nazionale Tumori di Milano, Milan, Italy; <sup>4</sup>Department of Gynecologic Oncology, Fondazione IRCCS Istituto Nazionale Tumori di Milano, Milan, Italy; <sup>5</sup>Dipartimento Scienze della Salute della Donna, del Bambino e di Sanità Pubblica, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; <sup>6</sup>Institute of Nuclear Medicine, Università Cattolica del Sacro Cuore, Rome, Italy; <sup>7</sup>Dipartimento Universitario Scienze della Vita e Sanità Pubblica Sezione di Ginecologia ed Ostetricia, Università Cattolica del Sacro Cuore, Rome, Italy; <sup>8</sup>Gynecology and Breast Care Center, Mater Olbia Hospital, Olbia, Italy

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**Introduction/Background** Melanoma of the vulva is a rare disease, often burdened by a poor prognosis. It is essential to define the optimal treatment in early stage disease. This multicenter retrospective study investigates the role of preoperative lymphoscintigraphy and sentinel node biopsy (SNB) and the impact of SNB on loco-regional control and survival in vulvar melanoma patients with clinically negative nodes (cN0).

**Methodology** All women treated between July 2013 and March 2021 were evaluated. Inclusion criteria consisted in: (i) histologically proven vulvar invasive melanoma, (ii) a Breslow tumor thickness of 1–4 mm and (iii) cN0 at preoperative evaluation. Patients selected underwent a preoperative lymphoscintigraphy followed by SNB with or without inguinofemoral lymphadenectomy. DFS and OS were assessed by the Kaplan-Meier method.

**Results** Eighteen women were included for a total of 28 groins studied. Planar images showed 51 sentinel nodes (SNs) in the enrolled inguinal regions. SNs were identified in all cases. Metastatic SNs were found in 5 patients (27,7%) for a total of 8 metastatic nodes in 7 groins (25%). Recurrent disease was diagnosed in 10 (55,5%) patients at 3 to 30 months: 7 were SN-negative, among which no specific groin recurrence was observed; 3 were SN-positive, among which 2 patients died of disease after 26.2 and 33.8 months, respectively. The overall mortality rate was 0% for SN negative and 40% in SN positive patients. OS and DFS at 36 months were 62.5% and 19.2%, respectively. The median DFS was 18.0 months (95% CI, 10.3–30.0).

**Conclusion** Lymphoscintigraphy followed by sentinel lymph node biopsy in patients with vulvar melanoma is feasible and allows adequate assessment of the stage of disease. Negative SNB is associated with low risk of groin relapse and good survival rate. Further prospective multicenter studies are needed to evaluate the criteria for clinical application.

**2022-RA-1303-ESGO** **ANALYSIS OF HOSPITALIZATION OF PATIENTS WITH MALIGNANT VULVAR DISEASES OPERATED BETWEEN 02.2020 AND 04. 2022 IN THE DEPARTMENT OF ONCOLOGICAL GYNECOLOGY OF THE CENTRE OF ONCOLOGY, OPOLE, POLAND**

Marcin Kalus, Krzysztof Nowak, Maja Mrugala, Zofia Borowiec, Ewa Milnerowicz-Nabzdzyk. Department of Oncological Gynecology, Dept Director Associate Prof. Ewa Milnerowicz-Nabzdzyk MD PD, Centre of Oncology, Opole, Poland

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**Introduction/Background**

**The objective** the analysis of patients with V-Y technique vulvar reconstruction in the treatment of malignant vulvar diseases between 02.2020 and 04. 2022 in the Department of Oncological Gynecology

**Methodology** The surgical treatment was performed in 25 patients: 21 with squamous cell carcinoma and 4 with vulvar Paget disease. 18 women underwent complete radical vulvectomy and 7 partial radical vulvectomy (hemivulvectomy or wide tumor resection). In the group with complete radical vulvectomy 6 patients were qualified to the V-Y technique vulvar reconstruction. In 12 patients the systemic inguinal lymphadenectomy (uni- or bilateral) was performed, of which 5 was diagnosed with node metastases. In 4 patients the SLN procedure was performed, with positive results (lymph node metastases) in 2 patients. 2 patients after the simultaneous reconstruction group required secondary wound suturing in the postoperative period. In the group of patients after partial or complete radical vulvectomy without the reconstruction 6 patients needed secondary surgical intervention.

**Results** The average operating time without the simultaneous reconstruction was 160 min. and with the reconstruction was 205 min. The average healing time without the reconstruction was 30 days and with the reconstruction 23 days. The mean satisfaction index without the reconstruction was 6/10 and with the reconstruction 8/10.

**Conclusion** 1. The surgical procedures in the vulvar malignant diseases with simultaneous reconstruction are more time-consuming but more effective for the patient's quality of life than the procedures without reconstruction. 2. Secondary wound suturing in the postoperative period had no impact on the patient's final treatment assessment. 3. The number of patients treated with reconstructive procedures is an obvious limitation of this analysis, but it should be considered as a pilot study. The number of patients enrolled will be growing and more detailed meta-analysis is planned for the following years.

**2022-RA-1376-ESGO** **INTRODUCTION OF CARE BUNDLE IN VULVAR CANCER**

Fatma Mohamed AlWahaibi, Heather Agnew, Ugochukwu Umeanozie, Ian Harley, Stephen Dobbs, Hans Nagar, Elaine Craig, Mark McComiskey. Gynecology Oncology, Belfast City Hospital, Belfast, UK

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**Introduction/Background** Surgery for vulvar cancer (VC) is associated with high morbidity. Design of 'care bundle' of