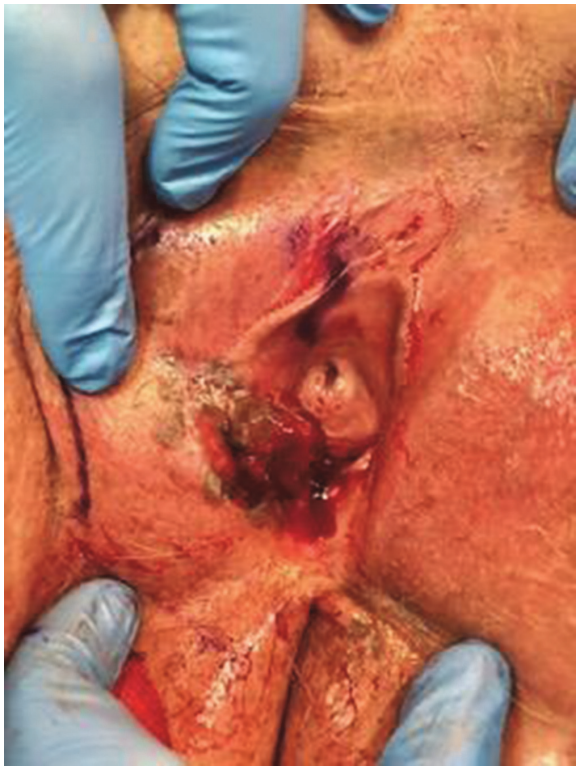
Introduction/Background Melanoma of the female lower genital tract is a rare and aggressive disease, with poor long-term clinical outcomes. Although rare, vulvar melanoma is the second most common histological type of vulvar cancer, representing 7–10% of all malignant vulvar neoplasms.

Methodology Management of vulvar malignant melanoma is challenging. No unified, effective, and standardized treatment plan has been established for this disease. Radiation therapy and chemotherapy do not seem to benefit survival. In fact, there is still no consensus on the use of adjuvant therapy and only a single case series and few case reports on this topic are available. Encouragingly, accumulating evidence supports the role of immunotherapy in improving survival of patients with metastatic melanoma however, there is no evidence of its use in relation to patients with high-risk melanoma as first-line adjuvant therapy.



Abstract 2022-RA-1689-ESGO Figure 1

Results We herein describe the preoperative, postoperative and follow-up clinical data of two patients with the diagnosis of high-risk vulvar malignant melanoma, 6-mm and 4,2-mm Breslow depth, respectively. Both of them underwent radical surgery consisting of radical vulvectomy and inguinal lymphadenectomy. Histopathological study revealed that the margins of the surgical pieces were free of disease and the inguinal staging was negative. No adjuvant therapy was proposed in multidisciplinary committee due to the lack of scientific evidence. However, very soon after radical surgery, they presented with recurrent disease and extensive metastasic disease.

Conclusion Malignant vulvar melanoma has a poor prognosis not only for those with regional and distant metastatic disease but also for patients with high-risk disease. The use of immunotherapy has increased over time and may improve survival in those with distant disease. The current dilemma is the lack of consensus on its use after surgery, even in high-risk patients. These data support further investigation into the role of immunotherapy for vulvar melanoma to optimize outcomes.

2022-RA-1696-ESGO IMPACT OF ERAS IMPLEMENTATION FOR VULVAR CANCER SURGERY

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Introduction/Background Surgical literature and information on vulvar cancer is restricted. *Centre hospitalier de l'Université de Montréal*(CHUM) has a high volume of vulvar cancer patients. Gynaecological Enhanced Recovery after Surgery(ERAS) guidelines was implemented in 2017. This study compares CHUM's practices to available ERAS guidelines, evaluates ERAS compliance and the impact of its implementation on vulvar cancer outcome.

Methodology A retrospective cohort study was conducted at CHUM and included vulvar cancer patients operated in 2015 (pre-ERAS implementation) and 2019–2020 (post-ERAS implementation). Same day discharge and non-elective patients were excluded. Vulvar surgery and gynaecologic oncology ERAS guidelines were compared to CHUM's practices by comparing protocol items. ERAS impact was measured by comparing pre-post implementation cohorts: length of stay (LOS), rates of complications, readmissions, and survival outcomes. Statistical significance was 0.05.

Abstract 2022-RA-1696-ESGO Table 1. Comparison between ERAS vulvar surgery and gyneocologic surgery guidelines and CHUM's practices

Item number	ERAS protocol item description	Vulvar guidelines recommendations Altman, 2020[2]	Gynaecologic oncology guidelines Nelson, 2019[1, 3] Nelson, 2019[4]	CHUM's vulvar and vaginal practices from 2017 to 2020
	Preadmission information, education, and counseling			
1	Preoperative information, education, and counseling	Strong recommendation	Present	Yes
	Preoperative optimization			
2	Avoidance of routine removal of pubic hair	Strong recommendation	Not present	Yes
	Use of razor if going over hair shaving	Strong recommendation	Not present	Yes
	Preoperative bowel preparation			
4	Avoidance of preoperative bowel preparation	Strong recommendation	Present	Yes
	Prophylaxis against venous thromboembolism			
5	Dual mechanical prophylaxis and chemoprophylaxis for surgery lasting at least 30 minutes	Strong recommendation	Present	No
	Compression socks	X	Present	No
	Pneumatic compression devices	X	Present	Yes
	Low-molecular-weight heparin	Strong recommendation	Present	Yes
	Unfractionn nedheparin	Strong recommendation	Present	No
6	Preoperative and hospitalization prophylaxis	Strong recommendation	Present	Yes
7	Extended postoperative prophylaxis	Weak recommendation	Present	Variable
	Antimicrobial prophylaxis			
8	Antibiotic prophylaxis (and cultures/vectorns)	Strong recommendation	Present	Yes
	Standard anesthetic protocol and fluid management			
9	Use of short-acting anesthetics	Strong recommendation	Present	Yes
10	Objective monitoring of neuromuscular block level and complete reversal	Strong recommendation	Present	Yes
11	Fluid balance to achieve euvolemia	Strong recommendation	Present	Yes
	Urinary drainage			
12	Urinary catheters removed as soon as possible	Strong recommendation	Present	Yes
	Postoperative analgesia			
13	Multimodal postoperative analgesic protocol and minimized home-going opioid prescriptions	Strong recommendation	Present	Yes
14	Combination of acetaminophen and non-steroidal anti-inflammatory drugs	Strong recommendation	Present	Only acetaminophen
	Preoperative and postoperative nutrition			
15	Ingestion of light snack up until 6h before anesthesia and clear fluids up until 2h before anesthesia	Strong recommendation	Present	Yes
16	Regular diet 24h after surgery	Strong recommendation	Present	Yes
	Postoperative dressing care			
17	Use of occlusive dressings (wear surgery)	Weak recommendation	Not present	No
	Postoperative drains and adjuvant therapies			
18	Maintenance of inguinofemoral drains until < 30-50 cc/day of drainage	Strong recommendation	Not present	Yes
19	Saphenous vein preservation in inguinofemoral lymph node dissections	Strong recommendation	Not present	Yes

Results 78.9% of CHUM's practices correspond with ERAS vulvar surgery guidelines (table 1). 113 patients were analysed: 51(45.1%) pre-ERAS and 62(54.9%) post-ERAS. Histological types were 69,9% squamous-cell carcinoma, 5.3% adenocarcinoma, 4.4% melanoma, 5.3% squamous-cell carcinoma with other components, 9.7% persistent VIN-III, and 5.3% Paget's disease. 73.5% of patients had primary treatment and 23% had an adjuvant treatment. Compliance increased from 50.84% pre-ERAS to 56.89% post-ERAS (p=0.523). Post-operative LOS significantly decreased from 7 to 3 nights (p=0.004). No serious complication occurred

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during hospitalisation, only one serious complication in post-ERAS cohort occurred after hospitalisation. Readmissions decreased from 11.8% to 4.8% (p=0.173). Survival analysis was conducted on stages I-II squamous-cell carcinoma; no significant difference was found between pre-post implementation on overall survival (p=0.277) and disease-free survival (p=0.671).

Conclusion Although CHUM's practices correspond to 78.9% of the ERAS vulvar surgery guidelines, our compliance remains below 60% and did not significantly increase after ERAS implementation. This might be due to a lack of documentation in patients' record. The main impact of ERAS implementation was the LOS significant decrease.

2022-RA-274-ESGO PREHABILITATION TO IMPROVE OUTCOMES OF PATIENTS WITH GYNAECOLOGICAL CANCER: A NEW WINDOW OF OPPORTUNITY?

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Introduction/Background Prehabilitation programmes aim to optimise the period between cancer diagnosis and treatment, by enhancing an individual's functional and mental capacity prior to surgery. The aim of this study was to review the literature evaluating the effect of prehabilitation programmes on postoperative outcomes and quality of life of patients with gynaecological cancer undergoing surgery.

Methodology This was a systematic review, performed according to Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines. Databases including Pubmed, Medline, EMBASE (Ovid) and PsycINFO were systematically searched to identify studies evaluating the effect of prehabilitation programmes on patients with gynaecological cancer. Both unimodal and multimodal prehabilitation programmes were included encompassing physical exercise, nutritional and psychological support. Primary outcomes were operative complications and quality of life. Secondary outcomes were anthropometrics and adherence to the programme.

Results Seven studies fulfilled the inclusion criteria, comprising 580 patients. Included studies comprised non-randomised prospective studies (n=4), retrospective studies (n=2) and one case report. Unimodal programmes and multimodal programmes were included. In patients with ovarian cancer, multimodal prehabilitation resulted in significantly reduced hospital stay and time to chemotherapy. In patients with endometrial and cervical cancer, prehabilitation was associated with significant weight loss, but no significant effects on operative complications or mortality. No adverse events of the programmes were reported.

Conclusion Evidence on the effect of prehabilitation for patients with gynaecological cancer is limited. Future studies are needed to determine the effects on postoperative complications and quality of life.

2022-RA-296-ESGO NON-PHARMACOLOGICAL, PATIENT-RELATED PREDICTIVE MODEL FOR THE OCCURRENCE OF CINV: PROSPECTIVE, MULTICENTRE STUDY IN GERMANY (NOGGO-EMRISK TRIAL)

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Introduction/Background Nausea and vomiting are one of the most common and challenging side effects related to chemotherapy. The aim of the study was to develop a predictive score for chemotherapy-induced nausea and vomiting (CINV) in patients with gynaecological cancers planned for chemotherapy by identifying non-pharmacological, patient-related risk factors.

Methodology A research-based questionnaire of 27 risk factors was designed and handed out to chemotherapy-naïve patients with gynaecological malignancies. Data on nausea and vomiting from at least 3 cycles of therapy was collected. Variable selection via stepwise and LASSO regression combined with patients' history was used to determine few questions with high predictive power. Bayesian logistic regression (risk prediction model) was implemented with a cut-off chosen to reach a sensitivity of 80%. Area under the curve analysis (AUC) was performed and the accuracy of prediction calculated.

Results 191 patients were enrolled, of which 174 (91.1%) received at least one dose of chemotherapy (intention-to-treat population). Most patients suffered from ovarian cancer (68.0%) and received the carboplatinum/paclitaxel chemotherapy combination (57.5%). Leading predictive factors for CINV were educational status, nausea and vomiting due to other medication, motion sickness, anxiety from therapy in general, anxiety from nausea due to therapy, emetogenic potential of the therapy and distress level. 142 (81.6%) patients answered all questions concerning these factors. Among those, 107 (66.0%) were affected by nausea or vomiting. The AUC of the predictive score based on the above mentioned factors was 0.727 (95% CI [0.636, 0.818]), with a sensitivity of 80.4% [72.9%, 87.9%], a specificity of 48.6% [31.4%, 65.7%] and an overall accuracy of 72.5% [65.5%, 79.6%].

Conclusion To this day, a patient-related predictive model for the occurrence of CINV is missing, making the choice of the right antiemetic prophylaxis difficult. The score featured in our study showed very promising predictive power and is currently being validated.

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