pulmonary artery thrombosis 13.6% (n=3). Low risk GTN received single agent methotrexate for mean 4.7±1.5 cycles. Women with WHO score 5 (n=2) received methotrexate for mean 7.5±3.5 cycles. Women with score 6 (n=6); one received 8 cycles of methotrexate, one crossed over to EMACO and received 8 cycles. Three cases received EMACO for a mean of 8.7±4.5 cycles. Of high risk GTN (n=9), three received mean 6 cycles EMACO, another received 3 cycles induction with cisplatin/etoposide followed by 6 cycles EMACO, one required 9 cycles EMACO followed by pneumonectomy and 21 cycles of second-line chemotherapy but succumbed to disease. Two were lost to follow-up while two are on treatment. Ultra-high risk GTN (n=2), responded to 9 cycles of EMACO. Surgical interventions were needed in four. 15 achieved remission, two lost to follow up, two succumbed to disease and three on treatment. Grade1–2 toxicity were seen in majority. COVID 19 pandemic caused cumulative delay of 146 days in one with ultra-high risk GTN. 

Conclusions Research into newer and effective chemotherapy/targeted regimens for intermediate and high-risk GTN are needed.

E-poster viewing: Vulvar and vaginal cancer

**EP411/#99 HIV AND VULVAR CANCER IN SAINT PAUL’S HOSPITAL MILLENNIUM MEDICAL COLLEGE, SUB-SAHARAN AFRICAN ETHIOPIA**

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**Objectives** This work is aimed to study the incidence and characteristics of patients with this cancer within the study period in view of the changing pattern.

**Methods** This is a retrospective study of histologically diagnosed gynecological cancers seen in our gynecologic oncologic unit between January 2016 and December 2020 GC, over five-year period. The records of the patients were retrieved from our Gynecologic oncology register and the histopathology laboratory. Then the incidence of vulvar cancer was computed and the frequency distribution of demographic features patients with this cancer were determined using SPSS version of 25. HIV positive vulvar cancer patients were compared with those negative patients.

**Results** There were a total of 2055 gynaecological malignancies over the study period and vulvar cancer accounted for 63 (3.1%) of all the gynaecological cancers. Their ages ranged from 18 to 80 years with a mean of 43.6 years. More than half (57.1%) of patients had concomitant HIV/AIDS infection. The average age at diagnosis of vulvar cancer in HIV-positive patients is a decade lower than in sero-negative patients (39.3 years vs 49.8 years). Women living with HIV are twelve times more likely to get vulvar cancer at young age (<45 years) compared to women without HIV (adjusted odd ratio (OR) = 12.4, 95%CI: 3.6–42.7, P=0.0001).

**Conclusions** The incidence of vulvar cancer in this hospital is comparable to other reports. In this study, it was noted that there is an association between HIV/AIDS is quit alarming.


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**Objectives** To evaluate the clinical profile and management of vulvar cancer in India and assess the impact of the revised FIGO staging on outcomes.

**Methods** This retrospective observational study reviewed hospital records of 82 biopsy-proven vulvar cancers. FIGO staging was assigned by 2009 and 2021 classifications. Survival function was calculated using Kaplan Meier and multivariable analysis using Cox proportional hazards model.

**Results** The median age of patients was 61 (24–92) years. Primary therapy was surgery in 73.2%; definitive radiotherapy±chemotherapy in 10.9%; neoadjuvant radiotherapy and surgery in 4.9% and palliation in 10.9% cases. Adjuvant RT was administered in 31.7% (26/82) cases. Disease-specific recurrence and mortality rates were 32.9%(26/82) and 30.5%(25/82), respectively. Median DFS and OS were 17(IQR 1–36) and 27(IQR 9–52) months, respectively. With 2021 staging, stage shift was observed in 18% cases of advanced vulval cancer (3 upstaged from IIIA to IIIB; 5 downstaged from IVA to IIIA). The 3-year DFS was reduced for stage IIIA from 71.4% to 67%, and 5-year-DFS from 71.4% to 33%. The 3-year OS reduced from 100% to 50%, and 5-year-OS from 83% to 33%. In Stage IVA 3-year-OS reduced from 23% to 20%, 5-year-OS from 11% to 0%, and increased for stage IIIB (3-year-DFS from 60% to 69%, 5-year-DFS from 20% to 34%; 3-year-OS from 46% to 56.7%, 5-year-OS from 35% to 47.3%).

**Conclusions** There is a wide variety of patterns of care in LMICs. The FIGO 2021 staging is simpler and easier to use. Nearly one-fifth of advanced vulvar cancer were restaged. There was better correlation with outcomes.

**EP413/#936 VULVAR CANCER: CLINICAL PRESENTATION AND MANAGEMENT OPTIONS IN A LOW RESOURCE COUNTRY**

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**Objectives** We aim to study the epidemiological features of vulvar cancer in Tunisia and report the management strategies in a low-resource country.
Methods It is a retrospective study. We included all patients diagnosed, at our institution, during a 12-year period (2010-2021), with invasive vulvar cancer. We collected the data regarding the epidemiological, clinical, imaging, pathological, oncological management strategies and outcomes.

Results We included 65 patients of whom 89% were menopausal at the time of diagnosis. The average age is 65 years [49-94]. A history of lichen was reported in 20% of patients, and 5% had vitiligo. The comorbidity rate was 45.8%. The main symptom was vulvar pruritus in 94%. A vulvar lump was reported in 50% of cases. Inguinal lymph nodes were present in 39.21% of cases. Among the 65 patients, 2 patients were metastatic. All patients had vulvar surgery (vulvectomy 89%) and inguinal lymph node dissection (blue dye sentinel lymph node detection rate was 65%). The mean postoperative hospital stay was 24 days [6-31]. The postoperative complication rate was 39% of whom 66% are infectious complications. 17% had radiotherapy within 12 months after the surgery. The 3 year recurrence rate is 14%.

Conclusions Vulvar cancer in Tunisia is mainly a menopausal women’s burden characterized by its late diagnosis and the perioperative complication of oncological surgery.

HISTOLOGY RESULTS OF WOMEN PRESENTING WITH LARGE WARTY VULVA LESIONS

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Objectives Lower genital tract lesions are commonly found in South African women, especially in HIV-infected patients. Here we describe the histological results of wart-like vulva lesions, clinically classified as Condylomata acuminata, pre-invasive and invasive squamous lesions.

Methods Women with large vulvo-vaginal warty lesions were recruited. At first visit, clinical examination was performed and biopsies collected for histopathology. Treatment-type was based on size, number of lesions at time of treatment visit, and previous biopsy reports. Histopathology results of excised lesions were collected at treatment visit.

Results Included were 49 participants with mean age 34.2 years; 91.8% (45/49) were HIV positive. Worst grade histology of biopsies taken at first visit showed C. acuminata in 69.4% (34/49) women, VIN1 in 2.0% (1/49), VIN2 in 14.3% (7/49), VIN3 in 8.2% (4/49), squamous cancer in 4.1% (2/49) and one case of seborrhoeic keratosis. In 40 women, lesions were removed surgically and histopathology results collected. Worst of first-visit biopsy or treatment-visit result was regarded as final histological diagnosis: these showed C. acuminata in 46.9% (23/49), VIN1 in 4.1% (2/49), VIN2 in 4.1% (2/49), VIN3 in 34.7% (17/49) and squamous cancer in 10.2% (5/49) women.

Conclusions Only 47% of women had C. acuminata as worst diagnosis on histology. Histology of warty lesions that clinically resembles C. acuminata is essential to diagnose pre-invasive lesions or even invasive cancer. Among South African women who clinically and histologically have genital warts, pre-invasive and invasive lesions commonly co-exist. It is imperative to obtain excision biopsy of any suspicious warty vulva lesion in the era of HIV.

THE MODIFIED 5-ITEM FRAILTY INDEX (MFI-5) IS A PREDICTOR OF POSTOPERATIVE COMPLICATIONS IN VULVAR CANCER: A NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) ANALYSIS

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Objectives Frailty is a known predictor of post-operative morbidity, but the impact in women with vulvar cancer is unknown. Our objective was to determine whether frailty is associated with postoperative morbidity following radical vulvectomy (RV).

Methods Using the National Surgical Quality Improvement Program (NSQIP) database, women who underwent RV from 2014–2020 were identified. Frailty was defined utilizing the modified Frailty Index (mFI-5) assessing diagnoses of congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension requiring medication and partial/total functional dependence. Patients were categorized as non-frail (0–1) or frail (2+). Multivariable-adjusted logistic regression analyses were performed.

Results Of 886 women, 49.9% underwent RV alone, and 19.5% and 30.6% concurrent unilateral or bilateral inguino-femoral lymphadenectomy (IFLND), respectively. 24.5% had mFI ≥ 2 and were considered frail. Compared to non-frail women, frail women were more likely to have an unplanned readmission (7.8% vs 12.9%, p = 0.02), wound disruption (4.2% vs. 8.3%, p = 0.02), and deep surgical site infection (1.4% vs. 3.7%, p = 0.04). On multivariable-adjusted models, frailty was a significant predictor for minor (OR = 1.58, 95% CI = 1.09, 2.30) and any complications (OR = 1.46, 95% CI = 1.02, 2.08), specifically, for RV with bilateral IFLND, frailty was significantly associated with major (OR = 2.13, 95% CI = 1.03, 4.40) and any complications (OR = 2.10, 95% CI = 1.14, 3.87).

Conclusions In this NSQIP analysis, one-quarter of women undergoing RV were considered frail. Notably, frailty was associated with increased post-operative complications, especially in women concurrently undergoing bilateral IFLND. Frailty screening prior to RV may assist in patient counseling and improve postoperative outcomes.

PREGNANCY AFTER SURGERY AND BRACHYTHERAPY FOR VAGINAL CANCER – A CASE REPORT

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Objectives To report a successful pregnancy case, carried to term, after treatment for vaginal cancer. Primary vaginal