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.

EP415/#978  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 bilateralinguineal-moral 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= 1.14, 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.

EP416/#837  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 first-visit biopsy or treatment-visit result was regarded as pre-invasive and invasive squamous lesions. It is imperative to obtain excision biopsy of any suspicious warty vulva lesion in the era of HIV.

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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 seborrheic 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
cancer is infrequent, corresponding to 1–2% of all female genital tract cancer diagnoses. Treatment for vaginal cancer varies depending on tumor histology, size, location, and staging and may include one or more of the following: surgical excision, radiation therapy and/or chemotherapy. All treatments negatively affect fertility/pregnancy outcomes. Pelvic radiation therapy, even in doses < 2 Gy, may extinguish up to 50% of immature oocytes. In addition, radiotherapy may cause modifications in cervical length, loss of uterine junctional zone anatomy and lead to myometrial atrophy and fibrosis, increasing the risk for adverse pregnancy outcomes.

Methods We reviewed the medical charts of a patient who carried a pregnancy to term after surgery and brachytherapy for vaginal cancer.

Results A 28 year-old woman, presented with a 3 cm right vaginal wall tumor, diagnosed as grade 3, vaginal squamous cell carcinoma -FIGO 2009, stage IB. Computed tomography showed no evidence of lymph node spread or distant metastasis. The patient underwent surgery followed by 4 sessions of vaginal brachytherapy totaling a dose of 6 Gy at a 5 mm depth. One year and 9 months after treatment, the patient gave birth to a healthy child at 40 weeks. A C-section was needed due functional dystocia during labor.

Conclusions This is the first case report of a successful pregnancy carried to term after surgery and brachytherapy for vaginal cancer.

VALUE OF SURGICAL LYMPH NODE ASSESSMENT FOR PATIENTS WITH VULVAR MELANOMA

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Abstracts

RESULTS

Patients with vulvar melanoma, known depth of tumor invasion, no distant metastases, with/without inguinal lymph node sampling/dissection (LND) were identified. Median overall survival (OS) was compared with log-rank test. A Cox model was constructed to control for confounders.

RESULTS

1286 patients were included; 808 (62.8%) underwent LND. 8.6% of patients had chemotherapy and/or radiation therapy. Performance of LND was associated with younger age (median 66 vs 76 years, p<0.001), private insurance (42.9% vs 27.8%, p<0.001), tumor ulceration (65.9% vs 58.6%, p=0.01), deeper tumor invasion (p<0.001) and radical vulvectomy (26.4% vs 12.1%, p<0.001). Rate of LND was 55.9% when invasion ≤1 mm, 62.2% when 1.01–2.0 mm, 73.6% when 2.01–4.0 mm and 64.3% when >4 mm. LN metastases were found in 288 patients (35.6%); 20.8% when 1.01–2.0 mm in positive inguinofemoral sentinel lymph nodes (SN) -recurred after inguinofemoral lymphadenectomy (IFL). There were 28 (74%) with macrometastases; 1 of 3 recurred in the groin after adjuvant inguinofemoral radiotherapy, and 0 of 7 recurred after IFL. There were 2 (26%) with micrometastases; 1 of 3 recurred in the groin with no adjuvant therapy, 4 of 13 with adjuvant radiotherapy alone, and 0 of 3 after IFL. There were 2 of 10 who had IFL and adjuvant radiation who recurred with both groin and distant disease within 6 months of diagnosis. All recurrences in the macrometastatic subgroup were HPV independent.

CONCLUSIONS

Isolated groin recurrence rate after adjuvant radiotherapy only with macrometastatic SN in VSCC is high, in keeping with GROINSS-V II findings. All groin recurrences in macrometastatic SN were in HPV independent tumours, implying need for alternate treatment in this subgroup.