inform alternative treatment options in patients predicted to have shorter survival.

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12. Trophoblastic diseases

#248 HOW LONG DO WE NEED TO MONITOR HCG AFTER EVACUATION OF A COMPLETE HYDATIDIFORM MOLE?

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Introduction/Background In every woman with a hydatidiform mole pregnancy hCG-levels will be monitored after evacuation. If hCG-levels persist or relapse after normalization gestational trophoblastic neoplasia (GTN) is diagnosed and chemotherapeutic treatment is required.

Purpose Following evacuation of a complete hydatidiform mole (CHM), the relative risk of malignant change after hCG normalization is uncertain. Here we examine this question in a large national data-set.

Methodology All registered cases of CHM in the Charing Cross Hospital Trophoblastic Disease Centre database and the Sheffield Trophoblastic Disease Centre were identified from Jan 1, 1980 to Nov 30, 2020. Patients receiving chemotherapy prior to hCG normalization for persistent GTN were excluded. Time to hCG normalization, relapse and treatment for GTN were collected. Pregnancies prior to surveillance completion were collected from Jan 1, 2010 – Nov 30, 2020.

Abstract #248 Table 1 Time to relapse and remaining risk of GTN

	<56 days to normal hCG			>56 days to normal hCG		
Time from normal hCG to relapse (months)	Cases in remission	Cases of pGTN	Remaining risk	Cases in remission	Cases of pGTN	Remaining risk
0	4804		1/1601	12619	1	1/504
1	4804		1/1601	12618	1	1/526
2	4804		1/1601	12617	1	1/548
3	4804		1/1601	12617		1/548
4	4803	1	1/2402	12617		1/548
5	4803		1/2402	12616	1	1/573
6	4803		1/2402	12615	1	1/600
7	4803		1/2402	12614	1	1/630
8	4803		1/2402	12613	1	1/664
9	4803		1/2402	12611	2	1/741
10	4803		1/2402	12611		1/741
11	4803		1/2402	12611		1/741
12	4803		1/2402	12610	1	1/788
18	4803		1/2402	12605	5	1/1146
24	4802	1	1/4802	12604	1	1/1260
36	4802		1/4802	12599	5	1/2520
>36		1	<1/4802		5	<1/2520

Results There were 17 424 patients with normalization of hCG after evacuation of CHM. The risk of relapse was 0.06% (n=3/4804) in patients with hCG normalization within 56 days from evacuation. The time from normalization to relapse ranged from 3.9 to 40.4 months. The risk of relapse was significantly higher at 0.2% (n=26/12620, p=0.038) in women with hCG normalization after 56 days from evacuation with the time from normalization to relapse ranging from 0.1–90.0 months. The majority of relapses (82.8% n=24/29) occurred after the current 6 months surveillance protocol. The risk of relapse after surveillance hCG for 6 months is 1/600, this risk halved to 1/1260 with surveillance until 2 years and halved again to 1/2520 with surveillance to 3 years. All 29 women treated for relapse are currently alive with no disease.

Conclusion Relapse after normalization of hCG with CHM is rare. For patients with hCG normalization within 56 days of evacuation, surveillance protocols can safely change to 1 confirmatory normal hCG.

13. Vaginal and vulvar cancer

#92 SENTINEL NODE BIOPSY IS FEASIBLE IN LARGE AND MULTIFOCAL VULVAR TUMOURS – RESULTS FROM A SWEDISH NATIONWIDE PILOT STUDY

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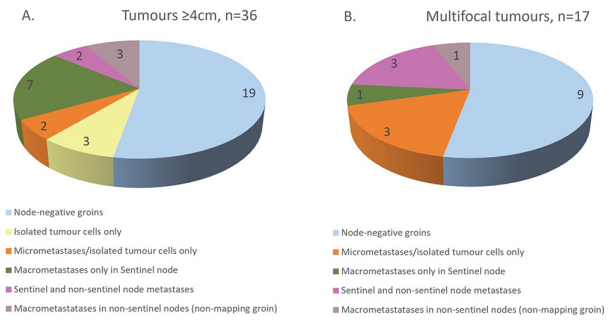
Introduction/Background Sentinel node biopsy (SNB) in vulvar cancer reduces morbidity. However, the oncological safety in tumours ≥4cm and in multifocal tumours has not been systematically studied. Since 2017, vulvar cancer treatment in Sweden is centralised to four university hospitals. All cases of primary or recurrent vulvar cancer are discussed at weekly national multidisciplinary conferences.

The aim of this study was to investigate the feasibility and oncological safety of SNB in vulvar squamous cell carcinoma (VSCC) with tumours ≥4cm, or multifocal disease.

Methodology In this prospective nationwide pilot study, women with primary VSCC ≥4cm (group 1) or multifocal tumours (group 2) diagnosed between December 2019 and December 2022, without clinical or radiological signs of dissemination, underwent both SNB and inguinofemoral lymphadenectomy. Detection rates, negative predictive values, and the prevalence of metastases (isolated tumour cells (ITC), micro- and macrometastases) were determined for each of the two groups.



Abstract #92 Figure 1 Distribution of lymph node metastases in the subgroups: A. Tumours =4cm, n=36 (58/69 groins with successful sentinel mapping) B. Multifocal tumours, n=17 (29/34 groins with successful sentinel mapping)