


#338 VAGINAL ENOMETRIOID ADENOCARCINOMA ARISING FROM ENDOMETRIOSIS AFTER TOTAL ABDOMINAL HYSTERECTOMY AND BILATERAL SALPINGO-OOPHORECTOMY

Roxanne Gillea Gueco Tan*. *St. Luke's Medical Center, Manila, Philippines*

10.1136/ijgc-2023-ESGO.813

Introduction/Background Primary carcinoma of the vagina is rare and accounts for 1% of gynecologic malignancies. Adenocarcinoma is the second most common primary cancer in the vagina. Although less common than squamous cell carcinoma, it represents 15% of all primary vaginal malignancies. The most common manifestation of this malignancy is vaginal bleeding. Specific criteria in establishing endometriosis-related malignancy as presented by Sampson include the presence of benign endometrial and malignant tissue at the same site, the presence of endometrial stroma surrounding glands, and the exclusion of metastasis from another primary site.

STUDIES	PATIENT
PREDISPOSING FACTORS	
Ages 45 to 81	✓
Previous Hysterectomy for Benign Disease	✓
History of Endometriosis	✓
SYMPTOMS	
Vaginal Bleeding	✓
Pelvic Pain	✓
Vaginal Discharge	✓
Dyspareunia	✓
Dysmenorrhea	✓
SAMPSON'S CRITERIA	
Presence of benign endometrial and malignant tissue at the same site	✓
Presence of endometrial stroma surrounding glands	✓
Exclusion of metastasis from another primary site	✓



Abstract #338 Figure 1

Methodology This is a case of a 63-year old G1P1 (1001), who presented with postmenopausal bleeding. She had a history of total abdominal hysterectomy and bilateral salpingo-oophorectomy for endometriosis 20 years ago. A 3 cm vaginal mass was appreciated on internal examination. Vaginal stump biopsy and immunohistochemical stains revealed vaginal endometrioid adenocarcinoma. Positron emission topography (PET) scan showed no metastasis; hence, surgical intervention was advised. The patient underwent peritoneal fluid sampling, excision of vaginal mass, vaginectomy, bilateral lymph node dissection, omentectomy under combined regional – general anesthesia where in histopathology revealed vaginal endometrioid adenocarcinoma, grade III.

Results Primary endometrioid adenocarcinoma of the vagina is the second most common subtype of vaginal adenocarcinoma and accounts to 8–10% of cases. In majority of cases, it is seen in association with endometriosis, which is a

finding that helps in the exclusion of metastatic disease. Treatment of vaginal carcinoma depends primarily on histology, tumor volume, anatomic location, stage, and age of the patient. The origin, natural history, malignant transformation, and laboratory management of endometriosis are not yet clearly investigated.

Conclusion Strategies for prevention, early detection, specific diagnosis, and treatment should be set up targeting the pathogenesis of endometriosis to better understand endometriosis-associated cancer.

Disclosures None

#341 EPIDEMIOLOGICAL, CLINICAL AND PATHOLOGICAL AND THERAPEUTIC FEATURES OF VULVAR CANCER: A SINGLE CENTER RETROSPECTIVE STUDY OF 192 TUNISIAN CASES

^{1,2}Houyem Mansouri, ^{3,2}Ines Zemni*, ^{3,2}Mohamed Ali Ayadi, ^{4,2}Nedia Boujelbene, ^{3,2}Tarek Ben Dhiab. ¹Regional hospital of Jendouba, Jendouba, Tunisia; ²Faculty of Medicine of Tunis, University of Tunis El Manar, Tunis, Tunisia; ³Salah Azaiz Institute, Department of Surgical Oncology, Tunis, Tunisia; ⁴Salah Azaiz Institute, Department of Pathology, Tunis, Tunisia

10.1136/ijgc-2023-ESGO.814

Introduction/Background Vulva cancer accounts for less than 4% of all gynecological cancers and less than 1% of women's cancers. In Tunisia, this pathology represents 1.3%–1.6% of gynecological malignant diseases, with an incidence varying from 0.5 to 1.2/100,000 women per year.

Methodology We retrospectively included 192 patients treated for VC at the Salah Azaiez Institute between 1994 and 2022. Epidemiological, clinical, pathological characteristics, and survival were analyzed.

Results The mean age was 64.93 ± 13.817 years (range, 24–104 years) and 42.2% of patients were aged more than 70 years. From all, 13.5% of patients reported a history of lichen. The revealing symptom was a genital lump in 63% of cases. Clitoris was involved in 50.5% of cases. Tumors were classified as stage FIGO I, II, III, and IV in respectively 55.2%, 9.4%, 32.8%, and 2.6% of cases. Surgery was a radical vulvectomy, hemipelvectomy, and pelvic exenteration in respectively 96.4%, 2.1%, and 1.6% of cases. Lymph node (LN) dissection was bilateral in 88.5% of cases and the mean number of retrieved lymph LN was 14. We omitted LND in 2 cases staged IA. The mean tumor size was 42.21 ± 24.018 mm. Vulvar tumors were staged pT1, pT2, and pT3 respectively in 84.9%, 13.5%, and 1.6% of cases. LN metastasis (LNM) was assessed in 67 patients (34.9%) with bilateral invasion in 35.8% of cases and 3 or more LNM in 13.3%. Adjuvant radiotherapy was indicated in 39.1% of cases. With a mean follow-up time of 35.48 ± 35.48 months, the 5-year overall survival and recurrence-free survival were 52.5% and 55.8% respectively, and were correlated to FIGO stage, LNR, and complete

Conclusion Vulvar cancer in Tunisia remains a rare disease, occurring mostly in elderly women and diagnosed at advanced stages. Our results suggest that a greater effort should be made to facilitate early diagnosis and treatment in order to improve survival.

Disclosures No potential conflict of interest