#522 RADICAL VULVECTOMY WITH TRIPLE INCISION AND BILATERAL INGUINO FEMORAL SUPERFICIAL AND DEEP LYMPHODECTOMY INTREATMENT OF SQUAMOUS CELL CARCINOMA

[1]Kadir Güzin, [2]Ayse Akbulut*. [1]*Hisar Intercontinental Hospital, Istanbul, Turkey*; [2]*Hisar Intercontinental Hospital, Istanbul, Türkiye*

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Introduction/Background Vulvar carcinomas comprise almost 5% of all malignant tumors of the female genital tract. The final diagnosis is made after histologic examination of biopsy specimens obtained from different sites in the vulva. Primary therapeutic approach in all cases is surgery, whereas the operative procedure depends on the size and location of the lesion, stage of the disease, general condition and age of the patient, as well as on the condition of the surrounding tissue and possible continuance of sexual life.
Methodology A 54-year-old female patient presented with a vulvar tumor of about 30x25 mm in size arising 1/3 upper side of the right vulva.
Results She underwent radical vulvectomy with triple insicion and bilateral inguinal lymph node dissection. Histopathological report showed well differentiated SCC of vulva with no lymphnodes involvement. All surgical margins and base of growth were free of tumor.
Conclusion Radical vulvectomy associated with bilateral inguinal-femoral lymphadenectomy is a standard procedure in surgical treatment of invasive stages of vulvar carcinoma protruding more than 1 mm.
Disclosures All authors declare that they have no conflicts of interest to report.

#530 MANAGEMENT OF INGUINAL LYMPHADENECTOMY IN PATIENTS WITH VULVAR CANCER IN GERMAN GYNECOLOGICAL DEPARTMENTS

Lina Judit Schiestl*, Theresa-Louise Buehrer, Annette Hasenburg, Roxana Schwab. *University Medical Center of Mainz, Mainz, Germany*

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Introduction/Background Lymph node involvement is the most important prognostic factor for recurrence and survival in vulvar cancer. Therefore, systematic inguinofemoral lymphadenectomy (IL) is a standard procedure in patients with metastatic disease in one or more inguinal lymph nodes.
Methodology To assess the current management of diagnostic and surgical procedures concerning IL in patients with vulvar cancer, a web-based survey was e-mailed to 612 gynecological departments. Data were presented as frequencies of selected items. Logistic regression analysis was used to assess differences in IL procedures concerning demographic variables of the respective departments.
Results A total of 191 hospitals (31.21%) answered the questionnaire concerning the management of IL. 94.1% of hospitals performed the IL by open surgery. Only 78.2% of hospitals dissected the fascia cribrosa to remove the deep inguinal lymph nodes. Being a certified gyneco-oncological center significantly increased the odds for complete IL (OR 2.803; 95% CI 1.317–5.964; p=0.007). Having two or more specialized gyneco-oncologists in the department significantly increased the odds of performing total IL (two specialized gyneco-oncologists OR 3.341; 95% CI 1.237–9.026; p=0.017, and more than two specialized gyneco-oncologists OR 3.964; 95% CI 1.318–11.925; p=0.014), and reporting a surgical experience of more than ten years significantly decreased the odds (OR 0.212; 95% CI 0.048–0.928; p=0.040), respectively.
Conclusion Being a specialized gyneco-oncological center and having two or more gyneco-oncological specialists significantly increased the odds of performing a complete inguinal lymphadenectomy in women with vulvar cancer. This procedure is crucial, as the recurrence rate was higher in women who did not receive total inguinal lymphadenectomy (7.3% vs. 0%, respectively) (Stehman et al., 1992). Thus, centralization of treatment of women with vulvar cancer may lower the groin recurrence rate and may increase survival.
Disclosures See attached files (COIs).

#531 MANAGEMENT OF PELVIC LYMPH NODES IN PATIENTS WITH VULVAR CANCER IN GERMAN GYNECOLOGICAL DEPARTMENTS

Roxana Schwab*, Lina Judit Schiestl, Theresa-Louise Buehrer, Annette Hasenburg. *University Medical Center of Mainz, Mainz, Germany*

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Introduction/Background Lymph node involvement is the most important prognostic factor for recurrence and survival in cancer of the vulva. National and international guidelines differ concerning the management of pelvic lymph nodes in advanced cancer of the vulva. The German guideline recommends pelvic lymphadenectomy (PL), and radiotherapy is only performed if metastatic disease of the pelvic nodes is proven.
Methodology To assess the current management of surgical procedures concerning PL in patients with vulvar cancer, a web-based survey was e-mailed to 612 German gynecological departments. Data are presented as frequencies of selected items. Logistic regression analysis was employed to assess differences in PL procedures concerning demographic variables of the respective departments.
Results A total of 191 hospitals (31.21%) answered the questionnaire concerning the management of PL. 75.4% of participants performed a lymphadenectomy of the pelvis, even if preoperative imaging procedures showed no metastatic lymph node involvement, while 24.6% would not perform lymphadenectomy, respectively. Being a certified gyneco-oncological center significantly increased the odds of pursuing PL (OR 2.197; 95% CI 1.029–4.689; p=0.042).

74.6% of respondents performed the pelvic lymphadenectomy by laparoscopic procedure. 24.8% of respondents would remove the lymph nodes attached to the ipsilateral iliacal external vessels, 4.2% would perform this procedure bilaterally, 68.5% would perform an ipsilateral pelvic lymphadenectomy, and 12.7% would opt for a bilateral lymphadenectomy (multiple answers possible). Univariate logistic regression analyses detected no significant differences concerning the anatomical sites of the removed pelvic lymph nodes when adjusted for the demographic characteristics of the hospitals.
Conclusion Being a specialized gyneco-oncological center significantly increased the odds of adhering to German national guidelines. Nevertheless, we observed heterogeneity of surgical management concerning the potentially involved