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 incision 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.
lymphatic drainage system of the pelvis. Further studies are needed to explore the optimal surgical procedure concerning pelvic lymphadenectomy in women with advanced cancer of the vulva.

Disclosures See attached files (COIs).

### Abstract #582

**ICG TRACER COMPARED WITH TECHNETIUM-99M FOR SENTINEL LYMPH NODE BIOPSY IN VULVAR CANCER**


**Introduction/Background** Lymph nodal status assessment is important for prognosis in vulvar cancer. The standard-of-care is the sentinel lymph node biopsy with radioactive tracer. However, there are controversies in its use, and the studies are limited. Indocyanine green fluorescence-ICG could be a promising option with the advantage of not needing nuclear medicine.

**Methodology** Prospective evaluation of sentinel lymph node in early-stage vulvar cancer by preoperative technetium and intraoperative ICG. The primary endpoint was to determine accuracy in the detection rate for ICG compared with technetium. Secondary objectives included tracer modality relationship with obesity, tumor size and location. This study evaluates ICG sentinel lymph node detection compared with the criterion-standard with technetium (dual modality method).

**Results** In total, 75 patients participated at 8 Spanish centers. The overall sentinel lymph node detection rate was 85.3% for technetium and 82.7% for ICG. For lateral tumors (38 cases), the detection rate was 84.2% vs. 89.5%, while for midline tumors (37 cases) it was 86.3% vs. 75.7% for midline tumors, using technetium and ICG, respectively. The median sentinel node harvest was 1.7 (range 1–4), with 24% metastatic involvement. The sensitivity and positive predictive value for ICG based on the standard technique was 91.08% (95% CI, 83.76–96.48) and 94.8% (95% CI, 84.84–96.48), respectively. No significant differences were found comparing the two tracers in patients with midline lesions, obesity (body mass index ≥30) and tumor size ≥2–4 cm.

**Conclusion** ICG is not superior to Technecium for detection of SN in vulvar cancer. Although without significance, tc shows better rate of detection. Anyway, ICG can be a good tool in Hospitals without facilita of nuclear.

### Disclosures

No disclosure