

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).

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

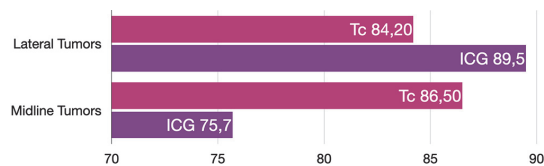
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10.1136/ijgc-2023-ESGO.823

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 86.5% vs. 75.7% for middle 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 with technetium was 91.08% (95% CI, 83.76–95.84) 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.



Abstract #582 Figure 1

Conclusion ICG is not superior to Technetium for 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 facilitita of nuclear.

Disclosures No disclosure

#606 PRIMARY CLEAR CELL ADENOCARCINOMA ORIGINATING FROM MALIGNANT ENDOMETRIOSIS

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10.1136/ijgc-2023-ESGO.824

Introduction/Background To describe a clinical case and review the literature of a primary clear cell adenocarcinoma of the vulva originating from malignant endometrioma, diagnosed and treated at the Hospital Universitario San Ignacio, in Bogotá, Colombia

Methodology A review was made of all articles in English or Spanish in databases: Scielo, LILACS, PubMed, Cochrane, Embase.

Results in our review of the literature, we only found nine (9) cases reported with this histological type, of which seven (7) are associated with malignant endometriosis and the age range is from 34 to 70 years.

Conclusion Vulvar clear cell carcinoma is an extremely rare pathology, we only found nine (9) cases, this being the first in our country and in Latin America. Most are associated with malignant endometriosis. There is no standard treatment, surgical management being the main one, associated with chemotherapy or radiotherapy in some cases.

Abstract #606 Table 1 Vulvar Adenoca

Author/Year	Age (Years)	Location/Size (cm)	Association With Endometriosis	Metastasis	Treatment	Follow-up
Mosko et al 1998	57	Right labium major 2 cm	Endometriosis within the canal of neck	Inguinal LN, skin, lungs	a1 Partial resection, a2 rt SO and rt common iliac node bx, a3 rt inguinal LND, a4 radiation	24 months, AWD (lung metastases)
Hed et al 1990	43	Right mediolateral epispony scar 1.8 cm	Endometriosis at the epispony scar	Inguinal LN, lung	a1 Chemotherapy and radiation. The patient refused surgery	30 months, DOD
Rols et al 2000	52	Left labium major 7 cm	Vulvar endometriosis	ND	a1 Surgical resection	5 months, NED
Todd et al 2000	54	Perineal epispony scar 3 cm	Endometriosis at the epispony scar	ND	a1 Radiation, a2 partial vulvectomy, Hartmann's operation, and rt SO	ND
Lim et al 2002	46	Left side of the vulva 4.5 cm	ND	No	a1 Partial vulvectomy and rt inguinal LND	9 months, NED
Kwon et al 2008	42	Posterior commissure, post epispony scar 2.5 cm	Endometriosis at the epispony scar	No	a1 Radical vulvectomy + ATR + pairs and rt inguinal LND	10 months, NED
Han et al 2014	36	Perineal epispony scar 1.9 cm	Endometriosis at the epispony scar	No	a1 Excisional bx, a2 chemotherapy, a3 radical vulvectomy and inguinal LND, a4 chemotherapy	4 months, NED
Support et al 2018	46	Right labium major and minor 7 cm	Vulvar endometriosis and ovarian endometriotic cysts	External iliac and inguinal LN	a1 Gelfox agent, followed by PMA, a2 chemotherapy. The patient refused surgery	17 months, DOD
Current case 2018	30	Left mediolateral epispony scar 1.8 cm	No	No	a1 Partial vulvectomy, rt inguinal LND and rt inguinal node bx	5 months, NED

Disclosures None

#608 EXPRESSION OF CYTOKERATIN 19 IN VULVAR CARCINOMAS FOR SENTINEL LYMPH NODE BIOPSY ASSESSMENT WITH ONE-STEP NUCLEIC ACID AMPLIFICATION TECHNIQUE

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10.1136/ijgc-2023-ESGO.825

Introduction/Background After the studies that demonstrate the usefulness and benefit of one-step nucleic acid amplification technique (OSNA) in sentinel lymph node biopsy (SLNB)