management. We pay particular attention to the prognostic factors such as recurrence and survival.
Results During our study period, fifteen women met our criteria. The mean age was 64 years [44–84]. Only one patient still has her menstruation and hasn't had any pregnancy. The average time for the consultation was 4 months. The clinical tumor size was more than 1 cm in all cases. All patients underwent partial or total vulvectomy with lymph node resection in ten cases. Histologically, thirteen of these cases were squamous cell carcinoma, one was verrucous carcinoma and, one was melanoma. Additional treatment consisted of chemotherapy and, or radiotherapy. Five patients progressed to recurrence in an average of six months.
Conclusion Cancers of the vulva are rare and occur at a late age. Squamous cell carcinoma being the main tumor. Despite the quality of management, the risk of recurrence is not negligible. Close and multidisciplinary surveillance is essential.
Disclosures No conflict of interest.

#1073 BILATERAL ADENOID CYSTIC CARCINOMA OF BARTHOLIN'S GLAND. A CASE REPORT TO KEEP US ATTENTIVE

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10.1136/ijgc-2023-ESGO.840

Introduction/Background Adenoid Cystic Carcinomas of Bartholin's gland (ACCBG) are a rare entity, as they only represent 0.1% to 7% of vulvar carcinomas and 0.001% of all female genital tract malignancies. Because of their low frequency, no guidelines can be found regarding their treatment and usually they are treated as any other vulvar cancer.
Results A 47-year-old woman is referred to our public health centre to evaluate a long-term and painful bilateral vulvar lump. A bilateral tumourectomy was performed and histological examination informed of a bilateral ACCBG, pT4a.

Immunohistochemistry showed positivity for p63 and S100 in myoepithelial cells and for CD117 (c-kit) and CD43 in the internal layer. Proliferation index Ki67 reached 30% in some tumoral nuclei. The case underwent the interdisciplinary tumour board and thoracic-abdominal CT scan and pelvic MRI were performed. There was no distant dissemination but the persistence of tumoral image of the surgical margins and bilateral inguinal adenopathy.

The patient had to go under rescission and inguinal lymphadenectomy due to affected margins. A new histological examination showed dermis and soft tissue infiltration with perineural infiltration. No lymph nodes were found affected. Thereupon, she undertook adjuvant radiotherapy. Four years later, lymphadenopathy images persist despite no other signs of remaining illness.
Conclusion Bilateral ACCBG wouldn't be the first diagnostic to come to mind if suspicion of Bartholinitis but to do a biopsy of BG may be a good option in long-term cases of recurrence. If not, rescission may need to be performed.
Disclosures The authors declare that they have no conflict of interest with respect to the author or publication of this article.

#1080 THE CYST OF CANAL OF NUCK. IS REALLY EASY TO MAKE DIAGNOSIS?

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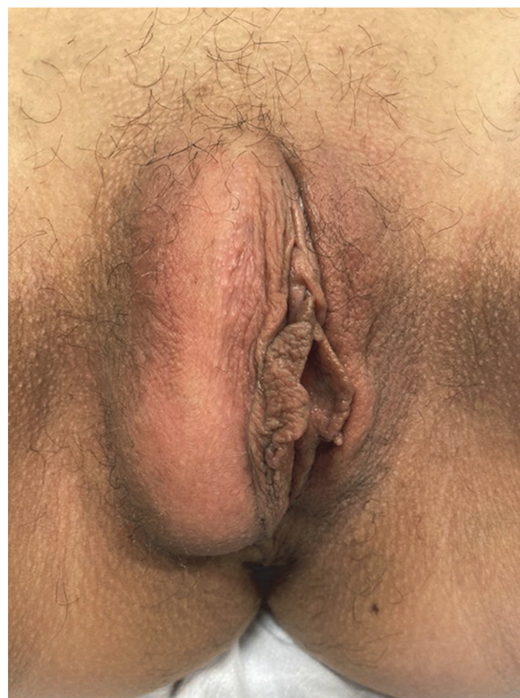
10.1136/ijgc-2023-ESGO.841

Introduction/Background The processus vaginalis is an invagination of the parietal peritoneum that descends anterior to the gubernaculum and is shorter in females than in males. The superior part of the processus vaginalis obliterates at or soon before birth, and this obliteration continues caudally until the entire structure vanishes during the first year of life. When there is a partial or total failure of obliteration of this processus vaginalis, the canal of Nuck forms as a potential space.
Methodology We present the case of a 39-year-old woman was referred to our gynaecological department with the diagnosis of a Bartholin's cyst. Three years ago she had undergone surgery for the same diagnosis, complicated with important hematoma. The patient presented with a painless vulval swelling, that gradually became conspicuous, bothering his sexual activity.
Results On physical examination, a soft fluctuant sausage-shaped mass was found, measuring approximately 5 cm, extending to the all labia majora. There were no signs of infection or inflammation and the overlying skin had no lesions. Ultrasound revealed a well-defined hypoechoic elongated mass with 4.5 cm of long axis, septated, extending into labia majora. Sonographic findings were consisting with the diagnosis of a cyst of the canal of Nuck and treatment choices were discussed with the patient. She opted for surgical excision to avoid the possibility of a recurrence associated with aspiration treatment.



Abstract #1080 Figure 1

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Conclusion The cysts of Canal of Nuck encompass various differential diagnoses, including lymph node, cyst, inguinal hernia, infection/abscess, inguinal gonad, endometriosis, benign tumors, and neoplasia. A thorough understanding of these masses' anatomy, clinical presentation, and imaging characteristics can help avoid misdiagnosis and inappropriate treatment. Surgical intervention is considered the gold standard for managing symptomatic masses in the canal of Nuck. In some cases, conservative management with close observation may be appropriate, especially in asymptomatic or low-risk lesions.
Disclosures No disclosures

#1092 SLN, DASELER ZONES AND THE INJECTION SITES IN VULVA CANCER: SHOULD WE THINK OUTSIDE THE BOX?

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10.1136/ijgc-2023-ESGO.842

Introduction/Background SLN had became the standard of care for Lymph node mapping and excision in management of vulva cancer. The technique has been adopted to minimize the morbidity associated with complete inguino - femoral dissection. Different techniques have been used, to locate the SLN, and the injection is standardized to be intra-tumoral or at the scar site.

The technique sometimes fail to locate the sentinel lymph node, and the adaptation was always in modifying the technique used, e.g. radioactive material versus methylene blue or combination of both.

Few studies examined the feasibility of injection around the scar site and found to be feasible.
The hypothesis Is it time to consider injection at the clitoris (mimicking the technique in breast cancer : peritumoral versus periareolar injection) to improve our detection rate, especially in High BMI patients.
Methodology A retrospective pilot study including 10 cases SLN detection conducted in Cancer center over a year.

The sites of sentinel lymph nodes images were reviewed and were allocated according to Daseler zones classification. The distribution was correlated to the primary tumor site, to detect the association.
Results In 1/10, no SLN was detected and complete LN dissection done.

6/10 SLN was detected in Daseler zone I (injected : 3 at perineal lesion, 2 left lesion < 2 cm from center, and 1 on right side < 2 cm from central).

2/10 SLN detected at zone IV (Injection: at perineum, and left upper side of vulva).

1/10 SLN detected at zone II (injection was at the clitoris)
Conclusion 60% of SLN were detected in Daseler zone 1 (and the injection site varied). The clitoris has good blood flow, and rich lymphatic drainage, that will improve the detection rate of SLN .

Is it time to check peritumor injection versus peri-clitorial injection ?
Disclosures No conflict of interest

#1101 DIAGNOSTIC AND THERAPEUTIC APPROACH TO VULVAR CANCER

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10.1136/ijgc-2023-ESGO.843

Introduction/Background Vulvar cancer is a rare disease, which represents 4% of gynecological tumors with an incidence of 0.5 to 1.5 per 100,000 women per year in France. Vulvar cancers are induced in 30 to 69% of cases by the presence of papillomavirus (HPV), in particular HPV 16 and 18, and can also occur in an inflammatory context. The diagnosis is made by histological examination of a vulvar biopsy. It usually affects older women and most often develops on a pre-existing dermatosis.
Methodology The aim of this work is to know the pre-cancerous and cancerous lesions in order to contribute to a better therapeutic approach.

Our study is a retrospective study of 10 cases of squamous cell carcinoma of the vulva collected over a period of 7 years.
Results The average age was 65.6 years with extremes ranging from 55 to 80 years. The time to consultation was very long with an average of 3.5 years.

Eighty percent of the patients had advanced tumors with an average size of 5.3 cm and in 80% of the case. Treatment was surgical in all cases, followed by radiotherapy in case of lymph node invasion and/or borderline vulvar resection. Overall survival at 5 years was 40%. The major prognostic factors were lymph node involvement and tumor size.s there were inguinal adenopathies.
Conclusion Vulvar cancer has a poor prognosis. The delay in diagnosis is a real problem despite the accessibility of the vulva. Only an earlier management is likely to improve the prognosis.

Management has evolved into a personalized multidisciplinary approach, where each therapeutic decision must be discussed in a multidisciplinary consultation meeting
Disclosures The information presented in this study is based on retrospective data and should be interpreted with caution. The findings and conclusions are specific to the study population and may not be generalizable to all cases of vulvar cancer.

#1107 THE BENEFIT OF RECONSTRUCTION IN VULVAR CANCER

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10.1136/ijgc-2023-ESGO.844

Introduction/Background Vulvar cancer is a rare pathology, which represents 4% of female genital tract tumors. It is a cancer generally affecting postmenopausal women with an average age at diagnosis of 70 years. The treatment is mainly surgical with total or partial vulvectomy associated or not with an inguinal lymphadenectomy.

In order to limit the surgical morbidity and the healing time, various techniques of pelviperineal reconstruction exist.
Methodology We present two cases of vulvar cancer, in the first case we treat the patient without vulvar reconstruction

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