Methods an analysis of one hundred and nine patients with complicated vaginal HSIL (32 patients in the RALV group and 77 patients in the CLV group) who underwent minimally invasive vaginectomy was conducted retrospectively.

Results Compared with the CLV group, patients in the RALV group demonstrated less estimated blood loss, a lower rate of intraoperative complications and shorter durations of paralytic ileus time, urinary catheter indwelling time and postoperative hospitalization time (all $p<0.05$). However, the RALV group had significantly higher hospital costs than the CLV group ($p<0.05$). The total operative time, postoperative complications, positive surgical margins, pathology upgrading or treatment outcomes did not significantly differ between the two groups (all $p>0.05$).

Conclusion/Implications Our results demonstrated that both RALV and CLV can achieve satisfactory treatment outcomes, while RALV has the advantages of less intraoperative blood loss, fewer intraoperative complications and faster postoperative recovery. RALV has the potential to become a better choice for vaginectomy without regard to the burden of hospital costs.

**EP416/#599 PREDICTIVE FACTORS OF LYMPH NODE INVOLVEMENT IN VULVAR CANCER**

1 Ines Zemni, 2 Houyem Mansouri, 3 Mohamed Ali Ayadi, 1 Ameni Jellali, 1 Riadh Chargui, 1 Tarek Ben Dhiab, 2 Salah Azaiez Institute, Faculty of Medicine of Tunis, University of Tunis El Manar, Department of Surgical Oncology, Tunis, Tunisia; 6 Regional Hospital of Jendouba, University of Tunis ElManar, Department of Surgical Oncology, Jendouba, Tunisia

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Introduction The aim of this study was to identify histological factors associated to lymph node metastasis (LNM) in vulvar cancer (VC).

Methods We retrospectively included 192 patients treated for VC at the Salah Azaiez Institute between 1994 and 2022. We analyzed the clinical and histological factors correlated with LN invasion.

Results The mean age was 64.93±13.817 years (range, 24–104 years). Surgery consisted on a radical vulvectomy, hemivulvectomy, and pelvic exenteration in respectively 96.4%, 2.1%, and 1.6% of cases. Lymph node (LN) dissection was bilateral 88.5% of cases. The mean tumor size was 42.21± 24.018 mm. LN metastasis was assessed in 67 patients (34.9%). Lymph node ratio LNR=0, LN0–0.2, and LNR≥0.2 were recorded in respectively 64.7%, 22.1%, and 13.2% of cases. Tumors were classified as stage FIGO I, II, III, and IV in 55.2%, 9.4%, 32.8%, and 2.6% of cases respectively. With a mean follow-up time of 35.48±35.48 months, the 5-year OS was 52.5% and the 5-year RFS was 55.8%. On multivariate analysis, the independent prognostic factor of OS was the LNR (HR=5.702; 95% CI= 2.282–14.245;p<0.0001), FIGO stage (HR=2.089; 95% CI=1.028–4.277;p=0.042) and free margins R0 (HR=2.247; 95% CI=1.215–4.155;p=0.01). Recurrence was recorded in 37.5% of cases. Independent prognostic factor of RFS were the LNR (HR=2.911; 95% CI=1.468–5.779;p=0.002), FIGO stage (HR=1.835; 95% CI=1.071–3.141;p=0.027) and free margins (HR=2.091; 95% CI=1.286–3.999;p=0.003).

Conclusion/Implications LNR, FIGO stage, and complete resection were the independent prognostic factors of survival and recurrence in VC.

**EP418/#626 WHAT IS THE IMPACT OF THE NUMBER OF RETRIEVED LYMPH NODE IN THE RECURRENCE FREE SURVIVAL OF VULVAR CANCER?**

1 Houyem Mansouri*, 2 Ines Zemni, 3 Mohamed Ali Ayadi, 4 Ameni Jellali, 6 Nedja Boujelbene, 2 Tarek Ben Dhiab. 3 Regional Hospital of Jendouba, University of Tunis ElManar, Department of Surgical Oncology, Jendouba, Tunisia; 6 Salah Azaiez Institute, Faculty of Medicine of Tunis, University of Tunis El Manar, Department of Surgical Oncology, Jendouba, Tunisia; 6 Salah Azaiez Institute, Faculty of Medicine of Tunis, University of Tunis El Manar, Department of Pathology, Tunis, Tunisia

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Introduction To investigate the impact of the number of retrieved lymph nodes (NRLN) in the recurrence-free survival (RFS) of patients with vulvar cancer (VC).

Methods We retrospectively included 192 patients treated for VC at the Salah Azaiez Institute between 1994 and 2022. The
PERINEURAL CHEMORADIATION FOR ADVANCED PRIMARY VULVAR CANCER: A RETROSPECTIVE STUDY OF 123 CASES

Introduction To identify clinical, pathological features and survival predictors of vulvar cancer in patients with no lymph node metastasis.

Methods A retrospective study of 123 patients who were diagnosed and treated for vulvar cancer staged I and II at the Salah Azaiez Institute of Oncology between 1994 and 2022.

Results Mean age was 65.61±14.081 years (range, 30–104 years) and median follow-up was 37.84±40.221 months. Tumors were classified as stage FIGO I, II, III, and IV in 55.2%, 9.4%, 32.8%, and 2.6% of cases. LN metastasis was recorded in respectively 35.4% of cases and the mean number of retrieved lymph nodes (LN) was 14. LN metastasis (LN M) was assessed in 67 patients (34.9%). NRLN<12 and NRLN ≥12 were recorded in respectively 31.8% and 68.5% of cases. Lymph node (LN) dissection was bilateral in 88.5% of cases. After a mean follow-up time of 35.48±35.48 months, the 5-year RFS in patients with NRLN<12 and NRLN≥12 was 38.2% and 64.9% respectively (p=0.092). The subgroup analysis revealed that a NRLN≥12 was significantly associated with a better 5 years RFS compared to NRLN<12 in stage pT1 (70.1% vs 38.9%, p=0.016), patients staged without LN M (81% vs 46.5%, p=0.032), patients with 3 or more LN M (33.6% vs 0%, p=0.027), in case of R0 resection (74.8% vs 36.6%, p=0.005) and in the absence of lymphovascular space invasion (64.9% vs 28.7%, p=0.046).

Conclusion/Implications The removal of more than 12 LN improves VC outcomes in patients with node-positive and negative disease, pT1 stage, and complete resection.

CHEMORADIATION FOR ADVANCED PRIMARY VULVAR CANCER – A RETROSPECTIVE SINGLE INSTITUTION ANALYSIS

Introduction Patients with advanced vulvar cancer that are considered inoperable can be cured with (chemo)radiation. We present a single institution experience with treatment outcomes and factors associated with survival.

Methods A retrospective cohort study of patients with proven carcinoma of the vulva diagnosed from 2011 to 2020 at Oslo University Hospital (Norway) is presented. Data were collected from the hospital radiation registry and medical records.

Results A total of 45 patients with inoperable vulvar cancer were included. Median age at diagnosis was 75 years (range 10–94 years). The mean age was 64.93±13.817 years (range, 24–104 years). Surgery consisted of a radical vulvectomy, hemivulvectomy, 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 nodes (LN) was 14. LN metastasis (LN M) was assessed in 67 patients (34.9%). NRLN<12 and ≥12 were recorded in respectively 31.8% and 68.2% of cases. A total of 45 patients with inoperable vulvar cancer were staged I and II at the Salah Azaiez Institute of Oncology between 1994 and 2022. The presence of PNI was associated with young age (46.7% vs 18.8%, p<0.0001), a decreased 5 years overall survival (OS) (12.8% vs 56.9%, p=0.0001) and decreased years recurrence-free survival (RFS) (20.8% vs 60%, p=0.01).