Methods It is a retrospective study. We included all patients diagnosed, at our institution, during a 12-year- period (2010-2021), with invasive vulvar cancer. We collected the data regarding the epidemiological, clinical, imaging, pathological, oncological management strategies and outcomes.
Results We included 65 patients of whom 89% were menopausal at the time of diagnosis. The average age is 65 years [49- 94]. A history of lichen was reported in 20% of patients, and 5% had vitiligo. The comorbidity rate was 45.8%. The main symptom was vulvar pruritus in 94%. A vulvar lump was reported in 50%of cases. Inguinal lymph nodes were present in 39.21% of cases. Among the 65 patients, 2 patients were metastatic. All patients had vulvar surgery (vulvectomy 89%) and inguinal lymph node dissection (blue dye sentinel lymph node detection rate was 65%). The mean postoperative hospital stay was 24 days [6- 31]. The postoperative complication rate was 39% of whom 66% are infectious complications. 17% had radiotherapy within 12 months after the surgery. The 3 year recurrence rate is 14%.
Conclusions Vulvar cancer in Tunisia is mainly a menopausal women's burden characterized by its late diagnosis and the perioperative complication of oncological surgery.

EP414/#837 HISTOLOGY RESULTS OF WOMEN PRESENTING WITH LARGE WARTY VULVA LESIONS

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Objectives Lower genital tract lesions are commonly found in South African women, especially in HIV-infected patients. Here we describe the histological results of wart-like vulva lesions, clinically classified as Condylomata acuminata, pre-invasive and invasive squamous lesions.
Methods Women with large vulvo-vaginal warty lesions were recruited. At first visit, clinical examination was performed and biopsies collected for histopathology. Treatment-type was based on size, number of lesions at time of treatment visit, and previous biopsy reports. Histopathology results of excised lesions were collected at treatment visit.
Results Included were 49 participants with mean age 34.2 years; 91.8%(45/49) were HIV positive. Worst grade histology of biopsies taken at first visit showed C. acuminata in 69.4% (34/49) women, VIN1 in 2.0%(1/49), VIN2 in 14.3%(7/49), VIN3 in 8.2%(4/49), squamous cancer in 4.1%(2/49) and one case of seborrheic keratosis. In 40 women, lesions were removed surgically and histopathology results collected. Worst of first-visit biopsy or treatment-visit result was regarded as final histological diagnosis: these showed C. acuminata in 46.9%(23/49), VIN1 in 4.1%(2/49), VIN2 in 4.1%(2/49), VIN3 in 34.7%(17/49) and squamous cancer in 10.2%(5/49) women.
Conclusions Only 47% of women had C. acuminata as worst diagnosis on histology. Histology of warty lesions that clinically resembles C. acuminata is essential to diagnose pre-invasive lesions or even invasive cancer. Among South African women who clinically and histologically have genital warts, pre-invasive and invasive lesions commonly co-exist. It is imperative to obtain excision biopsy of any suspicious warty vulva lesion in the era of HIV.

EP415/#978 THE MODIFIED 5-ITEM FRAILTY INDEX (MFI-5) IS A PREDICTOR OF POSTOPERATIVE COMPLICATIONS IN VULVAR CANCER: A NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) ANALYSIS

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Objectives Frailty is a known predictor of post-operative morbidity, but the impact in women with vulvar cancer is unknown. Our objective was to determine whether frailty is associated with postoperative morbidity following radical vulvectomy (RV).
Methods Using the National Surgical Quality Improvement Program (NSQIP) database, women who underwent RV from 2014–2020 were identified. Frailty was defined utilizing the modified Frailty Index (mFI-5) assessing diagnoses of congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension requiring medication and partial/total functional dependence. Patients were categorized as non-frail (0–1) or frail (2+). Multivariable-adjusted logistic regression analyses were performed.
Results Of 886 women, 49.9% underwent RV alone, and 19.5% and 30.6% concurrent unilateral or bilateral inguinofemoral lymphadenectomy (IFLND), respectively. 24.5% had mFI $\geq$2 and were considered frail. Compared to non-frail women, frail women were more likely to have an unplanned readmission (7.8% vs 12.9%, p=0.02), wound disruption (4.2% vs. 8.3%, p=0.02), and deep surgical site infection (1.4% vs. 3.7%, p=0.04). On multivariable-adjusted models, frailty was a significant predictor for minor (OR=1.58, 95% CI= 1.09, 2.30) and any complications (OR= 1.46, 95% CI= 1.02, 2.08). Specifically, for RV with bilateral IFLND, frailty was significantly associated with major (OR= 2.13, 95% CI= 1.03, 4.40) and any complications (OR= 2.10, 95% CI= 1.14, 3.87).
Conclusions In this NSQIP analysis, one-quarter of women undergoing RV were considered frail. Notably, frailty was associated with increased post-operative complications, especially in women concurrently undergoing bilateral IFLND. Frailty screening prior to RV may assist in patient counseling and improve postoperative outcomes.

EP416/#785 PREGNANCY AFTER SUGERY AND BRACHYTHERAPY FOR VAGINAL CANCER – A CASE REPORT

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Objectives To report a successful pregnancy case, carried to term, after treatment for vaginal cancer. Primary vaginal