Dermatology and Plastic Surgery, Rome, Italy; [5] *University of Rome "La Sapienza"-, Department of Internal Medicine and Medical Specialties-Division of Dermatology, Rome, Italy;* [6] *University Medical Centre Ljubljana, Department of Otorhinolaryngology and Cervicofacial Surgery, Ljubljana, Slovenia;* [7] *Albert Szent-Györgyi Clinical Center- University of Szeged, Department of Dermatology and Allergology, Szeged, Hungary;* [8] *Zealand University Hospital, Center for Experimental Drug and Gene Electrotransfer CEDGE- Department of Clinical Oncology, and Palliative Care, Roskilde, Denmark;* [9] *Western Gateway Building University College Cork, Cork Cancer Research Centre, Cork, Ireland;* [10] *Veneto Institute of Oncology IOV - IRCCS, Surgical Oncology Unit, Padua, Italy;* [11] *Barts Health NHS Trust, Department of Plastic Surgery, London, United Kingdom;* [12] *St. George's University Hospitals NHS Foundation Trust, Department of Plastic Surgery, London, United Kingdom;* [13] *Whiston Hospital, Department of Plastic Surgery, Prescot, Merseyside, United Kingdom;* [14] *University of Turin, Department of Medical Sciences- Dermatologic Clinic, Turin, Italy;* [15] *Artemed Fachklinik München, Department of Dermatologic Surgery and Dermatology, Munich, Germany;* [16] *Southmead Hospital- North Bristol NHS Trust, Department of Plastic and Reconstructive Surgery, Bristol, United Kingdom*

Background. Basal cell carcinoma(BCC) is one of the most common skin malignancies worldwide. In comparison to current management strategies for BCC, electrochemotherapy (ECT) proved to be a valid alternative in the management of primary and secondary lesions. ECT refers to intratumoural or intravenous injection of bleomycin followed by the delivery of electric pulses to the tumour area under local or general anaesthesia. The International Network for Sharing Practice on Electrochemotherapy(InspECT) database was analysed with the aim to understand if ECT is safe and effective in the treatment of BCC of the skin and mucous membranes.

Materials and Methods. We performed a multicentre retrospective analysis of prospectively collected data from the InspECT database of 277 patients from 14 European centres affected by basal cell carcinoma who underwent ECT. Of the total number of patients analysed, 246 patients with a follow-up period above 2 months were included in the study for a total of 466 nodules studied.

Results. Six patients were not evaluable due to lost follow-up, death (unrelated to treatment), other treatment, or unable/unwilling to continue control. 240 patients were evaluable for tumour response according to lesion presentation (primary vs secondary), size of the lesion, previous treatments, pain score and side-effects. We found an objective response (complete response plus partial response) of 93.8% per patient, and 95.2% per nodule, with a complete response of 79.2% and 81.5% respectively. Primary presentation ($p=0.0035$) and smaller nodules ≤ 3 cm ($p=0.0009$) which were not previously treated ($p=0.0003$) or preirradiated ($p<0.0001$) were associated with higher complete response rates. Multivariate analysis further confirmed these results. Ulceration and hyperpigmentation were found to be the most common side effects, whilst pain intensity after the ECT session ($p=0.036$) and during follow-up ($p=0.0015$) remained significantly low.The one-year local progression free survival was 94%; 21 patients (8.5%) had a recurrence or a post-treatment local progression within a median of 312 days.

Conclusions. Data extrapolated from the InspECT analysis suggest that ECT is a safe and effective treatment in patients with BCC; the evidence that tumour response is significantly higher in small, primary and not previously treated nodules could lead to ECT being considered as a first-line treatment option in selected cases, such as the elderly or other patients not suited to standard therapies.

Conflict of interest: No conflict of interest.

63

SURGICAL QUALITY METRICS FOR LYMPH NODE STAGING OF INTERMEDIATE THICKNESS MELANOMA: A POPULATION BASED STUDY

T. Hieken [1], A. Glasgow [2], J. Inselman [2], E. Habermann [2]. [1] *Mayo Clinic, Surgery, Rochester, Minnesota, USA;* [2] *Mayo Clinic, Heatlh Care Policy and Research, Rochester, USA*

Background. Variability in compliance with guidelines for lymph node (LN) surgery for melanoma patients has been attributed to controversy about patient selection and quality metrics. Prior data indicate suboptimal practice of sentinel LN biopsy (SLNB) and a trend for omission of LN dissection (LND) for LN+ disease that began well before publication of the MSLT-II trial data. To minimize bias, we studied compliance with ASCO/SSO guidelines in patients for whom there is general agreement, namely T2-T3 (intermediate thickness) melanoma, and analyzed contributing factors and outcomes.

Methods. T2-T3, M0 melanoma cases were identified from 2004-2014 SEER data. Five-year cancer specific survival (CSS) was estimated using the Kaplan-Meier method, while the Cochran-Armitage test was used to assess trends over time and multivariable logistic regression to identify independent predictors of compliance.

Results. Overall, 72.9% (29867/40988) of T2-T3 melanoma patients underwent LN staging including SLNB in 26084 of 39792 (65.6%) clinically LN negative (cN0) patients. 2985/4206 cN0 pathology LN+ (pLN+) patients (71.0%) and 783/1196 cN+ patients (65.5%) had a LND. Over time, LND for pLN+ disease declined from 73.3% in 2004 to 68.3% in 2014, $p=0.0002$, including the subset with cN+ disease (69.1% to 66.4%, $p=0.05$). Multivariable analysis demonstrated that compliance with LN staging correlated with younger age, male sex, primary tumor anatomic site (extremity > trunk > head/neck) and mitotic rate ≥ 2, all $p<0.001$ (table). For cN0 patients, 5-year CSS was 83.2% for compliant vs 77.6% for non-compliant care, $p<0.0001$.

Conclusions. Despite a survival benefit, one third of recently diagnosed intermediate thickness cN0 melanoma patients did not have recommended LN staging. Further, these data confirm the trend over time for omission of LND for both SLN+ and cN+ pLN+ patients observed in earlier studies. Although the adjuvant Stage III melanoma trials evaluated only patients treated with LND, SLN status alone is now poised to determine eligibility for these new effective, but potentially quite toxic, adjuvant therapies. Therefore, improving compliance with SLN surgery for intermediate thickness melanoma patients is a logical strategy to improve melanoma-specific survival.

Variable	Level	P Value	Odds Ratio (95% CI)
Age Group	50-64 vs <50	<.001	0.891 (0.837-0.948)
	65-74 vs <50	<.001	0.701 (0.656-0.749)
	75+ vs <50	<.001	0.323 (0.304-0.344)
Sex	Female vs Male	<.001	0.893 (0.853-0.934)
Location	Head/Neck vs Trunk	<.001	0.663 (0.627-0.702)
	Lower Extremity vs Trunk	<.001	1.481 (1.389-1.580)
	Upper Extremity vs Trunk	<.001	1.302 (1.231-1.377)
Mitotic Rate	1 mit/mm^2 vs <1	0.014	1.145 (1.028-1.277)
	≥2 mit/mm^2 vs <1	<.001	1.222 (1.116-1.339)
	Unknown vs <1	0.045	0.917 (0.842-0.998)

Conflict of interest: No conflict of interest.

64

ELECTROCHEMOTHERAPY AS AN ADJUNCT TO THE SURGICAL MANAGEMENT OF METASTATIC MELANOMA: EXPERIENCE OF THE INSPECT GROUP (2008 TO 2018)

J. Odili [1], C. Kunte [2], J. Clover [3], G. Bertino [4], L. Campana [5], T. Muir [6], S.W. Liew [7], G. Moir [8], A. Orlando [9], E. Kis [10], D. Mowatt [11], W. Saxinger [12], P. Quaglino [13], G. Sersa [14], P. Curatolo [15], F. Bechara [16], P. Rutkowski [17], F. De Cian [18], P. Matteucci [19], J. Gehl [20]. [1] *St Georges' University Hospitals NHS Foundation Trust, Plastic and Reconstructive Surgery, London, United Kingdom;* [2] *Ludwig-Maximilian University Munich- Germany, Department of Dermatology and Allergology, Munich, Germany;* [3] *Western Gateway Building University College Cork, Cork Cancer Research Centre, Cork, Ireland;* [4] *University of Pavia, Department of Otolaryngology Head Neck Surgery, Pavia, Italy;* [5] *Veneto Institute of Oncology IOV-IRCCS, Department of Surgery Oncology and Gastroenterology, Padova, Italy;* [6] *James Cook University Hospital, Department of Reconstructive Plastic Surgery, Middlesbrough, United Kingdom;* [7] *Whiston Hospital, Department of Plastic Surgery, Liverpool, United Kingdom;* [8] *Barts Health NHS Trust, Department of Plastic Surgery, London, United Kingdom;* [9] *Southmead Hospital, Department of Plastic Surgery, Bristol, United Kingdom;* [10] *University of*