NCG GUIDELINES FOR VULVA CANCER

Treatment Algorithm: Vulva Cancer

Table 1 : Diagnosing Vulvar cancer

- Clinical presentation (lesion on the vulva, history of chronic prurites /soreness of vulva)
- Clinical examination should include general physical examination, lymphnode palpation of groin and supraclavicular nodes, vulval vaginal and cervical inspection, palpation and internal examination of uterus and adnexa

Biopsy of suspected lesion for diagnosis of cancer/precancer/benign pathology should be based on histopathology (not cytology)

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Staging CT scan and investigations for general fitness to treat should be done following confirmation of cancer/precancer

Imaging:

For primary tumor:

- Early lesion : Thorough Clincal Examination (EUA if necessary)
- Advanced lesion: MRI / CT pelvis may be required to rule out invasion of neighbouring structures including urethra / anorectum to assist in final treatment decision

For Nodal Staging :

- Early lesion : US inguinal region / CT pelvis / SLND
- Advanced lesion: MRI / CT

PET CT is required in melanomas

Table 2:Early stage vulvar cancer Stage 1 with normal groins

T1-2 lesion with <_ to 1mm invasion*

- Wide local excision
- Withhold groin node dissection (GND) followed by observation
- If unfit for Surgery, Radical Radiation therapy including brachytherapy may be effective alternative

All other T1/Early T2 lesions

- Wide-Radical excision with groin node dissection or
- Sentinel node dissection if facilities available (with radiotracer)

- Well lateralized T1 lesions more than 2cms from midlineIpsilateral GND/ sentinel node to be considered
- If ipsilateral nodes negative, then contralateral GND should be omitted
- If unfit for Sx, Radical Radiation therapy including brachytherapy may be an effective alternative

- Adjacent areas of lichen sclerosis/ hyperkeratosis/High grade VIN should preferably be excised without compromising on functionality of vulva
- Further adjuvant treatment is based on final surgical pathology report of primary lesion and groin nodes (see table)
- All patients are followed up for a minimum of 10 years and sometimes lifelong depending on MDT consensus

Table 3: Locally advanced stage vulvar cancer

• Large T2-3 lesion not involving the anus or urethra • Absence of enlarged groin nodes on palpation/ CT scan	• Wide local excision/ Radical Vulvectomy depending on the local extent of lesion and bilateral groin node dissection (GND) or • Radical Chemoradiation +/- Brachytherapy boost
• Large T2-3 lesion not involving the anus or urethra • Presence of enlarged groin nodes on palpation/CT scan	• Wide local excision/ Radical Vulvectomy depending on the local extent of lesion and fine needle aspiration of groin node or GND / debulking of groin node if feasible • Radical Chemoradiation +/- Brachytherapy boost
• Large T2-3 lesion involving or close to anus or urethra which requires diversion urinary/fecal stoma • With or without enlarged groin nodes	• Pre-op (Neoadjuvant) chemoradiation followed by local excision of vulval tumour or • Radical Chemoradiation +/- Brachytherapy boost • Exenterative surgery along with associated morbidity and Qol issues should be discussed as an alternative treatment strategy

- Reconstructive surgery of the vulva/groins should be considered when there is a large defect following surgery or non healing surgical wound which necessitates prolonged stay in the hospital
- Further adjuvant treatment is based on final surgical pathology report of primary lesion and groin nodes(table)
- All patients are followed up for a minimum of 10 years and sometimes lifelong depending on the MDT consensus

Table 4: Metastatic vulvar cancer

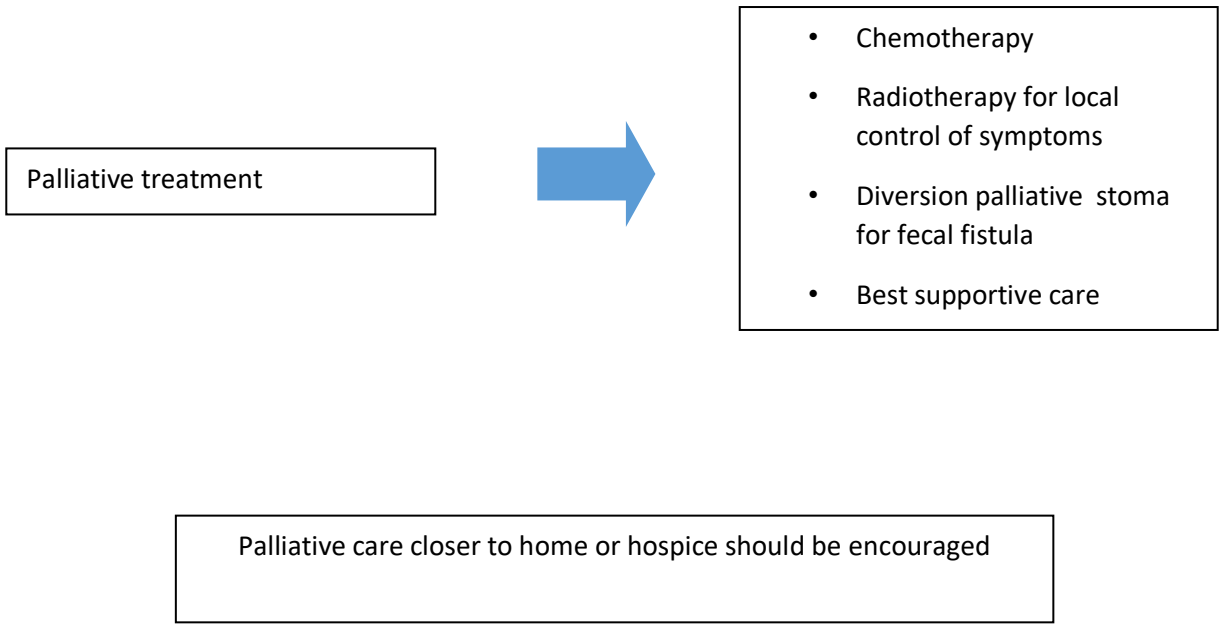

Table 5: Adjuvant treatment of vulva and groins following surgical excision

- Surgical pathology reporting close margin from cancer on vulval specimen (Tumour free margin of 1cm is considered adequate. No consensus for < 4mm margin and < 8mm margin).
- Local vulval recurrences are common (30-50%) if the margin is <4 mm.

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- Re-excision of margins if feasible
- In areas very close to anus/urethra, close observation if margin <8mm
- If margins <4mm close observation versus local radiotherapy should be discussed as vulval recurrences are salvageable at presentation

- Margins close or positive for preinvasive disease of vulva (VIN 2-3) in an adequately excised early vulval cancer

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- Close observation or excision without compromising on functionality of vulva
- Medical management of VIN2/3 is an alternative option

- Groin Node positive

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- If sentinel node positive, complete groin dissection is warranted
- Adjuvant RT is given if more than one node is positive

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- If one node is positive and metastasis is intracapsular, close observation of groins provided the yield of nodal dissection is good

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- > 1 node positive with / without extracapsular spread adjuvant radiation +/- concomitant cisplatin chemotherapy to the affected groin and ipsilateral external iliac / pelvic nodes (depending on the echelon positivity)