NCG RESOURCE STRATIFIED GUIDELINES FOR VULVA CANCER

	Optimal	Optional	Remarks
Imaging Vulva Cancer	**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**	PET CT for squamous or adeno histology	
Stage Wise Management			
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 local excision with groin node dissection or • Sentinel node dissection if facilities available (with radiotracer) • Well lateralized T1 lesions more than 2cms from midline ipsilateral groin node dissection • sentinel node to be considered • If ipsilateral nodes negative, then contralateral GND should be omitted **If Close Margin** • 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 **Groin Node positive** • If sentinel node positive, complete groin dissection is warranted. Close observation of groin if 1 node positive with only intracapsular spread. • > 1 node positive with / without extracapsular spread adjuvant radiation +/- concomitant cisplatin		• 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 • All patients are followed up for a minimum of 10 years and sometimes lifelong depending on MDT consensus

	chemotherapy to the affected groin and ipsilateral external iliac / pelvic nodes (depending on the echelon positivity) **Unfit for Sx** Radical Radiation therapy including brachytherapy may be an effective alternative . 3DCRT or IMRT can be considered along with concurrent chemotherapy		
-Large T2-3 lesion not involving the anus or urethra -Absence of enlarged groin nodes on palpation/ CT scan	• Wide local excision/ Simple Vulvectomy / Radical Vulvectomy depending on the local extent of lesion and bilateral groin node dissection (GND) or • Radical Chemoradiation +/- Brachytherapy boost • 3DCRT or IMRT can be considered **If Close Margin on surgery** • Re-excision of margins if feasible • In areas very close to anus/urethra, close observation if margin <8mm • Adj local radiotherapy to be considered if tumour size> 4 cm or margin positive/Close. 3DCRT or IMRT can be considered • **Groin Node positive on pathology** • If sentinel node positive, complete groin dissection is		• 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 • All patients are followed up for a minimum of 10 years and sometimes lifelong depending on the MDT consensus

	warranted . • If 1 node positive with extracapsular spread adjuvant radiation +/- concomitant cisplatin chemotherapy to the affected groin and ipsilateral external iliac / pelvic nodes (depending on the echelon positivity) • 3DCRT or IMRT can be considered		
-Large T2-3 lesion not involving the anus or urethra -Presence of enlarged groin nodes on palpation/CT scan	• Wide local excision/ Simple Vulvectomy / Radical Vulvectomy depending on the local extent of lesion and fine needle aspiration of groin node or GND / debulking of groin node if feasible followed by adjuvant chemoradiation to primary, inguinal and pelvic nodes. 3DCRT or IMRT can be considered OR • Radical Chemoradiation +/- Brachytherapy boost • 3DCRT or IMRT can be considered		• 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 • All patients are followed up for a minimum of 10 years and sometimes lifelong depending on the MDT consensus
-Large T2-3 lesion involving or close to anus or urethra which requires diversion urinary/fecal stoma -With or without enlarged groin	• Pre-op (Neoadjuvant) chemoradiation followed by local excision of vulval tumour or • Radical Chemoradiation +/- Brachytherapy boost • Exenterative surgery		• Reconstructive surgery of the vulva/groins should be considered when there is a large defect following surgery or non healing surgical wound which necessitates

nodes	along with associated morbidity and Qol issues should be discussed as an alternative treatment strategy • 3DCRT/IMRT may be considered.		prolonged stay in the hospital • Further adjuvant treatment is based on final surgical pathology report of primary lesion and groin nodes • All patients are followed up for a minimum of 10 years and sometimes lifelong depending on the MDT consensus
Palliative treatment	• Chemotherapy • Radiotherapy for local control of symptoms • Diversion palliative stoma for fecal fistula • Best supportive care		Palliative care closer to home or hospice should be encouraged