

Contents lists available at [ScienceDirect](http://www.sciencedirect.com)

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

The first leg video endoscopic groin lymphadenectomy in vulvar cancer: A case report



Angelica Naldini*, Cristiano Rossitto, Andrea Morciano, Giovanni Panico, Giuseppe Campagna, Pierluigi Paparella, Giovanni Scambia

Department of Obstetrics and Gynecology, Catholic University of the Sacred Heart, Rome, Italy

ARTICLE INFO

Article history:

Received 18 April 2014

Received in revised form 16 May 2014

Accepted 19 May 2014

Available online 4 June 2014

Keywords:

VEIL

Vulvar cancer

Video endoscopic inguinal

lymphadenectomy

Vulvectomy

ABSTRACT

INTRODUCTION: The current management of vulvar cancer depends on the extension of disease, and includes primary tumor resection with safety margin as well as inguino-femoral lymph node staging. We report the case of the first leg videoendoscopic inguinal lymphadenectomy performed in a woman with a squamous cell vulvar carcinoma.

PRESENTATION OF CASE: A 74 years old female referred to our institution complaining of vulvar mass associated with bleeding and swelling from external genitals, vaginal burning sensation and dysuria for 5 months. A vulvar–vaginal examination under narcosis reported a right major labium lesion of 5 cm with an irregular and ulcerated surface, easily bleeding on palpation, involving anteriorly the clitoral region and with a histological finding of a poorly differentiated squamous cell invasive carcinoma of the vulva ulcerating the surface epithelium. We performed, after adequate informed consent, a radical vulvectomy with a standard right inguino-femoral lymphadenectomy and a contralateral simultaneous video endoscopic inguinal lymphadenectomy–Leg procedure.

DISCUSSION: Our minimally invasive VEIL-Leg approach, performed for the first time in literature in a woman with vulvar cancer, could reduce the presence of high risk factors represented by surgical incision and by procedure-related complications, including wound infection and breakdown, hematoma, cellulitis and hernia formation.

CONCLUSION: A multicenter prospective randomized study will be helpful to clarify how this procedure could replace the standard laparotomic approach to inguinal lymphadenectomy in the vulvar cancer treatment and staging.

© 2014 The Authors. Published by Elsevier Ltd. on behalf of Surgical Associates Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/3.0/>).

1. Introduction

Vulvar cancer accounts for approximately 3–5% of all gynecological malignancies and the majority of cases are squamous cell carcinoma.^{1,2} Surgery is the cornerstone in the treatment of this cancer and prognosis is mostly linked to the presence of inguinal lymph node metastasis.^{3,4}

The current management of vulvar cancer depends on the extension of disease, and includes primary tumor resection with safety margin as well as inguino-femoral lymph node staging.⁵

In 2003 Bishoff et al. were first to report an endoscopic groin dissection in two cadavers and one patient,⁶ and many other studies later described a leg videoendoscopic technique (VEIL-Leg) in the treatment of cancers such the penile carcinoma or the melanoma.^{7–9}

Cui et al. described in 2013 the first endoscopic via hypogastric subcutaneous approach (VEIL-H) in vulvar cancer,¹⁰ with a technique substantially different from the leg procedure.

The aim of the present paper was exactly to report the case of the first videoendoscopic inguinal lymphadenectomy performed by our group in Italy on November 2013 in a woman with a squamous cell vulvar carcinoma.

2. Presentation of case

A 74 years old female referred to our Institution complaining of vulvar mass associated with bleeding and swelling from external genitals, vaginal burning sensation and dysuria for 5 months.

On recovery at our department blood exams revealed mild anemia but were negative for other abnormalities.

The patient was extremely in pain at gynecological examination and she was submitted to vulvar–vaginal examination under narcosis, which reported a right major labium lesion of 5 cm with an irregular and ulcerated surface, easily bleeding on palpation, involving anteriorly the clitoral region. Moreover, on the left major

* Corresponding author at: Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, L.go A. Gemelli 8, 00168 Rome, Italy.
Tel.: +39 06 30154979; fax: +39 06 30156332.

E-mail address: naldini.angelica@gmail.com (A. Naldini).

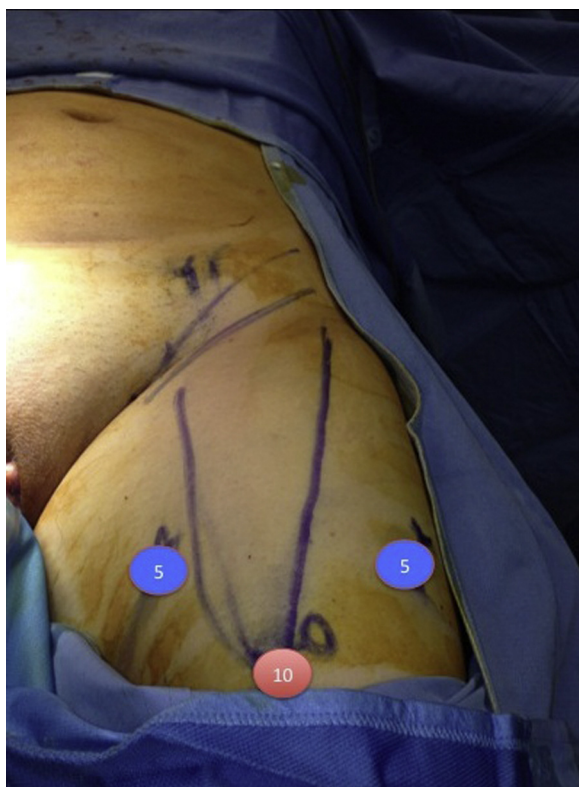


Fig. 1.

labium we observed an initial area of suspected metaplasia as for “kisses tumor”.

Multiple biopsies of the lesion and nearer tissues were performed with histological finding of a poorly differentiated squamous cell invasive carcinoma of the vulva ulcerating the surface epithelium, located on the right major labium.

The abdomen–pelvic computed tomography (CT) revealed an enlarged area in the right vulvovaginal wall and right inguinal enlarged lymph nodes measuring 2 cm in the largest diameter.

These findings, along with the microscopical features of the tumor, were supportive for an important extension of the disease (FIGO stage III).

After adequate counseling a surgical strategy was suggested. We proposed a radical vulvectomy with a standard right inguino-femoral lymphadenectomy and a contralateral simultaneous VEIL-Leg procedure. The novel nature of this procedure was discussed in detail with the patient and it was also specifically explained that, due to its novelty, some of the risks may not be clearly anticipated. A specific informed consent was signed by patient, after our local ethics committee approval.

In the surgery room, she was positioned in a split-leg table with the boundaries of the femoral triangle mapped out (Fig. 1). This marking was necessary for correct trocar placement as well as to aid in determining the extent of dissection.

The surgical procedure started with an excision of the vulvar lesion with an *en bloc* removal of a segment measuring 4.5 cm in length plus adjacent vulvar skin and with a right groin dissection.

The procedure was followed by an inguinal 15-French fully fluted drain placement.

For the left VEIL-Leg procedure, we proceeded modifying the previously described approach by Delman et al.⁸

The assistant stood on the outside of the operative limb and the surgeon in between the patient’s leg.

We practiced the first 15-mm incision about 2 cm distal to the apex of the femoral triangle. With a scalpel we incised the skin

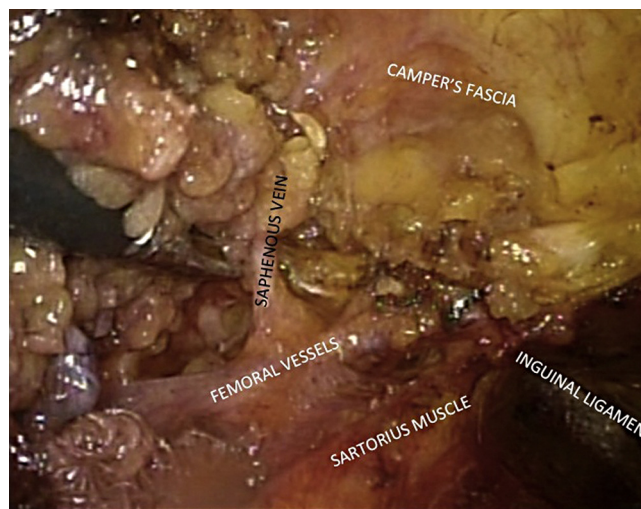


Fig. 2.

and Camper’s fascia to the Scarpa’s fascia. We, then, proceeded with a finger development of a 4–5 cm space on either side of our initial incision. Once enough space was created, we placed a 12-mm balloon port trocar in the original incision with a 10-mm 30° laparoscope. Patient pressure was set a 12 mmHg and no end-tidal transient CO₂ increase was observed. Two short bladeless trocars were then placed, about 5 cm from the port. In particular, a medial 5-mm and a lateral 10-mm trocars were placed almost 3 cm outside of the medial and lateral boundaries of the femoral triangle, respectively (Fig. 1).

Before additional dissections, we proceeded with the anterior working space development, raising the flaps as for an open procedure, between the fibrofatty packet containing the lymph nodes and the subcutaneous fat.

We then delimited the medial and lateral boundaries which were, respectively, the adductor longus and the sartorius muscle, by identifying the fascia of the respective muscles and transilluminating the established skin markings.

A medial and lateral blunt dissection was started using a rolled endoscopic sponger and was continued superiorly and inferiorly to define the posterior boundaries of the node packet. Small perforating vessels and lymph vessels are controlled with clips.

The saphenous vein along with the femoral vein and artery were visualized and spared, after a careful and accurate dissection (Fig. 2).

An exposure of the saphenofemoral junction was practiced, as previously described by Ames,¹¹ continuing inferomedial dissection around the femoral vein to obtain a complete deep inguinal nodes resection. The packet was placed into a laparoscopic specimen retrieval bag and withdrawn from the apical port.

No intraoperative complications occurred.

Finally, we placed a 15-French fully fluted drain through the medial port site and we closed the skin.

The bilateral drain outputs were <50 ml in the subsequent 24 h for site and were then removed on the VII day after surgery. The patient was discharged on the V day after surgery, without any complications during hospitalization.

Operative times were 40 min for the standard right groin lymphadenectomy and 120 min for the left VEIL-Leg.

Postoperatively, after 1 and 3 months follow-up, no genital edema, lymphocele or lymphedema were observed on both the groin sides.

Characteristically, the only complication was a minimal wound infection on the right groin, observed at 1 month follow up, treated

Download English Version:

<https://daneshyari.com/en/article/4289635>

Download Persian Version:

<https://daneshyari.com/article/4289635>

[Daneshyari.com](https://daneshyari.com)