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Review article

Surgical management of squamous cell vulvar cancer without clitoris, urethra or anus involvement

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ABSTRACT

Vulvar cancers, which constitute 5% of all gynecologic cancers, are the fourth most common female genital cancers, preceded by uterine, ovarian and cervical cancers. The treatment methods employed for vulvar cancers have changed over the years, with previously applied radical surgical approaches, such as en bloc resection, being gradually suspended in favor of treatment approaches that require dissection of less tissue. While the removal of less tissue, which today's approaches have focused on, prevents morbidity, this method seems to result in higher risks of recurrence. It is therefore important that the balance between preventing the recurrence of the disease and forefending against postoperative complications and vulvar deformity be properly understood. As a working assumption, if patients with vulvar cancer are diagnosed at an early stage, properly evaluated and administered appropriate treatment, the most positive results can be obtained. This paper aims to highlight this assumption and demonstrate, through the provision of actual data, how to plan the treatment approach for patients who are diagnosed early. Statements extracted from the National Comprehensive Cancer Network (NCCN) Guidelines Version 1.2016 Sub-Committees on vulvar squamous cell carcinoma and articles by the European Society of Gynaecological Oncology (ESGO) regarding Vulvar Cancer Recommendations were used to obtain updated information.

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1. Introduction

Vulvar cancers, which constitute 5% of all gynecologic cancers, are the fourth most common female genital cancers, preceded by uterine, ovarian and cervical cancers (Siegel et al., 2014). Although the histological types of vulvar cancers, such as malignant melanoma, basal cell carcinoma, Bartholin gland adenocarcinoma, Paget's disease and sarcoma, are rare, 90% of vulvar cancers have squamous cell carcinoma histology features (Gunther et al., 2012). In more than half of the patients, the disease is localized, while in 5%, distant metastatic disease occurs (SEER Cancer Stat Facts: Vulvar Cancer, 2017). Recent data shows that when the disease is diagnosed at the localized stage, the survival rate is 86.1% (SEER Cancer Stat Facts: Vulvar Cancer, 2017).

The treatment methods employed for vulvar cancers have changed over the years, with previously applied radical surgical approaches, such as en bloc resection, being gradually suspended in favor of treatment approaches that require dissection of less tissue. These changes in treatment approaches aim to prevent postoperative morbidity and to reduce vulvar deformity and sexual dissatisfaction, which especially occur in younger patients following treatment.

Recurrence is a particularly problematic feature of vulvar cancer cases. Relapses can generally be attributed to the disease's nature (multi-focused), delayed diagnosis and inadequate treatment (Rouzier et al., 2002). Studies have found that en bloc resections yield better results in terms of recurrence (de Hullu et al., 2002; Van der et al., 2004; Leminen et al., 2000; Magrina et al., 1998). While the removal of less tissue, as today's approaches have focused on, prevents morbidity, this method seems to result in higher risks of recurrence. It is therefore important that the balance between preventing the recurrence of the disease and forefending against postoperative complications and vulvar deformity be properly understood.

As a working assumption, if patients with vulvar cancer are diagnosed at an early stage, properly evaluated and administered appropriate treatment, the most positive results can be obtained. This paper aims to highlight this assumption and demonstrate, through the provision of actual data, how to plan the treatment approach for patients diagnosed early. Statements extracted from the National Comprehensive Cancer Network (NCCN) Guidelines Version 1.2016 Sub-Committees on vulvar squamous cell carcinoma and articles by the European Society of Gynaecological Oncology (ESGO) regarding Vulvar Cancer Recommendations were used to obtain updated information.

1.1. Vulvar anatomy

The vulva consists of the labium majus and minus, the clitoris, the vestibule, the vaginal introitus and the urethral meatus. Additionally, the Bartholin gland complex (gland and ductus) is a component of the vulva. Bartholin gland malignancies are recognized to be a function of vulvar cancers. A build-up of blood mainly originates from the internal pudendal artery, with a far greater amount generated from the external pudendal artery. The anterior and posterior parts are innervated by branches of the ilioinguinal nerve, as well as the pudendal nerve and the posterior cutaneous nerve. Lymphatic drainage affects the superior inguinal nodes, whereas the deep inguinal and external iliac nodes may be directly subjected to drainage from the front parts of the clitoris and labium minus.

2. Pre-treatment evaluation

During the evaluation of a patient suspected of having vulvar cancer, the first step is to conduct a biopsy of the vulva section under question. Only a hemogram is necessary before performing the biopsy (if anamnesis shows there to be no risk of bleeding diathesis), which can be done under local anesthesia. At this stage, it is important to avoid making a broad excisional biopsy, as this could possibly complicate the surgical plans related to a vulvectomy that may be required later. Instead, the dissection should be conducted in punch biopsy form. Furthermore, the dissected tissue should also contain some dermis and connective tissues in order to determine the invasion depth. In cases of multiple lesions, all lesions should be subjected to biopsy and analyzed. The histological type and depth of invasion need to be specified in the pathology report. If invasive squamous cell carcinoma (SCC) is diagnosed as a result of the biopsy, the stage of the disease should be noted. Vulvar cancers are staged according to the surgical staging system of the American Joint Committee on Cancer (AJCC) and the International Federation of Gynecology and Obstetrics (FIGO) (Table 1).

Table 1
Surgical staging of vulvar cancer cases.

IA	Lesions ≤ 2 cm in size, confined to the vulva or perineum and stromal invasion ≤ 1.0 mm
IB	Lesions > 2 cm in size or any size with stromal invasion > 1.0 mm, confined to the vulva or perineum
II	Tumor of any size, with extension to adjacent perineal structures (lower/distal 1/3 urethra, lower/distal 1/3 vagina, or anal involvement)
III	Tumor of any size, with or without extension to adjacent perineal structures (lower/distal 1/3 urethra, lower/distal 1/3 vagina, or anal involvement) and with positive inguino-femoral lymph nodes
IVA	Tumor of any size, with extension to any of the following: upper/proximal 2/3 of urethra, upper/proximal 2/3 vagina, bladder mucosa, rectal mucosa, or fixed to pelvic bone
IVB	Any distant metastases involving pelvic lymph nodes

In patients diagnosed with invasive cancer, imaging techniques, such as magnetic resonance imaging (MRI), computed tomography scan (CT) and positron emission tomography (PET), can be used to determine the limits of the tumor and any possible metastases. Here, it is important to note that CTs and MRIs should be performed in such a manner as to show contrast. However, in the event that a thorax CT is performed, the showing of contrast is not required. If invasion is suspected in the urethra, bladder or anal channel during the imaging examination, a cystoscopy or proctoscopy may help to clearly identify this. Moreover, patients should be evaluated through the performance of a papanicolaou smear in addition to a cervical and vaginal colposcopy (Berek and Hacker, 2015) to determine whether other simultaneous malignancies in the lower genital tract exist. Should all these examinations reveal that the diameter of the tumor does not exceed 4 cm and that there is no vaginal, anal, or urethral involvement, the patient can then be diagnosed with early stage vulvar cancer.

In general, treatment approaches may differ according to the following four management criteria (Fig. 3):

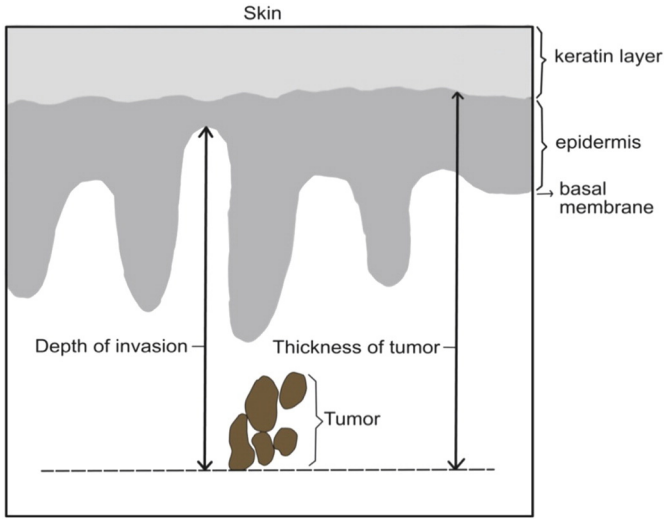

Fig. 1. Measurement of tumor invasion depth.

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