RECURRENT CANCER OF THE VULVA

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RECURRENT CANCER OF THE VULVA

- Paucity of data
- No national guidelines
- Societal recommendations not consistent
- Departmental approach depends on available expertise

- Review article by Nooij et al in *Critical Reviews in Oncology* has only 24 retrospective studies dating from 1982 with more than 20 patients per study

- No randomized study
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- Invasive cancer of vulva is rare. 3-5% of all female genital cancers.
- Recurrence rates vary from country to country, 12-39%.
- 40-60% will occur in first 2 years after primary treatment, with high rate of local recurrence (50-70%).
- Recurrence is considered to be appearance of a new tumour 6 months after primary therapy with radical intent.
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- Outcome of patients with recurrence within 2 years is worse than if recurrence > 2 years after initial treatment.

- Symptoms of recurrence differ and patients may be asymptomatic.

- Diagnostic workup includes medical history, careful examination, biopsies of suspicious vulval areas, fine needle aspiration of groin nodes, CXR, CAT scan of pelvis, abdomen and chest, cystoscopy and proctoscopy. PET scan may be indicated if other radiological imaging is inconclusive.

- Recurrences are said to be perineal, inguinal, pelvic, distant.

- Recurrences beyond 3 years may be considered as second primary.
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- Commonest sites of recurrence are
  - Perineal: 50%
  - Inguinal: 15-20%
  - Pelvic: 5-6%
  - Distant: 10%
  - Multiple: 15%

- Stage 1: 20%
- Stage 2: 35%
- Stage 3: 45%
- Stage 4: 45%

Podratz et al 2008
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CHARACTERISTICS

- Isolated perineal recurrences are more common with initial stage 1 disease (70%), whereas distant and multiple recurrences are more frequent in women with advanced initial disease.

- Location of primary lesion does not dictate likelihood of recurrence, (lateral, anterolateral or posterolateral).

- Perineal recurrences more likely in 1st year of treatment with equal distribution during following years. Other types appear within 24 months (later).
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PROGNOSTIC FACTORS

- Accounting for specimen preparation and fixation, a 1 cm tumour-free surgical margin on vulva results in high rate of local control, whereas < 8mm has a 50% recurrence
  
  *Hacker N, Berek J. 2004*

- Surgical margins being clear of disease of paramount importance with recurrence being higher when < 1cm without correlation with vulval surgery (mod wide radical vulval excision vs total radical vulvectomy)

Prognostic factors related to primary disease

- Stage of disease, tumour dimensions (< 2.5 cm / > 2.5 cm), lymph nodal involvement, lymph-angiovascular space involvement, depth of stromal invasion > 9 mm, number of nodes with metastatic disease.

- Least important include tumour site of primary disease and whether multiple or local only

- Lymph nodal involvement is predictive for earlier recurrence, for inguinal recurrence, for multiple and distant recurrences, a lower rate of isolated perineal recurrence and a poorer prognosis

- Number of lymph nodes involved may also reflect a poorer prognosis ( <3 vs >3 ), extracapsular lymph node spread
119 patients

No recurrences among women if primary disease was unifocal, < 2.5 cm greatest dimension, free surgical margins, no LVSI and no VIN 2 or VIN 3

Figo stage, greatest tumour dimension ( < 2.5 cm / > 4 cm), multifocality, depth of stromal invasion >9 mm, number of metastatic inguinal nodes ( >3-5 ), LVSI, presence of associated VIN 2 and positive surgical margins were statistically associated with a shorter disease free survival

Disease free interval from primary treatment to recurrence may also be of prognostic significance

Preti et al. 2007
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Treatment strategies of recurrences depend on

- (a) Whether irradiation therapy had been given for primary therapy
- (b) Site of recurrence
- (c) Extent of recurrence

**LOCAL RECURRENCE** - Surgery is cornerstone including inguinal nodes if not removed initially

**INGUINAL RECURRENCE** - Controversial and associated with poor outcome. If no irradiation, previous incomplete resection of nodes (= or < 3 ) and lines of excision > 1 cm can attempt resection. Some data to support interstitial brachytherapy

**PELVIC** - Chemo-irradiation if previously not given, chemotherapy only as palliative measures if previous irradiation or palliation only

**DISTANT** – palliation only
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OPTIONS INCLUDE

- Wide local excision only, hemivulvectomy, radical vulvectomy
- As above but with skin flaps
- Radical exenterative procedures if recurrence involves urethra, bladder, vagina, and/or anorectal cana
- Chemo-irradiation prior to surgery
- Chemo-irradiation only
- Chemotherapy – 5 fluro-uracil, cisplat, bleomycin, taxane
- Palliative
Survival after retreatment is influenced by the site of recurrence, tumour grade, interval to recurrence.

Presence of multiple recurrences, presence of distant metastases (lung, bones), lymph nodal involvement represent a subgroup of patients with a poor prognosis.

Perineal recurrences are amenable to surgery in about 70% of cases with wide local resection having a very acceptable prognosis, about 60% of women surviving 5 years.

Prior to exenterative procedures best to determine planes by CAT.

Surgery is not advocated in women with pelvic recurrences.

NOOIJ et al. 2016
IN CONCLUSION

- Vulval cancer is not common, recurrences after primary treatment are common

- Stage, tumour dimensions, depth of invasion, lymph nodal involvement, LVSI predict likelihood of recurrence

- Recurrences are perineal, inguinal, pelvic, distant or multiple

- Surgery is cornerstone of treatment, esp for perineal recurrence

- Inguinal recurrence has a poor outcome

- Palliative therapy should be offered to the pelvic, distant recurrences unless irradiation had not been given and chemo-irradiation is choice
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Thank you for your attention