Management of CA Vulva

→ CA vulva:

→ Epidemiology | Pathology | natural history:

- Post menopausal women.

① → vulvar SCC → Preceded by Vulvar intraepithelial neoplasia (VIN)

VIN → VIN 1, 2, 3 similar to CIN.

- HPV dependant Usual VIN (uVIN)
  - Verrucous Subtype
  - Keratinising
  - Warty / Bowenoid.
- HPV independant differentiated VIN (dVIN)
  - ↓
  - dd Lichen sclerosis / Lichen planus

② → Extramammary Paget of vulva

③ → Vulval malignant melanoma

④ → Bartholin Gland Carcinoma → SCC, adenoid cystic, adeno CA.

⑤ → vulval Sarcoma.

→ Patterns of spread

- >80% from labia majora
  - ↓
  - >2 cm away from midline
    - ↓
    - Ipsilateral spread.
  - < 2cm from midline
    - ↓
    - B/L spread.

Inguinal LN mets is the most important prognostic factor.

* Superficial Inguinal → Deep femoral → Lateral circumflex iliac LN → pelvic LN.
* Nodal mets risk increases with DOI > 1mm

→ Staging:

Stage	Description
I	Tumor confined to vulva
	IA: Tumor size ≤2 cm and stromal invasion ≤1 mm
	IB: Tumor size >2 cm or stromal invasion >1 mm
II	Tumor of any size with extension to lower one-third of the urethra, lower one-third of the vagina, lower one-third of the anus with negative nodes
III	Tumor of any size with extension to upper part of adjacent perineal structures or with any number of nonfixed, nonulcerated lymph node
	IIIA: Tumor of any size with disease extension to upper two-thirds of the urethra, upper two-thirds of the vagina, bladder mucosa, rectal mucosa, or regional lymph node metastases ≤5 mm
	IIIB: Regional lymph node metastases >5 mm
	IIIC: Regional lymph node metastases with extracapsular spread
IV	Tumor of any size fixed to bone, or fixed, ulcerated lymph node metastases, or distant metastases
	IVA: Disease fixed to pelvic bone, or fixed or ulcerated regional lymph node metastases
	IVB: Distant metastases

→ only Gynae malignancy in which Bladder/rectal mucosa infiltration is stage III A and NOT stage IV A.

→ Staging work up

- Full thickness Bx for DOI
- MRI > CT
- PET/CT
- EUA + cystoscopy + Proctoscopy.

→ Treatment:

- → LSIL → not precancerous, no treatment if asymptomatic.
- → HSIL
  - → progression to malignancy → 2-15%
  - → Options
    - → Excision
    - → Laser ablation → for extensive focal disease
    - → Topical → 5FU, imiquimod

→ Invasive disease (Early stage)

Primary → WLE ≥ 1cm circumferential margin + deep margin upto inferior fascia of urogenital diaphragm.

↓

Radical vulvectomy for tumors ≥ 4cm

→ DOI measurement → from deepest tumor free rete ridge to deepest point of invasion.

→ Role of adjuvant RT is locally disease

→ close/ positive margin
→ T size ≥ 4 cm
→ LVI ⊕
→ LN ⊕

→ management of LN in CA vulva:

Earlier → IFLND for all tumors c DOI > 1mm

↓

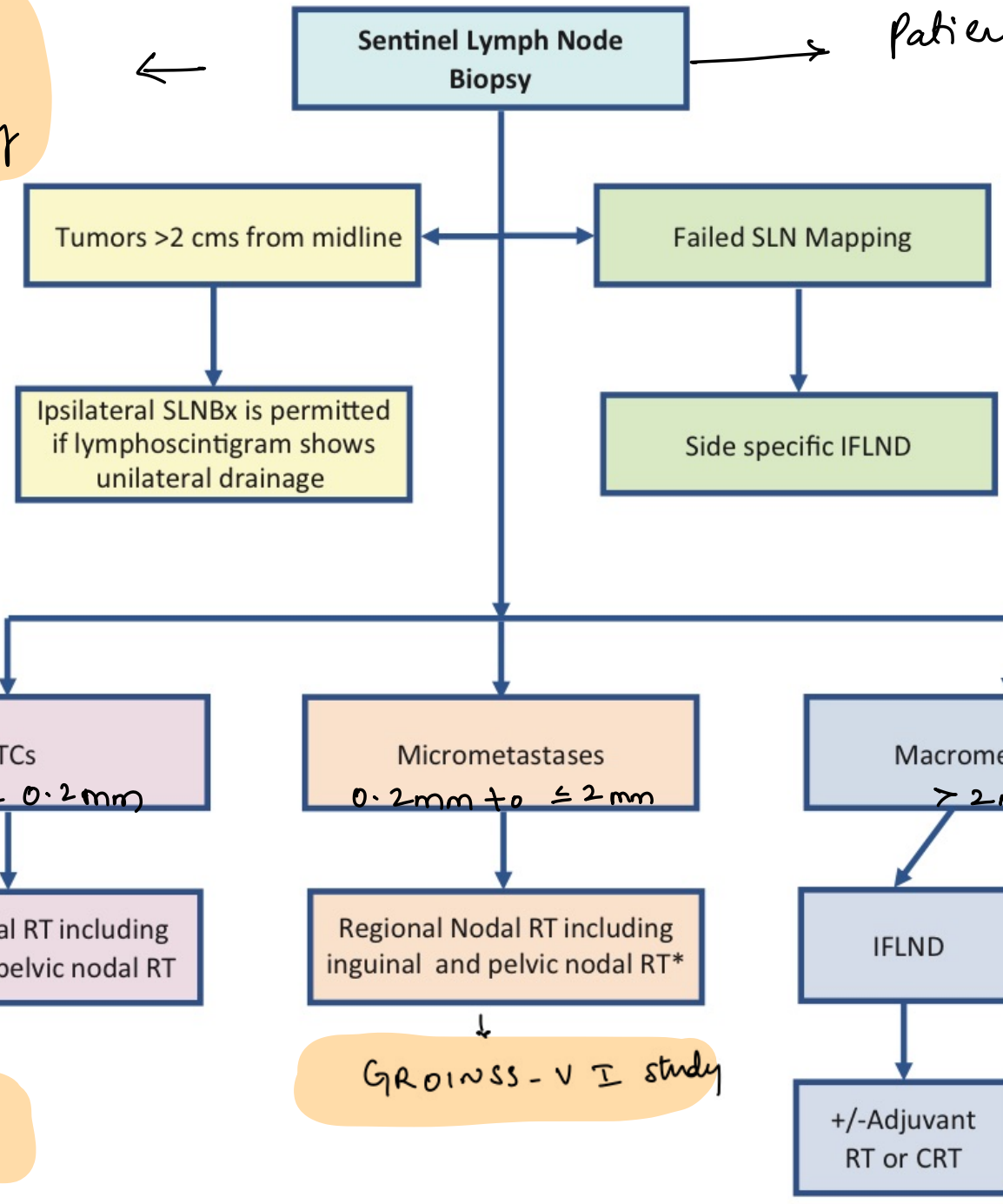
increased morbidity

- lymphedema, wound breakdown.

↓

Now, SLNB is the standard of care

Role of SLNB in CA vulva established by GROINSS-V I study.



Patient selection criteria for SLNB

1) Node negative on clinical & imaging.
2) unifocal tumor
3) ≤ 4 cm
4) No prior History of vulvar surgery.

SLN ⊖

↓

Observe

↓

GROINSS-V II study

GROINSS-V I study

ongoing → GROINSS-V III study.

cisplatin + 56 Gy RT.

↓

Observation

vs

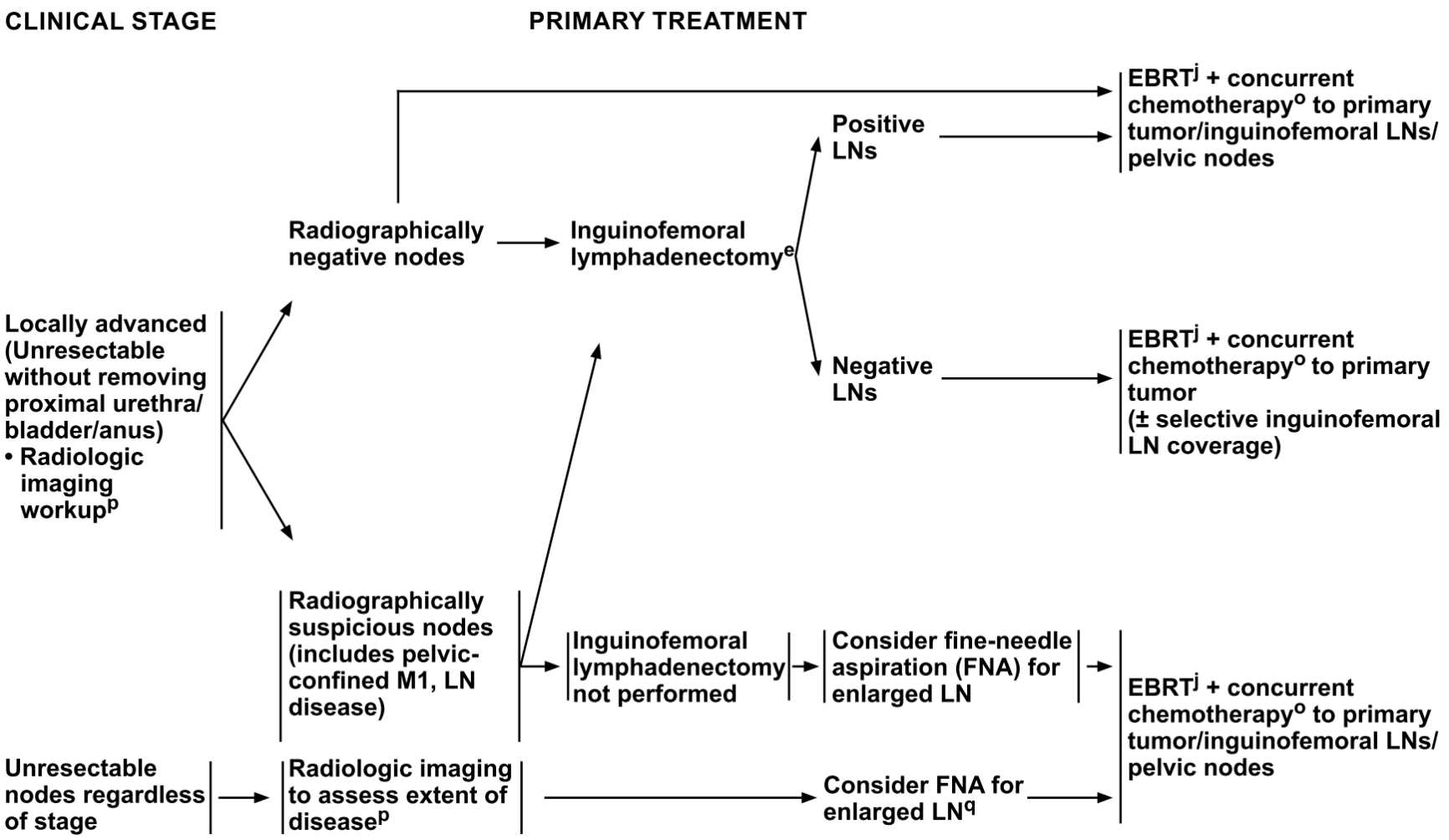
RT if SLN ⊕

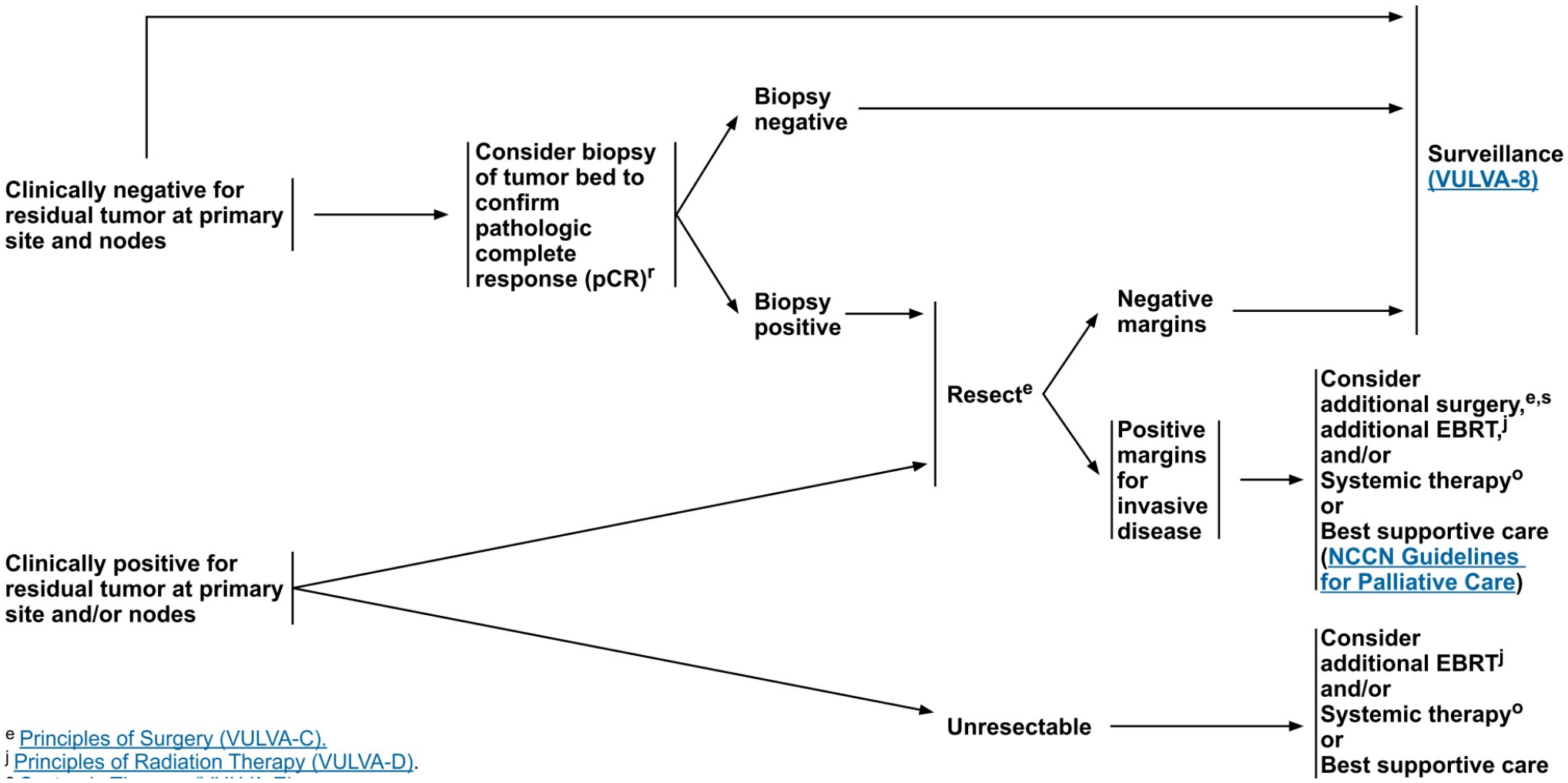
*Consider concurrent chemotherapy if >1 micrometasatses or any macrometastases or extra nodal extension.

* GROINSS-V I study results
  - ↓ lymphedema rate (1 vs 25%)
  - LN recurrence → 2.5% in SLN negative
    → 8.0% in SLN positive
  - 10yr DSS → 91% SLN ⊖
    65% SLN ⊕

→ management of advanced CA vulva:

→ GOG 101 study → CRT followed by Sx for Residual disease.
GOG 205 study
↳ pCR in 31% patients.





e Principles of Surgery (VULVA-C).
j Principles of Radiation Therapy (VULVA-D).

→ metastatic CA vulva :

- platinum + Taxane based
- Nivolumab
- Pembrolizumab
- Bevacizumab

} investigational.