Current vulvar cancer treatment in Bulgaria

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Summary

Purpose of investigation: Our aim was to outline the treatment of carcinoma of the vulva at the National Oncological Centre in Sofia, Bulgaria.

Methods: We examined the records of 250 patients over a 10-year period treated at the Gynaecologic-Oncology Clinic of our Centre.

Results: There were 130 patients (52%) treated with surgery and radiation. There were 120 patients (48%) treated by surgery only. Thirty of these patients were treated by pelvic exenteration with radical vulvectomy. The five-year survival rate was 36% - 12 patients. The 1-year survival rate for all patients was 80% - 200 patients. The five-year survival rate was 50%.

Discussion: We have results similar to other clinics in the world working in this field. We now emphasize external radiation for advanced disease but the treatment must be individualized.

Conclusion: We have outlined the treatment of carcinoma of the vulva at our Centre, over a 10-year period.

Key words: Vulvar cancer; Surgery; Radiotherapy.

Introduction

In the last ten years in gynecology-oncology, there have been a number of changes in the treatment of vulvar cancer [1] and the quality of life for these patients has improved [2]. We have outlined trends in the management of carcinoma of the vulva in our Clinic.

Materials and Methods

We examined the records of 250 patients over a 10-year period from January 1, 1990 to January 1, 2000 treated at the Gynaecologic-Oncology Clinic at the National Oncological Centre in Sofia, Bulgaria.

The trends in treatment are:

1. Individualized treatment for all patients with invasive vulvar disease [3, 5, 6].
2. Vulvar conservation for patients with unifocal tumours and normal vulvar skin beyond the lesion [1, 7].
3. Routine pelvic lymphadenectomy has been eliminated [8].
4. Groin dissection for patients with T1 tumours with 1 mm invasion or less is not done.
5. Radical local excision is the procedure for localized primary lesions with 1 mm or less invasion.
6. In patients with T1 tumours and invasion more than 1 mm the ipsilateral inguinal and femoral lymph nodes are removed. The femoral nodes lie medial to the femoral vein. It is not necessary to remove the fascia lata to adequately remove these nodes.
7. Contralateral groin dissection in patients with lateral T1 lesions and negative ipsilateral nodes is not done.
8. To improve wound healing separate groin incisions for groin dissection are used.
9. Patients with positive groin nodes, 1/3 or more disease outside the node, receive postoperative radiation.
10. Patients with three or more groin micrometastases, or one macrometastasis (10-15 mm or greater) receive postoperative radiation to the groins and the pelvis.
11. Patients with clinically suspicious groin nodes undergo ultrasound or CT scan of the groin and pelvis. Only the bulky nodes are removed from the groin and pelvis prior to postoperative radiation [9].
12. The original groin incision is not extended.
13. We believe the selective resection of sentinel lymph nodes will reduce the need for full groin resection and decrease the morbility significantly. This area requires additional research to be confirmed [[8, 9, 10].
14. Preoperative radiation therapy is used and we discuss the need for exenteration in patients with advanced disease [4].
15. When the anus, rectum, rectovaginal septum or proximal urethra are involved, pelvic exenteration with radical vulvectomy is performed.
16. Combined radiation and surgery is an alternative to pelvic exenteration for some patients with advanced vulvar cancer.
17. For patients who develop severe vulvitis with external radiation at about 25-30 Gy, the treatment is interrupted for 2-3 weeks and then continued to 50 Gy [9].

Results

There were 130 (52%) patients treated with surgery and radiation. There were 40 (31%) of these patients who developed unilateral lymphoedema and 20 (15%) patients with bilateral lymphoedema.

There were 120 (48%) patients treated by surgery only. Thirty of these patients were treated by pelvic exenteration with radical vulvectomy. The five-year survival rate was 36% - 12 patients.

The 1-year survival rate for all 200 patients was 80%.

The five-year survival rate was 50%.

Fifty patients with advanced vulvovaginal cancer and

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combined radiation + surgery had a 30% (15 patients) five-year survival rate.

We now advocate external radiation for advanced disease but the treatment must be individualized [6].

Conclusion

The treatment of carcinoma of the vulva at the National Oncological Centre in Sofia, Bulgaria, over a 10-year period from January 1, 1990 to January 1, 2000 has been outlined.

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