Vulval cancer, 1992-2002 audit - Multidisciplinary care and prognostic factors

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Abstract
Vulval carcinoma is becoming increasingly common. Thirty-four cases of vulval carcinoma were treated from 01/01/1992/31/12/2002. The mean age was 67, range (18-90). The presenting complaints were a lump (76%) (25/33), itch (49%) (16/33), discomfort (30%) (10/33) and postmenopausal bleeding (21%) (7/33). Most patients presented with stage 1 or 2 disease (73%) (n=24/33). The majority (97%) (32/33) underwent surgical treatment. Five-year survival was 61% (17/28), (disease-free survival 76% (13/17)). There were 12 cases of local/regional recurrence. Five-year survival from 79% (11/14), if negative, to 17% (1/6) if positive. Age > 70 reduced survival from 69% (11/16) to 50% (6/12). We conclude that age, the stage of disease, and lymph-node status were important prognostic factors. The favourable outcomes reflect multidisciplinary care, combining clinical examinations with regular home contact with specialist nurses, by telephone.

Aim
To review the outcomes and prognostic factors for patients diagnosed with vulval cancer.

Method
A computerized search of the database at the Mater Hospitals was carried out to identify all cases of vulval carcinoma diagnosed between January 1992 and December 2002. The case notes were individually reviewed. All data was analysed using a SPSS database.

Demographics
There were 34 cases of vulval cancer managed by the Gynae-oncology team between January 1992 and December 2002. One patients record could not be found.

The demographics of this population reflect our catchment area. The majority of our patients, 70% (n=23), were living in Dublin City. The mean average age was 67 years (range18 to 90). 55% (18/33) were parous. 49% (16/33) were married, 24% (8/33) of women were widowed and 27% (9/33) were single/separated. 27% (9/33) of our population were smokers or ex-smokers. Pre-invasive disease was present in 2 cases (6%), with leukoplakia and VIN3 respectively. There were no recorded cases of lichen sclerosis in our cohort.

Results
The most common presenting complaints are shown in Figure 1. These presentations were not mutually exclusive.

The histological types were reported as 85% (28/33) squamous cell carcinoma, 3% (1/33) adenocarcinoma, 6% (2/33) malignant melanoma and 6% (2/33) basal cell carcinoma. All types were included in the overall survival analysis.

The results for the clinical staging of disease at diagnosis are shown in Table 1 (n=33). The outcome results for these patients for whom five years follow up is available (n=28), is shown in Table 2 and illustrated in Figures 2 - 4.

Outcome Complications
There were seven cases of lymphoedema. There were four other complications; a seroma, a wound dehiscence, a DVT and one patient required a colostomy as part of the Vulval and abdomino-perineal resection, (following previous radiotherapy).

Outcome Recurrence
There were nine cases of local recurrence, eight were treated with local excision, of these two patients also received radiotherapy. Seven of these were alive at 5 years.

As regards lymph node dissection, 71% (20/28) of patients underwent a groin lymph node dissection, (1 sentinel node biopsy, 6 unilateral and 13 bilateral). Lymph node dissection was not performed on 8 patients, (- 3 patients with significant co-morbidities and one patient with an invasive depth of <2mm). 10 patients (36%) underwent radiotherapy, of which 9 were for adjuvant treatment.

Figure 1: Patients with vulval carcinoma presenting Symptoms
Figure 2: 5 Year Survival of patients with vulval carcinoma depending on stage of disease

Figure 3: 5 Year Survival of patients with vulval carcinoma depending on lymph node status

Figure 4: 5 Year Survival of patients with vulval carcinoma depending on lymph node status

Discussion
Vulval carcinoma is a rare disease, but appears to be on the increase. In Ireland, there were 42 cases of Vulval carcinoma and 14 deaths in 1999. Our study has shown that our management of patients with vulval carcinoma is in line with European standards. The 5-year survival rate of 61% is comparable to published audits, which suggest survival rates of 55 - 69% at five years. We attribute our success in part, to the multidisciplinary nature of our management. We hold weekly case meetings with the pathology, radiotherapy and oncology services in order to plan management. The multidisciplinary specialist nurses are involved from the diagnosis to long-term follow up, so that optimum management is individualized for each patient.

It is suggested that the majority of those with local recurrence should be suitable for local excision. In our study, eight out of nine patients with local recurrence were suitable for local resection. Of these, seven patients are still alive today.

As discussed, local recurrence is amenable to treatment. Therefore, we must endeavour to identify local recurrence early. To achieve this, our patients receive summaries of their clinic, as recommended by the EOCOG. However, as part of the multidisciplinary care our patients also receive regular home contact by telephone (about once every three months) from the oncology specialist nurse, to educate and help identify early symptoms of disease recurrence. Recurrence tends to be heralded by symptoms. Therefore, identifying these cases may be best achieved by patient education. We feel that this role could be extended into the community, by active recruitment of the family doctor to educate his/her elderly patient to recognize the early signs and symptoms.
As regards prognosis, it is obvious that nodal metastases, at time of presentation, are an important prognostic factor. In our cohort, positive lymph nodes did indeed reduce survival at five years from 79% to 17%.

Routine lymph node dissection remains a controversial management issue. Rhodes suggested that lack of lymph node dissection was an independent risk factor in itself. Lymph node dissection was carried out in 71% of our population. In our study, the 5-year survival statistics for those who underwent a lymph node dissection was 60%, compared to 63% of those who did not undergo a lymph node dissection (although the latter included those with non-squamous histological types).

Age at diagnosis has been verified as a poor prognostic indicator. The overall 5-year survival in this study was reduced from 69% to 50% in those aged over 70 years. Of note, the mean age was 67 for our cohort, which may have adversely influenced the overall survival statistics.

Advanced stage was also confirmed as a poor prognostic factor in our population, as 5 year survival for those with Stage 1 disease was 67%, Stage 2 disease was 64%, Stage 3 disease was 40% compared to 5% for those with Stage 4 disease.

Rhodes also suggested that undergoing treatment at hospitals dealing with a small caseload was a poor prognostic factor. This has been refuted by our study. Our population was admittedly small (34 patients 1992-2002), however we feel that our standards of practice remain comparable to international standards, considering our population.

Conclusion
We feel that the favourable outcomes for survival after a diagnosis of vulval carcinoma reflect the care of a multidisciplinary team, particularly regarding recurrence. We combine clinical examinations, with regular home contact by telephone by the oncology specialist nurses. This helps to identify those with early recurrence and has improved overall patient care. We feel that we should endeavour to educate the community of the symptomatology of this disease so that patients can be diagnosed with early stage disease. Similarly those with recurrence could be identified earlier whilst the disease is amenable to local treatment.

We conclude that age greater than 70, the stage of disease, and the lymph node status were important prognostic survival factors.

References

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