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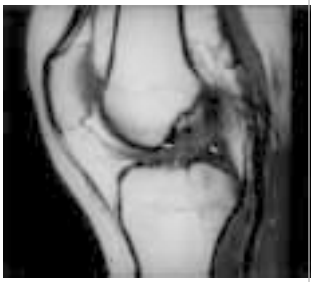

Cover Picture:
Sagittal T1-weighted (TR/TE 540/12) MR image shows complete rupture of the anterior cruciate ligament with a haemorrhagic mass (arrows).
(Refer to page 332-336)

Editorial

Vulvar Cancer – (r)evolution in Management

A Ilancheran

Vulvar cancer is rare in Singapore. This issue has the first reported series of vulvar cancer in Singapore. It is timely to remind ourselves of the (r)evolution that has occurred in the treatment of this disease[1]. There is no other gynaecological cancer that has undergone so much change in management as vulvar cancer. The change mirrors what happened in the surgical management of breast cancer. Following the Halsteadian principle and the pioneering work of Taussig[2] and Way[3] in the 40s and 50s, en bloc radical vulvectomy and bilateral dissection of the groin and pelvic nodes became the standard treatment for operable vulvar cancer. The disfigurement produced by the surgery and its long-term morbidity were disregarded in the face of a remarkable improvement in the cure rates that were attained.

However, over the last three decades, several factors have led to the modifications to the "standard" approach. These may be summarised as follows:

1. A better understanding of the lymphatic pathways from the vulva to the groins and the pelvis[4]. It was clearly demonstrated that in the vast majority of patients, the lymph flowed in a systematic manner from the vulva to the superficial groin nodes, then to the deep groin nodes and then to the pelvic nodes. Tumour metastases followed this route and skipping of the nodes was very rare. It was also shown that the lymphatics from either half of the vulva communicated mainly in the midline. Other studies showed that the disease usually spread by embolism from the primary lesion to the draining lymph nodes with little or no opportunity for metastatic sites to develop along the pathway (the intervening "skin bridge")[5].
2. The finding that local radical excision with a good margin was as equally effective as radical vulvectomy in terms of local recurrence rates[6]. With increasing number of younger women developing vulvar cancer, this was a very important factor in preventing the severe psychosexual consequences associated with radical vulvectomy which involved the removal of the clitoris.
3. Chemoradiation for squamous cell carcinoma of the vulva was very effective[7]. Initially studied in head and neck cancers, chemoradiation was so successful in reducing the size of tumours, that a less radical and disfiguring dissection could be performed. When applied to the vulva, tumours which previously required very radical procedures like posterior exenteration because of involvement of the anal canal by the vulvar tumor, could now be treated much less radically often requiring only a vulvectomy after chemoradiation.

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4. The concern about the post-operative morbidity and the associated long term hospitalisation common with the *en bloc* dissection.

The current approach to vulvar cancer involves individualisation and conservation. Individualised treatment implies varied approach based on the primary lesion and the regional nodes. Some very early lesions may require only a wide excision for cure, whereas extensive lesions may require more than radical vulvectomy, for example chemoradiation prior to surgery. With regards to the regional nodes, in some cases no therapy may be warranted, but in others it may involve, ipsilateral or bilateral groin node dissection with or without radiation therapy to the pelvic nodes. Conservation of the clitoris in non-central lesions, especially in the younger women is very important to avoid serious psychosexual sequelae; similarly, conservation of the non-involved skin of the vulva and thigh by the "triple incision" technique has considerably reduced wound breakdown and prolonged hospitalisation and their associated morbidity. SMJ

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