### NCCN Guidelines Version 1.2016 Sub-Committees

#### Vulvar Cancer (Squamous Cell Carcinoma)

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<tr>
<th>Principles of Surgery</th>
<th>Principles of Radiation</th>
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<tr>
<td>Amanda Nickles Fader, MD Ω/Lead</td>
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<td>David Mutch, MD Ω</td>
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**SQUAMOUS CELL CARCINOMA**

**WORKUP**

- H&P
- CBC
- Biopsy, pathologic review
- LFT/renal function studies
- Imaging (CT/PET/MRI) as needed for delineating extent of tumor or for treatment planning
- EUA cystoscopy or proctoscopy as indicated
- Smoking cessation and counseling intervention if indicated (See NCCN Guidelines for Smoking Cessation)

**CLINICAL STAGE**

- Early Stage: T1, Smaller T2
  - See Primary Treatment (VULVA-2)

- Locally advanced: Larger T2, T3 (non-visceral–sparing primary surgery)
  - See Primary Treatment (VULVA-5)

- Metastatic disease beyond pelvis: Any T, Any N, M1 beyond pelvis
  - See Primary Treatment (VULVA-7)

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aHistologic high-grade squamous intraepithelial lesion (HSIL; formerly defined as carcinoma in situ [CIS] and incorporates vulvar intraepithelial neoplasia 2 and 3 [VIN2/3]) can be treated with wide local excision.

bCT and MRI performed with contrast throughout the guidelines unless contraindicated. Contrast not required for screening chest CT.

cSmaller T2 tumors: ≤4 cm, without involvement of the urethra, vagina, or anus.
**NCCN Guidelines Version 1.2016**

**Vulvar Cancer (Squamous Cell Carcinoma)**

### CLINICAL STAGE

<table>
<thead>
<tr>
<th>PATHOLOGIC FINDINGS</th>
<th>PRIMARY TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤1 mm invasion</td>
<td>Wide local resection&lt;sup&gt;d,e&lt;/sup&gt;</td>
</tr>
<tr>
<td>&gt;1 mm invasion</td>
<td>Radical local resection or modified radical vulvectomy and ipsilateral groin node evaluation&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

#### Early Stage:
- **T1**, Smaller T2<sup>c</sup> → Biopsy
  - Lateral lesion (≥2 cm from vulvar midline)
  - Vulvar midline lesion (anterior or posterior)

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<sup>c</sup>Smaller T2 tumors: ≤4 cm, without involvement of the urethra, vagina, or anus.
<sup>d</sup>See Principles of Surgery (VULVA-A).
<sup>e</sup>If wide local resection pathology reveals tumor in aggregate of ≥1 mm invasion, then additional surgery may be warranted.
<sup>f</sup>Groin node dissection is required on side(s) where sentinel nodes are not detected.
<sup>g</sup>See Principles of Vulvar Surgery: Tumor Margin Status (VULVA-A 1 of 4).
Vulvar Cancer (Squamous Cell Carcinoma)

PRIMARY TUMOR RISK FACTORS

- Negative margins

- Positive margin(s) for invasive disease

- Unresectable

ADJUVANT THERAPY TO THE PRIMARY SITE

- Observe or
  Adjuvant RT\textsuperscript{l} based on other risk factors\textsuperscript{j}

- Re-excision\textsuperscript{d}

- Negative margins for invasive disease

- Positive margins for invasive disease

- Adjuvant RT\textsuperscript{i}

\textsuperscript{d} See Principles of Surgery (VULVA-A).

\textsuperscript{h} The management of positive margins for HSIL (non-invasive disease) should be individualized.

\textsuperscript{i} See Principles of Radiation Therapy (VULVA-B).

\textsuperscript{j} Other primary risk factors include: lymphovascular invasion, negative but close tumor margins (<8 mm), tumor size, depth of invasion, pattern of invasion (spray or diffuse). Nodal involvement (as an indicator of lymphovascular space invasion) may also impact selection of adjuvant therapy to the primary site.
Vulvar Cancer (Squamous Cell Carcinoma)

ADJUVANT THERAPY TO THE NODES

NODAL EVALUATION

<table>
<thead>
<tr>
<th>LN-negative (sentinel node(s) or inguinofemoral nodes)</th>
<th>Observe</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SLN(s) positive(^k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT(^i) ± concurrent chemotherapy(^l) (category 1 for radiation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inguinofemoral node dissection with positive LN(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT(^i) ± concurrent chemotherapy(^l) (especially if ≥2 LNs positive or 1 LN positive with &gt;2 mm metastasis) (category 1 for radiation)</td>
</tr>
</tbody>
</table>

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\(^i\)See Principles of Radiation Therapy (VULVA-B).


\(^l\)See Systemic Therapy (VULVA-C).

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**CLINICAL STAGE**

Locally advanced:
- Larger T2\textsuperscript{m}, T3 (non-visceral sparing primary surgery)
- Radiologic imaging workup if not previously done

**PRIMARY TREATMENT**

- Clinically/radiographically negative nodes
  - Inguinal/femoral LN dissection\textsuperscript{d}
    - Positive LNs
      - RT\textsuperscript{I} + concurrent chemotherapy\textsuperscript{I} to primary tumor/groins/pelvis
    - Negative LNs
      - RT\textsuperscript{I} + concurrent chemotherapy\textsuperscript{I} to primary tumor (± selective groin LN coverage)

- Clinically/radiographically positive nodes (includes pelvic-confined M1, lymph node [LN] disease)
  - Inguinal/femoral LN dissection not performed
    - Consider fine-needle aspiration (FNA) for enlarged LN
      - RT\textsuperscript{I} + concurrent chemotherapy\textsuperscript{I} to primary tumor/groins/pelvis

\textsuperscript{d}See Principles of Surgery (VULVA-A).
\textsuperscript{I}See Principles of Radiation Therapy (VULVA-B).
\textsuperscript{C}See Systemic Therapy (VULVA-C).
\textsuperscript{m}Larger T2 tumors: >4 cm or with involvement of the urethra, vagina, or anus.

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EVALUATION OF RESPONSE

Clinically negative for residual tumor at primary site and nodes

Consider biopsy of tumor bed to confirm pathologically complete response (PCR)

Biopsy negative

Biopsy positive

Clinically positive for residual tumor at primary site and/or nodes

Consider biopsy of tumor bed to confirm pathologically complete response (PCR)

Biopsy negative

Biopsy positive

Resect<sup>d</sup>

Unresectable

Negative margins

Positive margins

Unresectable

Consider additional, individualized RT<sup>i</sup> and/or Chemotherapy<sup>i</sup> or Best supportive care

<sup>d</sup>See Principles of Surgery (VULVA-A).
<sup>i</sup>See Principles of Radiation Therapy (VULVA-B).
<sup>i</sup>See Systemic Therapy (VULVA-C).

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<table>
<thead>
<tr>
<th>CLINICAL STAGE</th>
<th>PRIMARY TREATMENT</th>
</tr>
</thead>
</table>
| Metastatic disease beyond pelvis:  
  • Any T, Any N, M1 beyond pelvis | RT\(^1\) for locoregional control/symptom palliation and/or Chemotherapy\(^1\) or Best supportive care ([See NCCN Guidelines for Palliative Care](https://www.nccn.orgprofessionals/physician-gls/pdf/palliative.pdf)) |

\(^1\)See *Principles of Radiation Therapy (VULVA-B)*.

\(^2\)See *Systemic Therapy (VULVA-C)*.

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SURVEILLANCE

- Interval H&P
every 3–6 mo for 2 y,
every 6–12 mo for 3–5 y,
then annually based on patient’s risk of disease recurrence
- Cervical/vaginal cytology screening as indicated for the detection of lower genital tract neoplasia
- Imaging (chest radiography, CT, PET, PET/CT, MRI) as indicated based on symptoms or examination findings suspicious for recurrence
- Laboratory assessment (CBC, blood urea nitrogen [BUN], creatinine) as indicated based on symptoms or examination findings suspicious for recurrence
- Patient education regarding symptoms of potential recurrence and vulvar dystrophy, periodic self examinations, lifestyle, obesity, exercise, smoking cessation, and nutrition counseling
- Patient education regarding sexual health, vaginal dilator use, and vaginal lubricants/moisturizers (eg, estrogen creams)

WORKUP

- Clinically suspect recurrence
- Metastatic workup with imaging
- Consider biopsy to confirm distant metastasis

Therapy for recurrence clinically limited to the vulva
(See VULVA-9)

Therapy for clinical nodal or distant recurrence
(See VULVA-10)

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Regular cytology can be considered for detection of lower genital tract dysplasia, although its value in detection of recurrent genital tract cancer is limited. The likelihood of picking up asymptomatic recurrences by cytology alone is low.

**Vulvar Cancer (Squamous Cell Carcinoma)**

#### SITE OF RECURRENCE

<table>
<thead>
<tr>
<th>SITE OF RECURRENCE</th>
<th>THERAPY FOR RECURRENCE</th>
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<tbody>
<tr>
<td>Clinically vulva-confined recurrence (nodes clinically negative), not previously irradiated⁹</td>
<td>Radical excision⁴,⁹ and unilateral or bilateral inguinofemoral LN dissection (if not done prior)⁸</td>
</tr>
<tr>
<td>Clinical vulva-confined recurrence (nodes clinically negative), previously irradiated</td>
<td>Radical excision⁴,⁹ and unilateral or bilateral inguinofemoral LN dissection (if not done prior)⁸</td>
</tr>
<tr>
<td>Margins negative; LN(s) surgically or clinically negative</td>
<td>Observe</td>
</tr>
<tr>
<td>Margins positive; LN(s) surgically or clinically negative</td>
<td>Re-excision⁴ or RT¹ ± concurrent chemotherapy¹ (category 2B for concurrent chemotherapy)</td>
</tr>
<tr>
<td>Margins negative; LN(s) surgically positive</td>
<td>RT¹ ± concurrent chemotherapy¹</td>
</tr>
<tr>
<td>Margins positive; LN(s) surgically positive</td>
<td>RT¹ ± concurrent chemotherapy¹ ± re-excision⁴,⁹</td>
</tr>
</tbody>
</table>

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⁹See Principles of Surgery (VULVA-A).
⁸See Principles of Radiation Therapy (VULVA-B).
⁴See Systemic Therapy (VULVA-C).
⁹For patients who previously received chemoradiation, see Additional Treatment (VULVA-6).
⁸Consider pelvic exenteration for large central recurrence.

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VULVA-10

SITE OF RECURRENCE

THERAPY FOR RECURRENCE

Clinical nodal or distant recurrence

- Multiple pelvic nodes or Distant metastasis or Prior pelvic RT
- Isolated pelvic nodal recurrence and no prior pelvic RT

No prior RT

- Groin
  - Fixed positive node(s) or large recurrence
    - RT\textsuperscript{i} + concurrent chemotherapy\textsuperscript{l}
    - Surveillance (See VULVA-8)
  - Prior RT
    - Systemic chemotherapy\textsuperscript{l}
    - or Palliative/Best supportive care (See NCCN Guidelines for Palliative Care)
    - or Clinical trial

Prior RT

- Resection of positive LN(s)\textsuperscript{d} ± inguinofemoral LN dissection
  - RT\textsuperscript{i} ± concurrent chemotherapy\textsuperscript{l}
  - Surveillance (See VULVA-8)

\textsuperscript{d}See Principles of Surgery (VULVA-A).
\textsuperscript{i}See Principles of Radiation Therapy (VULVA-B).
\textsuperscript{l}See Systemic Therapy (VULVA-C).
\textsuperscript{q}Consider pelvic exenteration for large central recurrence.

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PRINCIPLES OF VULVAR SURGERY: TUMOR MARGIN STATUS

• Studies suggest a high overall incidence of local recurrence in vulvar carcinoma. Tumor margin of resection has been postulated as a significant prognostic factor for recurrence in squamous cell carcinoma of the vulva.

• Efforts should be made to obtain adequate surgical margins (1–2 cm) at primary surgery.

• In the setting of a close or positive surgical tumor margin (<8 mm from tumor), re-resection may be considered to obtain more adequate margins. Adjuvant local radiation therapy is another alternative. The risk-benefit ratio and morbidity of these approaches must be considered and individualized in each patient.

• Close or positive margins that involve the urethra, anus, or vagina may not be resectable without incurring significant potential morbidity and adverse impact on patient quality of life.

• Other factors including nodal status should be considered in the decision whether to perform subsequent surgery. Re-resection of close or positive vulvar tumor margins may not be beneficial in patients with metastases to the inguinal nodes that require treatment with RT ± chemotherapy after surgery.

• Pathologists often have a challenging time assessing the presence and depth of invasion in vulvar SCC. The depth of stromal invasion is currently defined as the measurement of the tumor from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion. Alternative ways to measure the depth of invasion have recently been proposed.

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For margins that are free but close (>0 mm but <8 mm), evidence is lacking to support decreased recurrence and improved survival with re-resection of disease or adjuvant local radiation to the primary tumor site.
PRINCIPLES OF VULVAR SURGERY: SURGICAL STAGING

- Vulvar cancer is staged using the American Joint Commission on Cancer (AJCC) and the International Federation of Gynecology and Obstetrics (FIGO) staging systems (Table ST-1).
- Staging involves complete surgical resection of the primary vulvar tumor(s) with at least 1-cm margins and either a unilateral or bilateral inguinofemoral lymphadenectomy, or a SLN biopsy in select patients. Inguinofemoral lymphadenectomy removes the LNs superficial to the inguinal ligament, within the proximal femoral triangle, and deep to the cribriform fascia.
- LN status is the most important determinant of survival.
- Historically, en bloc resection of the vulvar tumor and complete bilateral inguinofemoral lymphadenectomy (resection of superficial inguinal and deep femoral nodes) were performed, but this approach was associated with significant morbidity.
- The current standard involves resection of the vulvar tumor and LNs through separate incisions.
- The choice of vulvar tumor resection technique depends on the size and extent of the primary lesion and may include radical local excision and modified radical vulvectomy.
- The depth of the resection is similar for both radical local excision and radical vulvectomy (ie, to the urogenital diaphragm).
- There are no prospective trials comparing the resection techniques above. Retrospective data suggest there is no difference in recurrence outcome between radical local excision compared with radical vulvectomy.
- For a primary vulvar tumor that is <2 cm, located 2 cm or more from the vulvar midline and in the setting of clinically negative inguinofemoral LNs, a unilateral inguinofemoral lymphadenectomy or SLN biopsy is appropriate (See Principles of Surgery: Inguinofemoral Sentinel Lymph Node Biopsy VULVA-A 3 of 4).
- For a primary vulvar tumor located within 2 cm from or crossing the vulvar midline, a bilateral inguinofemoral lymphadenectomy or SLN biopsy is recommended.
- Some patients are not candidates for lymphadenectomy including those with Stage IA disease due to a <1% risk of lymphatic metastases.
- For patients with stage IB-II disease, inguinal lymphadenectomy is recommended due to a risk of >8% of lymphatic metastases.
- A negative unilateral lymphadenectomy is associated with <3% risk of contralateral metastases.
- In the setting of positive LN disease after unilateral lymphadenectomy, contralateral lymphadenectomy or radiation of the contralateral groin is recommended. Any nodes that are grossly enlarged or suspicious for metastases during the unilateral lymphadenectomy should be evaluated by frozen section pathology intraoperatively in order to tailor the extent and bilaterality of the LN dissection.
- Those with locally advanced disease may benefit from neoadjuvant radiation with concurrent platinum-based radiosensitizing chemotherapy. If a complete response is not achieved, surgical resection of the residual disease is recommended in patients with resectable disease who are appropriate surgical candidates.
- The management of bulky inguinofemoral LNs in the setting of an unresectable or T3 primary vulvar lesion is unclear. It is reasonable to consider either 1) primary cytoreductive surgery of the bulky LNs followed by platinum-based chemosensitizing radiation to the bilateral groins and primary vulvar tumor, or 2) Platinum-based chemosensitizing radiation to the bilateral groins and primary vulvar tumor alone.
PRINCIPLES OF VULVAR SURGERY: INGUINOFEMORAL SENTINEL LYMPH NODE PROCEDURE

- Unilateral or bilateral inguinal lymphadenectomy is associated with a high rate of postoperative morbidity; 20%–40% of patients are at risk for wound complications and 30%–70% of patients are at risk of lymphedema.\(^{14}\)
- Increasing evidence suggests that the use of SLN biopsy of the inguinofemoral LN basin is an alternative standard of care approach to lymphadenectomy in select women with squamous cell carcinoma of the vulva.\(^{15,16}\)
- SLN biopsy results in decreased postoperative morbidity without compromising detection of LN metastases.\(^{15,17}\)
- Prospective, cooperative group trials have evaluated the SLN technique and demonstrate feasibility, safety, validity, and a low risk of groin recurrences with this surgical approach in vulvar cancer.\(^{15,16}\)
- Candidates for SLN biopsy include patients with negative clinical groin examination and imaging, a primary unifocal vulvar tumor size of <4 centimeters, and no previous vulvar surgery that may have impacted lymphatic flow to the inguinal region.\(^{16,18}\)
- If SLN biopsy is considered, it ideally should be performed by a high-volume SLN surgeon, as high-volume surgeons exhibit improved SLN detection rates.\(^{16}\)
- Increased sensitivity of SLN detection is observed when both radiocolloid and dye are used.\(^{15,16,17}\) The radiocolloid most commonly injected into the vulvar tumors is technetium-99m sulfur colloid. It is most commonly injected 2–4 hours prior to the vulvectomy and lymphadenectomy procedure. A preoperative lymphoscintigraphy may be performed to aid in anatomically locating the sentinel node. The dye most commonly used is Isosulfan Blue 1%. Approximately 3–4 cc of dye is injected peri-tumorally using a four-point injection technique at 2, 5, 7, and 10 o’clock. The dye is injected intradermally in the operating room within 15–30 minutes of initiating the procedure.
- It is recommended that the SLN procedure is performed prior to the excision of the vulvar tumor, so as not to disrupt the lymphatic network between the primary vulvar tumor and the inguinal LN basin. Additionally, the injected blue dye will only transiently localize (ie, for 30–60 minutes) in the first group of nodes that correspond to the primary vulvar tumors.
- Use of a gamma probe to detect the injected radiocolloid within the inguinofemoral region is recommended prior to making the groin incision in order to tailor the location and size of the incision.
- A complete inguinofemoral lymphadenectomy is recommended if an ipsilateral SLN is not detected.
- The management of positive SLNs is currently being evaluated and may include performance of complete inguinofemoral lymphadenectomy and/or administration of adjuvant radiation to the affected groin(s).
- If ipsilateral SLN is positive, the contralateral groin should be evaluated surgically and/or treated with RT.
PRINCIPLES OF VULVAR SURGERY: REFERENCES


PRINCIPLES OF RADIATION

General Principles
- Tumor-directed RT refers to RT directed at sites of known or suspected tumor involvement. In general, tumor-directed external beam RT (EBRT) is directed to the vulva and/or inguinofemoral, external and internal iliac nodal regions. Brachytherapy can sometimes be used as a boost to anatomically amenable primary tumors. Careful attention should be taken to ensure adequate tumor coverage by combining clinical examination, imaging findings, and appropriate nodal volumes at risk to define the target volume.\textsuperscript{1,2}
- The target tissues should be treated once daily, 5 days per week. Breaks from treatment should be minimized. Adequate dosing is crucial and can be accomplished with either 3D conformal approaches or intensity-modulated radiation therapy (IMRT) as long as care is given to assure adequate dosing and coverage of tissues at risk for tumor involvement.\textsuperscript{1,3} Doses range from 50.4 Gy in 1.8 Gy fractions for adjuvant therapy to 59.4–64.8 Gy in 1.8 Gy fractions for unresectable disease. In select cases, large nodes may be boosted to a dose of approximately 70 Gy.
- Ensure coverage of gross tumor burden with margin. In highly selected cases where only a superficial vulvar target is to be treated, an enface electron beam may be used.

3D Conformal/Anterior-Posterior/Posterior-Anterior (AP/PA) Fields
- The target is best defined by both physical examination and CT-based treatment planning; contouring of the target structures is recommended. When an AP/PA technique is primarily used, often wide AP and narrower PA fields are used with electrons supplementing the dose to the inguinal region, if the depth of the inguinal nodes allow for electron coverage. More conformal techniques such as three- or four-field approaches may allow for greater sparing of bowel and/or bladder, depending on tumor extent and patient anatomy. CT or MRI planning, with possible image fusion technology, should be used to assure adequate dosing and coverage with contouring of the primary, and the inguinofemoral and iliac nodes. Radio-opaque markers should be placed on key landmarks at the time of simulation to assist in definition of the primary target volume.
- The superior field border should be no lower than the bottom of the sacroiliac joints or higher than the L4/L5 junction unless pelvic nodes are involved. If pelvic nodes are involved, the upper border can be raised to 5 cm above the most cephalad positive node. The superior border should extend as a horizontal line to cover the inguinofemoral nodes at the level of the anterior inferior iliac spine. The lateral border will be a vertical line drawn from the anterior-inferior iliac spine. To adequately cover the inguinal nodes the inferolateral inguinal nodal border is parallel to the inguinal crease and inferior enough to encompass the inguinofemoral nodal bed to the intertrochanteric line of the femur or 1.5–2 cm distal to the saphenofemoral junction. The inferior vulvar border will be lower and should be at least 2 cm below the most distal part of the vulva. Care should be taken to spare the femoral heads and necks.
- Bolus should be used to ensure adequate dosing to superficial target volume.
PRINCIPLES OF RADIATION

Intensity-Modulated Radiation Therapy (IMRT)

• The vulvar and nodal targets should be contoured on the planning CT. Any gross vulvar disease should be contoured as a gross tumor volume (GTV) and include any visible and/or palpable extension into the vagina. The vulvar clinical target volume (CTV) target is defined as the GTV or tumor bed plus the adjacent skin, mucosa, and subcutaneous tissue of the vulva excluding bony tissue. A wire placed clinically to define the vulvar skin borders and the GTV during CT simulation is essential. In addition, a marker on the anus, urethra, clitoris, and the wiring of any scars will aid in planning.

• To ensure adequate distal margin on the vulvar target volume, a “false structure” or bolus should be placed over the vulva for treatment planning purposes. Doses to the target areas should be confirmed using thermoluminescent dosimeter (TLD) at first treatment.

• The pelvic nodal CTV is the vasculature of the bilateral external iliac, obturator, and internal iliac nodal regions with a minimum of 7 mm of symmetrical expansion excluding bone and muscle.

• Symmetrical geometric expansions on the vessels should NOT be used for the inguinal nodes. The inguinal nodes CTV will extend laterally from the inguinal vessels to the medial border of the sartorius and rectus femoris muscles, posteriorly to the anterior vastus medialis muscle and medially to the pectineus muscle or for 2.5–3 cm medially from the vessels. Anteriorly the volume should extend to the anterior border of the sartorius muscle (the most anterior muscle on the lateral inguinal border). The caudal extent of the inguinal nodal basin is the top of the lesser trochanter of the femur.2

• The groin CTV volume will not extend outside the skin and should be trimmed by 3 mm in the absence of skin involvement (with skin involvement, the CTV should extend to the skin with bolus material applied during treatment). Planned treatment volume (PTV) expansion is then 7–10 mm.

• Consider use of image-guided radiation in select cases such as vulva edema or marked tumor regression.

• Planning should be taken with care to respect normal tissue tolerances such as rectum, bladder, small bowel, and femoral head and neck.4

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PRINCIPLES OF RADIATION
(REFERENCES)

### SYSTEMIC THERAPY

#### Chemoradiation
- Cisplatin
- 5-FU and cisplatin
- 5-FU and mitomycin-C

#### Chemotherapy for Advanced, Recurrent/Metastatic Disease
- Cisplatin
- Cisplatin/vinorelbine
- Cisplatin/paclitaxel

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# Vulvar Cancer (Squamous Cell Carcinoma)

## Staging

**Table 1 AICC Tumor-Node-Metastases (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging Systems for Carcinoma of the Vulva**

<table>
<thead>
<tr>
<th>Primary Tumor (T)</th>
<th>TNM Categories</th>
<th>FIGO Stages</th>
<th>Regional Lymph Nodes (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>TX</td>
<td></td>
<td>NX</td>
</tr>
<tr>
<td>T0</td>
<td>T0</td>
<td></td>
<td>N0</td>
</tr>
<tr>
<td>Tis*</td>
<td>Tis*</td>
<td></td>
<td>N1</td>
</tr>
<tr>
<td>T1a</td>
<td>T1a A</td>
<td></td>
<td>N1a IIIA</td>
</tr>
<tr>
<td>T1b</td>
<td>T1b IB</td>
<td></td>
<td>N1b IIIA</td>
</tr>
<tr>
<td>T2***</td>
<td>T2** II</td>
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<td>N2 IIIB</td>
</tr>
<tr>
<td>T3****</td>
<td>T3**** IVA</td>
<td></td>
<td>N2c IIIC</td>
</tr>
</tbody>
</table>

**Note:** FIGO no longer includes Stage 0 (Tis).

**Note:** The depth of invasion is defined as the measurement of the tumor from the epithelial–stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.

**FIGO uses the classification T2/T3. This is defined as T2 in TNM.**

**FIGO uses the classification T4. This is defined as T3 in TNM.**

### Distant Metastasis (M)

<table>
<thead>
<tr>
<th>TNM Categories</th>
<th>FIGO Stages</th>
<th>Stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td></td>
<td>No distant metastasis</td>
</tr>
<tr>
<td>M1</td>
<td>I VB</td>
<td>Distant metastasis (including pelvic lymph node metastasis)</td>
</tr>
</tbody>
</table>

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Discussion

NCCN Categories of Evidence and Consensus

**Category 1:** Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

**Category 2A:** Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

**Category 2B:** Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

**Category 3:** Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.