The article by Kim et al is a comprehensive summary of several decades of research in the management of cervical and vulvar cancer. It describes the current status of treatment and possible future trials.

**Surgical Staging**

For the management of cervical cancer, two issues need to be further addressed. The first is surgical staging of cervical cancer. For decades it has been known that nodal metastasis to the pelvic and para-aortic regions is common in cervical cancer including clinical stage I disease. Moreover, nodal metastasis is a well-documented indicator of poor prognosis, particularly in apparent early-localized disease. Identification of microscopic nodal disease may alter the treatment plan, especially if the para-aortic nodes are involved.

Despite the poor accuracy of currently available imaging modalities in detecting pelvic and para-aortic metastasis, cervical cancer continues to be clinically staged in most institutions in the United States. The use of clinical staging may be justified in the absence of technology to accurately determine disease status, particularly in developing nations with limited medical resources.

However, with the advent of minimally invasive surgical approaches, surgical staging of apparent local cervical cancer can be adequately performed through transperitoneal or extraperitoneal laparoscopic pelvic and bilateral para-aortic lymph node dissection with minimal morbidity and delay in treatment.

The laparoscopic approach has been used for the past decade by many national and international investigators with excellent lymph node yield, limited operative time, short hospital stay, and a very low overall complication rate.[1-4] Pathologic evaluation of retroperitoneal lymph nodes remains the gold standard for detecting metastasis.

Until accurate imaging techniques are commonly available, surgical staging should be offered to women with cervical cancer who have access to minimally invasive surgery and are at risk for para-aortic nodal metastasis as well as to those for whom identification of retroperitoneal nodal metastasis will modify the treatment plan. The results of randomized trials in cervical cancer are most informative when the protocol mandates pretreatment surgical staging.

**Compliance Issues**

The second issue of concern in the application of results from phase III chemoradiation trials is compliance with treatment, particularly in the indigent population. Indigent, uninsured, and minority women in the United States continue to share a large burden of cancer, and cervical cancer is among the most common gynecologic cancers in these patients.

The addition of chemotherapy to radiation substantially increases the complexity of treatment. Chemotherapy and radiation are commonly delivered in separate areas by independent services, so that problems in patient orientation, staff integration, and coordination of schedules are exacerbated. Indigent, minority women have difficulty complying with standard radiation protocols for cervical cancer, and different cultural models of cancers prevalent in indigent and minority communities may compound obstacles, including lack of transportation, child care, and time off from work.

Epidemiologists have distinguished between the efficacy of therapy, as demonstrated in the controlled and carefully prepared setting of clinical trials at academic centers, and the effectiveness of therapy, as delivered in ordinary conditions to unselected patients in disparate environments. Recently, reports on chemoradiation in this setting indicated that nearly one-third of the indigent women treated with chemoradiation for cervical cancer did not fully complete the prescribed treatment.[5] Although the efficacy of chemoradiation for cervical cancer has been demonstrated, its
effectiveness in the general population remains to be determined.

**Invasive Vulvar Cancer**

For the management of invasive vulvar cancer, treatment can be simply divided into two groups: operable lesions (T1/2), for which a radical local excision or partial vulvectomy plus inguinofemoral dissection is feasible vs extensive lesions (T3/4), for which ultraradical surgery such as exenteration plus vulvectomy and inguinofemoral lymphadenectomy may be required.

For operable lesions, surgery remains the gold standard, as modern surgical approaches provide excellent cure rates with short hospital stay, limited overall treatment time, limited vulvar alteration, and acceptable long-term side effects such as lymphedema and dyspareunia. In addition, this approach limits the use of multimodality therapy with radiation or chemoradiation to a small percentage of patients such as those with nodal metastasis or close/positive surgical margins for which additional resection is not feasible.

On the other hand, patients with more extensive lesions may require ultraradical surgical approaches and are better candidates for primary chemoradiation. This approach usually requires vulvar, pelvic, and bilateral inguinal radiotherapy with concomitant chemotherapy and possibly brachytherapy but spares the majority of patients from permanent intestinal or urinary diversion. The acute and long-term local vulvar toxicity may be severe and devastating in some patients, and hopefully, with the advent of improved chemotherapy and radioprotective agents, the dose of radiation may be limited and overall toxicity reduced.

As with cervical cancer, phase III trials in vulvar cancer should focus on the optimal chemoradiation schedule and the role of radioprotective agents.

**References:**


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