PIPADOR REVISION

MRCOG Part 1 Revision Notes

Vulval Cancer

CLINICAL MANAGEMENT • LECTURE 500

VISUAL EXAMINATION REVISION NOTES

2026 Edition

500

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Vulval Cancer

Presentation, FIGO 2021 staging and BGCS-based management of vulval cancer

SCC ≈ 90%	Punch biopsy	SLNB	Groin nodes
Histology	Not excision	Unifocal < 4 cm, N0	Main prognostic factor

■ KEY FACTS: Learning objectives

- Define vulval cancer and its precursors, and the FIGO 2021 staging.
- Describe presentation, diagnosis and staging investigations.
- Describe surgical and non-surgical management (BGCS) including groin node assessment, adjuvant therapy, complications and follow-up.

500.1 Key definitions

Term	Definition
Vulval cancer	Malignancy of the vulva — ≈ 90% squamous cell carcinoma (HPV-associated or HPV-independent)
Depth of invasion	Distance from the epithelial–stromal junction of the nearest dermal papilla to the deepest point of invasion — ≤ 1 mm = minimal nodal risk
Radical wide local excision	Excision of the tumour with a clear margin down to the deep perineal fascia
Sentinel lymph node biopsy (SLNB)	Identification and removal of the first draining groin node(s) using radioisotope ± blue dye/ICG
Inguinofemoral lymphadenectomy (IFL)	Removal of superficial and deep groin nodes — high morbidity

■ IN PLAIN ENGLISH: Vulval cancer

Vulval cancer usually affects older women, often with long-standing **lichen sclerosus**, and spreads first to the **groin nodes**. Any persistent vulval lump, ulcer or itch not responding to treatment needs a **biopsy**.

500.2 Presentation and diagnosis

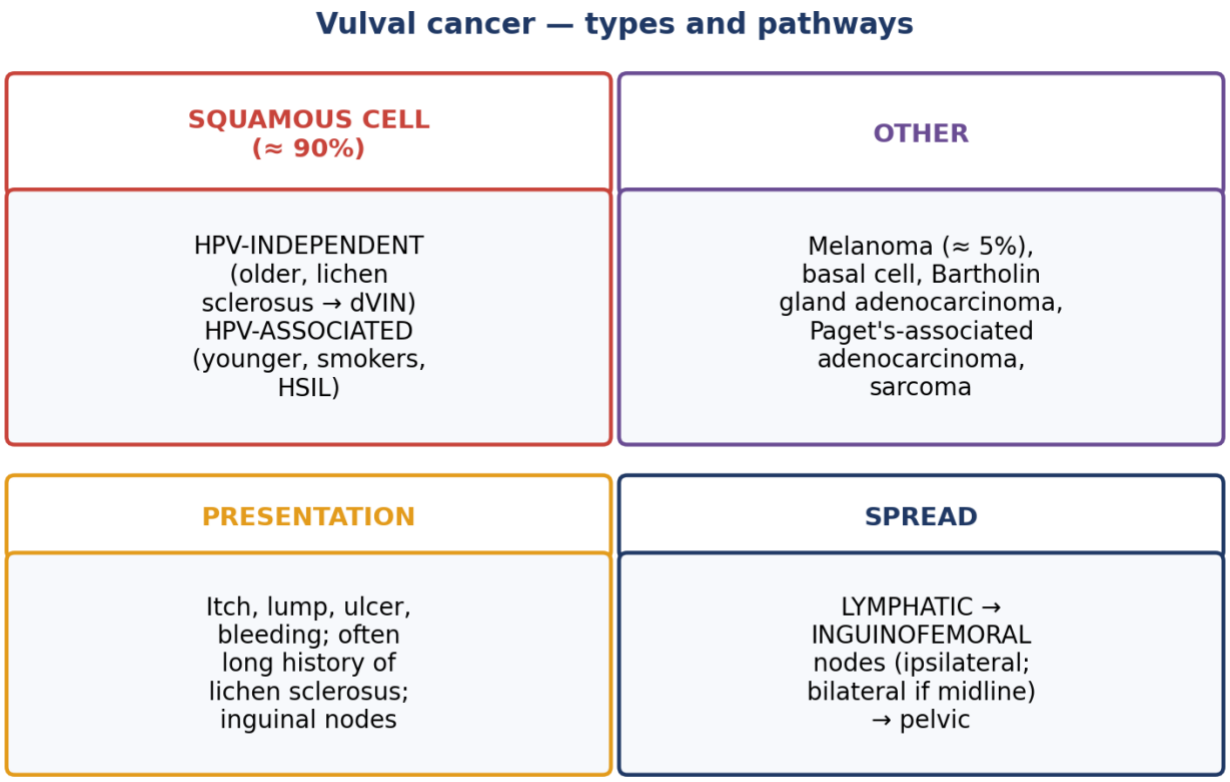


Figure 500.1 — Types and pathways

- Symptoms: itch, soreness, lump, ulcer, bleeding/discharge; groin mass; often delayed presentation.
- **Punch biopsy** of the lesion (do not excise — the whole lesion is needed for planning)
  - Refer via 2-week-wait pathway (NICE NG12: unexplained vulval lump, ulceration or bleeding).
- Staging: examination (± EUA, cystoscopy, proctoscopy), groin USS ± FNA, CT/MRI of pelvis and groins; CT chest if advanced.

500.3 Staging

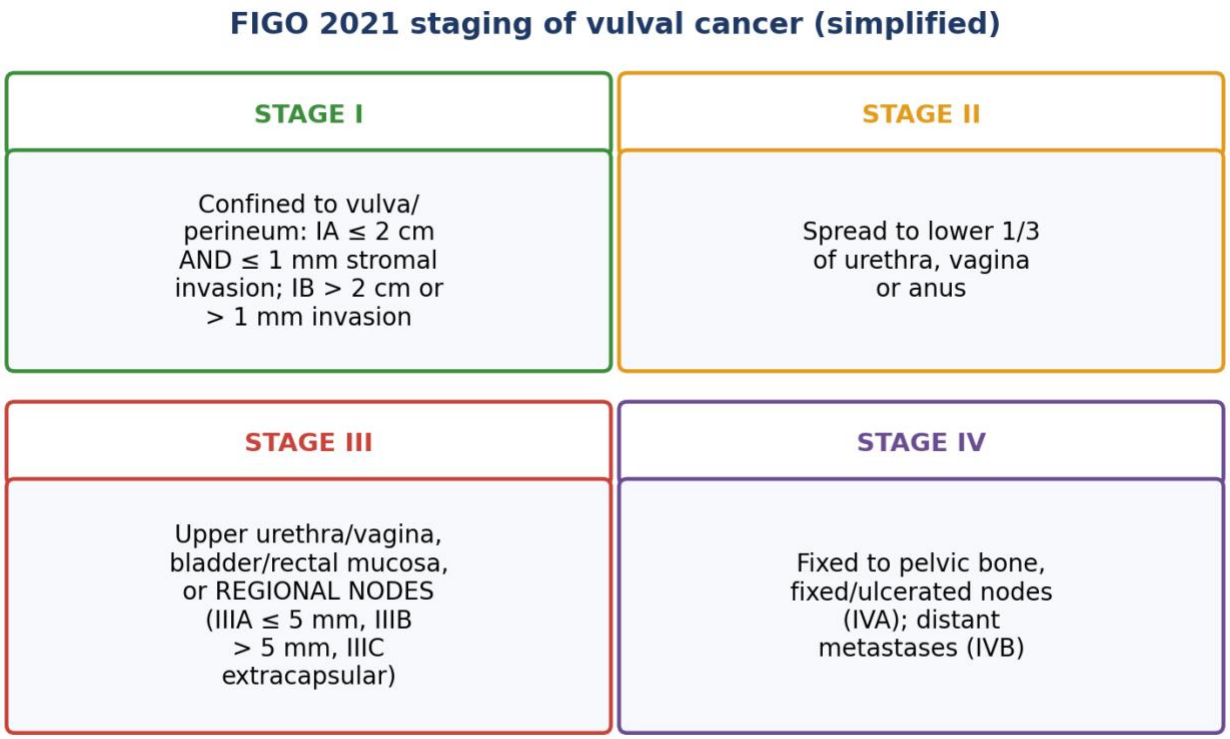


Figure 500.2 — FIGO 2021 staging (simplified)

500.4 Management (BGCS)

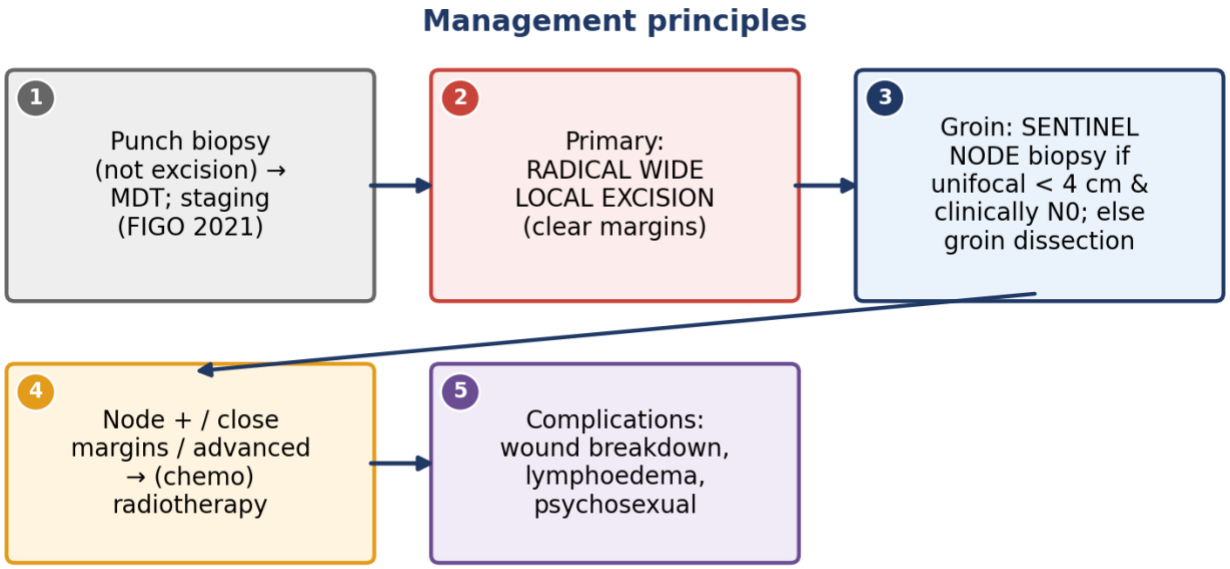


Figure 500.3 — Management principles

Situation	Management
Stage IA (≤ 2 cm, ≤ 1 mm invasion)	Wide local excision; groin assessment not required
Stage IB–II, unifocal < 4 cm, clinically/radiologically negative groins	• Radical wide local excision + SENTINEL lymph node biopsy (ipsilateral if lateral; bilateral if within 1 cm of midline) • IFL if SLN positive or not detected

Situation	Management
Larger/multifocal or suspicious nodes	Radical excision + inguinofemoral lymphadenectomy (separate incisions)
Margins	• Aim for a clear pathological margin • Re-excision or radiotherapy if margins close/involved
Adjuvant radiotherapy	• Positive nodes (≥ 2 involved, or any extracapsular spread/macrometastasis), close margins • Often chemoradiation
Locally advanced (stage III–IV)	Primary chemoradiation (cisplatin) ± surgery; exenteration in selected
Recurrence/metastatic	Surgery, radiotherapy, chemotherapy; palliative care
Other histology	Melanoma (WLE, SLNB, immunotherapy), Bartholin gland carcinoma, basal cell carcinoma (local excision)

500.5 Complications and follow-up

- Surgical: wound breakdown (≈ 30–50% after groin surgery), infection, lymphocyst
  - **Lymphoedema** of the legs
  - Sexual dysfunction
  - Altered body image
  - Urinary stream changes.
- Follow-up: regular examination (local recurrence common), surveillance and treatment of lichen sclerosus/VIN
  - Psychosexual support
  - Lymphoedema services.
- Prognosis: 5-year survival ≈ 80–90% node-negative vs ≈ 40–50% node-positive.

■ COMMON PITFALLS

Treating persistent vulval lesions without biopsy.

Excision biopsy instead of punch biopsy.

SLNB in multifocal tumours or > 4 cm.

500.6 Must-know summary

■ EXAM TIP

- SCC ≈ 90%; HPV-independent (older, lichen sclerosus/dVIN) vs HPV-associated (younger, HSIL).
- Punch biopsy → MDT; FIGO 2021: IA ≤ 2 cm & ≤ 1 mm; nodes = stage III.
- IA: WLE only; IB+ unifocal < 4 cm N0: radical WLE + SLNB; otherwise IFL; adjuvant (chemo)radiotherapy for positive nodes/margins.
- Complications: wound breakdown, lymphoedema; groin node status is the main prognostic factor.

■ MNEMONIC / MEMORY AID

Vulval cancer groins — 'Under 1 mm, no groin; under 4 cm, sentinel; otherwise, full groin'.