Unilateral inguinofemoral lymphadenectomy in patients with early-stage vulvar squamous cell carcinoma and a unilateral metastatic sentinel lymph node is safe


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1. Introduction

Treatment of patients with unifocal early-stage vulvar squamous cell carcinoma (VSCC), smaller than 4 cm, comprises wide local excision of the primary tumor and a sentinel node (SN) procedure. When the SN contains metastatic disease a uni- or bilateral inguinofemoral lymphadenectomy (IFL) or inguinofemoral radiotherapy is performed. The Goningen International Study on Sentinel Nodes in Vulvar cancer (GROINSS-V) and Gynecological Oncology Group (GOG) studies have demonstrated that it is safe to omit IFL with a negative SN [1,2]. The use of SN biopsy has significantly reduced treatment-related morbidity in patients with early-stage vulvar cancer [1,3,4]. The European Society of Gynecological Oncology (ESGO) guidelines recommend the SN procedure in patients with unifocal VSCC <4 cm without suspicious groin nodes at imaging [5]. In case of a unilateral metastatic SN, additional treatment of the ipsilateral groin with the metastatic SN is recommended. There is little evidence, however, to guide the correct management of the contralateral groin in this situation [5]. Following publication of the GROINSS-V II study, patients with SN-metastases ≥2 mm can now be offered inguinofemoral radiotherapy instead of IFL [6].

The lymphatic drainage of the vulva is well documented. Most of the lymph drainage of the labia flows to the ipsilateral inguinofemoral lymph nodes. The median part of the vulva with midline structures e.g., the clitoris, shows bilateral lymph drainage [7]. The majority of patients with a lateralized tumor (defined as tumors with medial border >1 cm from the midline) show ipsilateral drainage on lymphoscintigraphy. For these patients ipsilateral SN biopsy is sufficient if no contralateral drainage is visualized on the lymphoscintigram. For near-midline tumors (medial border of the tumor within 1 cm of the midline, but not involving the midline), there is no consensus whether only ipsilateral SN biopsy is sufficient. In the majority bilateral lymph drainage is detected. For most true midline tumors (tumors involving the midline), bilateral drainage is detected on the lymphoscintigram, and in those cases, bilateral SN biopsy should be performed. Where bilateral drainage is not identified for true midline tumors it is not safe to omit contralateral IFL, due to an increased risk of contralateral lymph node metastases, (4/32 patients (12.5%) in Coleman et al. (2013)) [8]. In those cases there is indication for contralateral IFL.

The primary aim of this study was to investigate whether limiting treatment to the ipsilateral groin is safe in patients with early-stage VSCC and a unilateral metastatic SN. The GROINSS-V studies are the largest available prospective studies on the SN-procedure in vulvar cancer and provide a robust dataset for further study. As such, an in-depth analysis of these studies should provide important evidence to guide management following unilateral SN metastasis and specifically, the management of the contralateral groin.

2. Methods

We used data from two large prospective multicenter studies in early-stage vulvar cancer: GROINSS-V I and II. GROINSS-V I investigated the safety of omitting IFL in patients with a negative SN. This study included 377 patients from 2000 to 2006 with unifocal VSCC <4 cm and no suspicious groin nodes at palpation [1]. Patients with a metastatic SN underwent uni- or bilateral IFL; IFL was omitted in patients with a negative SN. Follow-up of the included patients was updated in 2016 [6]. GROINSS-V II investigated the safety of inguinofemoral radiotherapy (50 Gy) as alternative to IFL in in patients with a metastatic SN. This study was conducted from 2005 to 2016 and also included patients with unifocal VSCC <4 cm without suspicious nodes at imaging. In total 1535 eligible patients were included. Five years after the first inclusion, the protocol of GROINSS-V II was amended because the isolated groin recurrence rate in patients with a metastatic SN who were treated with inguinofemoral radiotherapy went above the predefined threshold. Interim analysis showed that especially patients with SN-metastases >2 mm and/or extranodal tumor spread were at risk. From then on
patients with SN-macrometastases (>2 mm) underwent standard of care (IFL) while patients with SN-micrometastases (≦2 mm) continued to receive inguinofemoral radiotherapy [6]. Follow-up in both studies was performed until at least two years after primary treatment, since most groin recurrences occur within two years of primary treatment.

The SN-procedure in both studies was performed as previously described. The combination of a radioactive tracer (99mTc-labeled nano colloid) with performance of a lymphoscintigram, and blue dye was used. A lymphoscintigram was performed to determine number and localization of the SNs. The SNs were identified by ultrastaging (one section/500 μm; one for HE, one for cytokeratin AE1/AE3-immunohistochemistry, and one spare section). Each SN with tumor cells was regarded as metastatic, regardless of size of the metastasis (including isolated tumor cells).

In the present study we categorized the patients into three groups according to the localization of the primary tumor. The tumor was classified as lateralized if the distance from the midline was >10 mm, near-midline if the distance from the midline was >0 mm and ≤10 mm, and true midline if the midline was involved. In case of missing data, we used the case record file (CRF), which included a drawing of the tumor on the vulva, to determine the position of the tumor. We analyzed lymph drainage patterns for lateralized, near-midline and true midline tumors in the group of patients for whom tumor localization was known. We analyzed the incidence of contralateral non-SN metastases in patients with a unilateral metastatic SN who underwent bilateral IFL. In order to evaluate the incidence of contralateral metastases in patients who did not undergo IFL of the contralateral groin, we determined the incidence of contralateral isolated groin recurrences during follow-up.

We also analyzed the risk of contralateral groin recurrence in the whole group of patients with a near-midline tumor who underwent only ipsilateral SN biopsy.

2.1. Statistical analysis

Analysis was performed using IBM SPSS statistics software version 23. The tests were two sided and P-values below 0.05 were considered significant. Confidence intervals were calculated with the Wilson method. To determine the significance of differences in patient characteristics between subgroups (based on tumor location), we used Chi-Square for nominal variables with expected values above five, Fisher’s exact for nominal variables including expected values below five, and One Way ANOVA for scale variables.

3. Results

We analyzed 1912 patients (mean ± SD age, 65.2 ± 14.2 years) with early-stage VSCC from GROINSS-V I and II. Fourteen patients had an unknown tumor location and were therefore excluded from further analyses. Of the remaining 1898 patients, 723 (38.1%) had a lateralized tumor, 530 (27.9%) had a near-midline tumor and 645 (34.0%) had a

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Patient characteristics.</th>
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<tbody>
<tr>
<td>Women with early-stage vulvar cancer (n = 1898)</td>
<td>Total (n = 1898)</td>
</tr>
<tr>
<td>Mean age (SD)</td>
<td>65.2 years (14.3)</td>
</tr>
<tr>
<td>Mean tumor size (SD)</td>
<td>19.91 mm (10.46)</td>
</tr>
<tr>
<td>Mean invasion depth (SD)</td>
<td>4.00 mm (4.80)</td>
</tr>
<tr>
<td>Lymph drainage pattern</td>
<td>1409 (74.4%)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Table 2</th>
<th>Groin treatment and outcomes in contralateral groin for patients with unilateral metastatic SN.</th>
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</thead>
<tbody>
<tr>
<td>Women with unilateral metastatic SN (n = 366)</td>
<td>Total (n = 366)</td>
</tr>
<tr>
<td>Groin treatment</td>
<td></td>
</tr>
<tr>
<td>Only SN biopsy</td>
<td></td>
</tr>
<tr>
<td>- Contralateral groin recurrences</td>
<td>24 (6.6%)</td>
</tr>
<tr>
<td>- Unilateral IFL</td>
<td>70 (19.1%)</td>
</tr>
<tr>
<td>- Bilateral IFL</td>
<td>105 (28.7%)</td>
</tr>
<tr>
<td>Status of SN</td>
<td>1457 (76.8%)</td>
</tr>
<tr>
<td>- Bilateral</td>
<td>1099 (57.9%)</td>
</tr>
<tr>
<td>- Unknown</td>
<td>54 (2.8%)</td>
</tr>
<tr>
<td>- Other</td>
<td>20 (1.1%)</td>
</tr>
<tr>
<td>- Missing</td>
<td>3 (0.2%)</td>
</tr>
<tr>
<td>SN biopsy</td>
<td>760 (40.0%)</td>
</tr>
<tr>
<td>- Bilateral SN biopsy</td>
<td>1137 (59.0%)</td>
</tr>
<tr>
<td>- Unknown</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>Status of SN</td>
<td>1457 (76.8%)</td>
</tr>
</tbody>
</table>
true midline tumor. Table 1 summarizes the patient characteristics, lymph drainage patterns and SN biopsy results. The mean tumor size was 19.5 mm (SD = 10.4) and the mean depth of invasion was 3.5 mm (SD = 4.2). Lymph drainage patterns were significantly different for lateralized, near-midline and true midline tumors (p ≤ 0.001). Detection of bilateral metastatic SNs was significantly higher in true midline tumors compared to near-midline and lateralized tumors (p < 0.001) (Table 1).

Metastatic SNs were found in 441 (23.2%) of 1898 patients, of whom 366 (83.0%) had a unilateral metastatic SN and 75 (17.0%) had bilateral metastatic SNs. Of the 366 patients with a unilateral metastatic SN, 175 (49.5%) underwent IFL (70 (40.0%) unilateral IFL and 105 (60.0%) bilateral IFL). Inguinofemoral radiotherapy (instead of IFL, by protocol of the GROINSS-V II study or by physicians' preference in GROINSS-V I) was administered to 167 (45.6%) patients (45 (26.9%) unilateral and 122 (73.1%) bilateral). In 24
(6.6%) patients with a unilateral metastatic SN no additional groin treatment was performed (Table 2).

Of the 105 patients with unilateral SN metastasis who underwent bilateral IFL, five (5/105; 4.8% [95% CI: 2.1%–10.7%]) had a contralateral non-SN metastasis (Table 2). Notably, four of these patients had a primary tumor ≥30 mm and two had a depth of invasion ≥10 mm. In three patients bilateral IFL was performed, and a metastatic non-SN was found in the contralateral groin where previously the SN was found to be negative (false-negative SN). In two patients a bilateral IFL was performed, and a metastatic node was found in the contralateral groin where no SN was identified (false-negative SN). In total, 139 patients with a unilateral metastatic SN and no contralateral groin treatment (unilateral IFL or inguinofemoral radiotherapy, or no further treatment) were available for analysis. Two of these patients (2/139; 1.4% [95% CI: 0.4%–5.1%]) developed a contralateral isolated groin recurrence (time to recurrence 10.0 and 7.6 months) (Table 3). Both of these patients had a lateralized tumor with bilateral flow on the lymphoscintigram, underwent bilateral SN procedure and were treated with unilateral IFL because of unilateral SN-metastasis. Both had a groin recurrence in the SN-negative groin (false-negative SN). One patient had a tumor ≥30 mm. No significant differences in frequency of groin recurrences were found between lateralized, near-midline and midline tumors ($p = 0.477$).

Of the 122 patients with a unilateral metastatic SN who underwent bilateral radiotherapy, one patient (1/122; 0.8% [95% CI: 0.1%–4.5%]) had a contralateral groin recurrence (after a negative SN in that groin, time to recurrence 6.6 months) (Table 3).

In total, seven patients (7/244; 2.9% [95% CI: 1.4%–5.8%]) with a successful SN biopsy and a unilateral metastatic SN had a contralateral non-SN metastasis at bilateral IFL, or contralateral groin recurrence when no treatment was given to the contralateral groin (Table 2). Of these patients, three had a lateralized tumor, three had a near-midline tumor and one had a true midline tumor.

When considering the effect of tumor size, contralateral groin recurrence or non-SN metastasis in patients with tumors ≥30 mm and a unilateral metastatic SN was 3.6% (5/140 [95% CI: 1.5%–8.1%]) compared to 1.4% (3/222 [95% CI: 0.5%–3.9%]) for tumors <30 mm (tumor size missing in 4 patients) ($p=0.11$).

With respect to tumor location, the risk of isolated contralateral groin recurrence or contralateral non-SN metastases amongst patients with a unilateral metastatic SN, was 2.2% (3/138 [95% CI: 0.7%–6.2%]) for those with a lateralized tumor, 2.7% (3/112 [95% CI: 0.9%–7.6%]) for those with a near-midline tumor, and 1.7% (2/116 [95% CI: 0.5%–6.1%]) for those with a true midline tumor (Fig. 1a–c).

For patients with near-midline tumors, it is matter of debate whether only ipsilateral drainage on the lymphoscintigram is sufficient. In this series, 157 patients had a near-midline tumor and underwent only unilateral SN biopsy. Of them, one (0.6% [95% CI: 0.1%–3.5%]) had a contralateral non-SN metastasis in the groin where no SN was identified. No patients had contralateral groin recurrences.

4. Discussion

In all 244 patients with early-stage vulvar cancer with one or more unilateral metastatic SNs treated with uni- or bilateral IFL, unilateral...
radiotherapy or no further treatment, seven patients (2.9%) with contralateral non-SN metastases or groin recurrences were observed. A risk of 2.9% is comparable to the risk of groin recurrence in patients with negative SNs at SN biopsy (2.7% in GROINSS-V II, \( p = 0.78 \)) [1]. The risk seems higher in patients with vulvar tumors ≥30 mm although this did not reach significance, and tumor location on the vulva (lateralized / near-midline / true midline) had no influence. In patients with unilateral metastatic SN subsequently treated with radiotherapy to both groins, the risk of contralateral groin recurrences was 0.8% [95% CI: 0.1%-4.5%]. This lower incidence reflects active treatment of the ‘negative groin’ and highlights that recurrence may still occur after treatment, in this case with radiotherapy.

Our percentages of contralateral non-SN metastases and contralateral groin recurrences are comparable to previously published results from by Woelber et al. (2016), Nica et al. (2019), and Ignatov et al. (2021), who observed 0.0% (0/28), 5.3% (1/19) and 0.0% (0/62) contralateral non-SN metastases respectively [9–11]. In contrast to this low incidence of contralateral metastasis, Winarno et al. (2021) reported four patients (22.2%; 4/18) with contralateral non-SN metastases in whom bilateral lymphadenectomy for a unilateral metastatic SN was performed [12]. All contralateral metastases were found in patients with midline tumors (defined as within 1 cm of the midline).

The strengths of our study are its prospective nature and the large number of patients. With 366 patients with unilateral SN-metastasis, our study is the largest thus far addressing the safety of omitting bilateral groin treatment in patients with a unilateral metastatic SN. Taking our results into consideration together with results from other published studies, we consider performing unilateral IFL or inguino-femoral radiotherapy alone in patients with a unilateral metastatic SN and a successful SN biopsy safe. We advise caution in patients with larger tumors, as the majority of the contralateral lymph node metastases and groin recurrences were diagnosed in patients with primary tumors ≥30 mm. On the basis of our findings, we propose a treatment guideline for patients with a unilateral metastatic SN (Fig. 2).

Lymph drainage patterns were significantly different for lateralized, near-midline and true midline tumors. Iversen et al. demonstrated that midline structures have bilateral drainage [7]. Coleman et al. (2013) showed bilateral drainage in 73/105 (70%) of midline tumors, and in 14/64 (22%) of lateralized tumors. In the lateral ambiguous group (defined in this study as within 2 cm from the midline but not involving the midline) 38/65 (58%) had bilateral drainage [8]. These findings are very similar to our results. Also, Deken et al. documented bilateral drainage in 25% of the patients with a lateralized tumor (defined as not crossing the midline) [13]. In our analysis of patients with near-midline vulvar tumors, only one patient (0.6% [95% CI: 0.1%-3.5%]) had a contralateral non-SN metastasis identified at bilateral IFL after a initial unilateral SN biopsy. Of all patients with near-midline tumors who underwent unilateral SN-procedure, no recurrences occurred in the groins where no SN was identified. Therefore, we conclude ipsilateral drainage is an acceptable finding for near-midline tumors. Furthermore, where the SN is positive in the ipsilateral groin, limiting further treatment to the ipsilateral groin appears safe, with a low risk of contralateral groin recurrence. It is important to appreciate that the results of the lymphoscintigram and the SN procedure are influenced by the exact site of injection of the radio-labeled tracer by the gynecological oncologist. This is subject to inherent bias because it is likely that surgeons will inject this at locations
that guarantee bilateral SN identification when dealing with a near-midline tumor. This arises from knowledge of lymphatic drainage patterns in the vulva and the fear of missing contralateral metastasis. We propose therefore, that contralateral IFL is only indicated in cases of unilateral lymph flow on the LSG when dealing with true midline tumors, and is not indicated when the tumor is near-midline. For true midline tumors, bilateral lymphatic drainage should be seen. We did not see contralateral recurrence in a small proportion of patients where treatment was limited to one groin on the basis of unilateral drainage with a metastatic SN (n = 9). However, we would still regard unilateral drainage on LSG for a true midline tumor to represent method failure. IFL for the groin in which no SNL was identified is recommended.

5. Conclusion

The rate of contralateral non-SN metastases/groin recurrences in patients with unilateral SN-invovement who underwent a successful SN biopsy is low (2.9%), with a relatively narrow confidence interval [95% CI: 1.4%-5.8%]. Accordingly, we consider unilateral groin treatment to be either IFL or inguinofemoral radiotherapy safe. For lateralized and near-midline tumors this means unilateral groin treatment can be performed when at least an ipsilateral SN is detected. For true midline tumors this means unilateral groin treatment can be performed, on the assumption that the contralateral groin was staged adequately (by a negative SN, or negative IFL). Tumor location had no influence on occurrence of contralateral additional non-SN metastases and contralateral groin recurrences. Overall, these results offer further opportunity to safely reduce the morbidity associated with treatment for early-stage vulvar cancer.

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References

