denectomy in Stage I endometrial carcinoma from August 1987 to December 1991 are seen.

The results show that only in progressive and deep cancer invasion of the myometrium a higher rate of 30% nodal invovement could be found. But even in this unfavourable group — usually we remove 25-40 lymph nodes by the procedure — the majority of 70% of the patients has histologically free pelvic nodes and needs no pelvic wall irradiation.

3) The third advantage may be a therapeutic benefit. This therapeutic benefit is, at present, not yet scientifically proven. At present, only the influence of sampling procedures can be assessed in the literature. And not unexpectedly these sampling procedures have not been found to improve survival rates. Studies with thorough lymphadenectomy have to be undertaken.

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SURGICAL STRATEGIES IN VULVAR CANCER

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As is well known, a precise knowledge of the stage and of the tumour aggressiveness factors is the fundamental basis for adequate therapy and prognosis.

In vulvar cancer, both FIGO and TNM staging are reliable enough, because these tumuors are localized in superficial tissues, yet precise knowledge of tumour stage is possible only with surgical and pathological examination.

Surgical-Pathological examination permits exact knowledge of local tumour spread, lymph nodal involvement, aggressiveness factors, possible neoplastic multicentricity, in the aim of reaching adequate therapy and prognosis.

In our case series, Surgery was performed in 93.6% of cases, and consequently in almost all cases a correct Surgical Pathological Staging (SPS) was possible. The surgery rate has not changed during the different decades of our research.

Unfortunately, surgical-pathological radicality was reached in only 87% of operated patients because of the high incidence of advanced stages and the cases of older women.

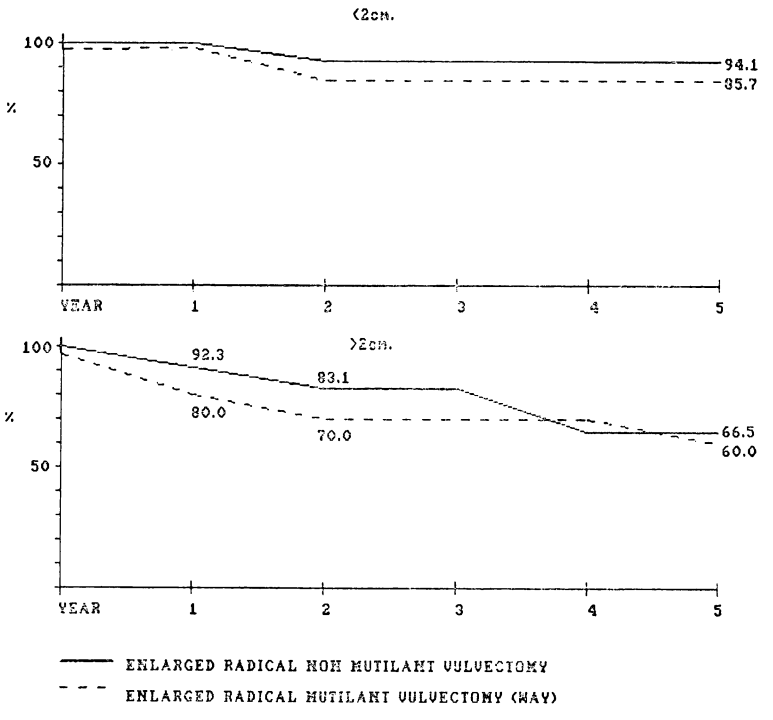
In the case series of our Institute, throughout 30 years, we have performed different types of surgery that in our opinion may be judged adequate or inadequate. The increasing incidence of vulvar cancer in young women has obliged us to reduce the cost of the therapy in order to improve the quality of life, without endagering survival.

We believe in the philosophy of radical non-mutilant surgery, also developed in breast cancer and we think it is advisable for vulvar cancer.

Since 1975 we have been performing personal radical enlarged non-mutilant vulvectomy techniques, progressively developed in two different types on the basis of tumoral sites ([1, 2, 3, 4]).

The results encouraged us because the 5-year survival rate appeared unchanged while the quality of life greatly improved in cases treated with our radical non-mutilant vulvectomy, compared with the cases treated by classical enlarged radical vulvectomy. Undoubtedly, the surgical techniques of enlarged radical non-mutilant vulvectomy are

Table 1. — *Vulvar cancer. 5 years survival in cancer limited to the vulva/N-(SPS A; postsurgical Figo I-II) according to tumour size and type of enlarged radical operation.*



more engaging, requiring absolute accuracy and delicacy in maneuvers of dissection, in order to obtain sufficiently wide margins of safety in healthy surrounding tissue, preserving the skin for adequate plastic reconstruction.

There are immediate advantages through a better post-operative period and more rapid healing.

Dehiscence of the sutures, which in the past had a significant incidence, may today be avoided by respecting adequately the subcutaneous tissue following a common plastic surgical practice. The patient's mobilisation is almost immediate. The long term advantages are given by the practically complete aesthetic conservation, so much to that, in some cases, the vulva presents a near-normal appearance.

Further advantages are the low incidence of anatomo-functional complications; the possibility of a normal sexual life and the positive psychological aspect are stimulating for the patient, compared with the disadvantages of the grave mutilations consequent upon classical enlarged radical vulvectomy. In every case bilateral systemic inguinal lymphadenectomy must be performed, and frozen biopsies are useful as a guide to eventual pelvic lymphadenectomy, or to the removal of the fascia cribrosa, or to the extension of the dissection locally.

Surgical strategy must be adequate for tumour stage, the age and performance of the patients and, in advanced stages, Way radical vulvectomy or personalized operations may be justified, integrated with polychemotherapy even in neoadjuvant strategy. Relapses, almost always central (at the border of the vagina and/or urethra), have been

treated by personalized re-operations, integrated with polychemotherapy. In our case series, the 5 year survival of relapsed cases is 56.2% (18/32). The incidence of relapses was nearly the same in patients treated by radical Way vulvectomy or by radical non-mutilant vulvectomy, though a trend has emerged towards a major incidence of relapses in cases of tumours more than 2 cm treated with radical non-mutilant vulvectomy.

The problem of central relapses (which cannot be resolved by enlarging the peripheric skin demolition) impose a more accurate central tissue demolition, such as in the vaginal wall (lower third) and/or urethra (lower third) in correlation with the tumour site.

Our radical non-mutilant vulvectomy must be improved in this critical area. Actually, we are developing some technical modifications, in order to obtain a greater central radicality and a deeper extension in the ablation of the vaginal wall, at the same time avoiding functional damage to sexual life, particularly in younger women. To this end, skin or mucosal grafting are used in particular cases.

In conclusion, Surgery is the management of choice in vulvar cancer and must be adequate to the stage of the tumour, the age and performance of the patients. We must avoid under- or overtreatment, both dangerous. As in breast cancer, non-mutilant surgery is important in respect to the quality of life. This is the aim we shall follow, improving the technique of our non-mutilant radical vulvectomy.

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