THE VALUE OF PELVIC LYMPHADENECTOMY IN ENDOMETRIAL CANCER

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The traditional surgical therapy in endometrial cancer Stage I consists of hysterectomy, bilateral salpingo-oophorectomy. This traditional treatment aims at the removal of the primary tumor, but fails in diagnosing and treating the metastatic disease. However, the problem for the survival of the patients is not the removal of the primary tumor, but the metastases. We call it the lymph node problem. The status of the lymph nodes should be assessed by a reliable technique and it should be emphasized that sampling procedures of the pelvic and/or paraaortic nodes are not as reliable as through lymphadenectomy. That is important for the present discussion with other authors preferring the sampling technique. But normal sized or non-palpable nodes may contain small or microscopic lymph node metastases and palpable node enlargement may be due only to reactive lymphoid hyperplasia. It is reported that 37% of node metastases have been found (1) to be smaller than 2 mm in diameter. Most of the reports in the literature regarding rates of lymph node metastases found by sampling can be considered only preliminary informations to the biologic behavior and natural history of endometrial cancer.

In our opinion pelvic lymphadenectomy is recommended in all medically fit endometrial cancer patients with Stage I-IV. There are three main advantages of this procedure (Fig. 1).

1) Diagnostic: Exact staging with assessment of lymph node involvement.
2) Individualisation of adjuvant therapy: Selection of patients for postoperative external beam irradiation or hormonal therapy.
3) Therapeutic benefit: Removal of metastases.

Fig. 1. — The three major advantages of lymphadenectomy in endometrial cancer.

Myometrial involvement	No.	Nodal involvement
1/3	54	7% (4)
2/3	13	8% (1)
3/3	33	30% (10)
	100	

Fig. 2. — Pelvic lymphadenectomy in endometrial cancer.
Between 8/87 and 12/91 164 patients with endometrial cancer have been operated, 100 of them with pelvic lymphadenectomy.

1) The histological nodal status allows reliable diagnosis and staging, with assessment of lymph node involvement. It is important for the individual prognosis of the patient.

2) The individualization of the adjuvant therapy is the second major advantage of this additional surgical procedure. Without pelvic lymphadenectomy and the histological nodal status patients are selected for post-operative external beam irradiation or hormonal therapy by the post-surgically histological staging and grading. For example, in the German Tumor Board post-operative irradiation is recommended in patients with more than one third myometrial infiltration and/or G2-G3 tumors. But by this policy the majority of patients receive unnecessary adjuvant therapy because of negative nodes, for we see no indication for post-operative irradiation of the pelvic fields in patients with negative lymph nodes. In figure 2 (Fig. 2) the results of pelvic lympha-

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