

ADGIN India E newsletter

The quarterly newsletter of Asia Oceania research organization on Genital Infections and Neoplasia- India
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From the Editor's desk

Dear friends,

Greetings

Hope this E-newsletter finds you in good health and high spirits. This issue includes New NCCN guidelines for management of Vulvar cancer by me; journal scan by AIIMS, Rishikesh team.; Skill page on LEEP by KGMU Lucknow team and information about ADGIN grants. Enjoy reading .This is your newsletter. Please share and contribute more actively.



Best wishes

Nisha Singh, Lucknow

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New NCCN Management Guidelines- for Vulvar cancer

Nisha Singh, Lucknow

Adapted from NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines)

Vulvar Cancer (Squamous cell Carcinoma), Version 1.2016, NCCN.org

Workup- History & Examination, CBC, Biopsy and histopathology, LFT, RFT, Imaging (CT,PET, MRI as required), EUA Cystoscopy or proctoscopy as needed, Counseling for smoking cessation if necessary.

Primary Treatment

1. Early stage- T1/Smaller T2c (tumor <4cm, not involving urethra, vagina or anus)

<1mm invasion---local wide excision----< 1mm invasion----Observe

>1mm invasion---**Lateral disease** (≥2cm from midline)---Modified radical vulvectomy (Radical local excision) with ipsilateral sentinel node or groin node dissection--

>1mm invasion---**Midline disease**- Modified radical vulvectomy (Radical local excision) with bilateral sentinel node or groin node dissection

Tumor margin – Negative--- Observe; Invasive disease—re excision ---negative—observe; Positive excised margin or Unresectable ---Adjuvant RT to primary site. Other indications for primary site RT- LVSI, Lymph nodes invasion, Close tumor margin (<8mm), depth of invasion

Nodal evaluation- Negative—Observe; Positive---RT with Concurrent CT

2. Locally advanced- Larger T2 (>4cm or involvement of urethra, vagina or anus), T3

Clinical or radiological nodal enlargement--- **Absent**---RT to tumor, groin and pelvis with concurrent CT **OR** IF groin dissection---LN negative- Local RT with concurrent CT; LN positive- RT to tumor, groin and pelvis with concurrent CT.

Clinical or radiological nodal enlargement --**Present**—FNAC of enlarged nodes---RT to tumor, groin and pelvis with concurrent CT

Evaluate response- Clinical disease Absent—Biopsy tumor bed-- Pathological disease absent—Surveillance.

Clinical disease present—resect if possible—margins negative—Surveillance; margins positive **OR** Unresectable---- Additional individualized RT/CT/Supportive care

3. Metastatic disease beyond pelvis (any T, any M, Metastasis beyond pelvis)

Palliative RT and/or CT Or Best Supportive Care

Surveillance- Every 3-6months for 2 years ; 6-12months for 3-5years and annually thereafter.

History, Clinical examination & cervico vaginal cytology as indicated.

Hematological, radiological and pathological evaluation if recurrence is suspected.

Journal Scan Amrita Gaurav, Anupama Bahadur, Jaya Chaturvedi. AIIMS Rishikesh**Sentinel Nodes In Vulvar Cancer: Long Term Follow Up of The Groningen International Study****On Sentinel Nodes In Vulvar Cancer (GROINSS-V) I**

N.C te Grootenhuis, A.G.J. van der Zee, H.Cvan Doorn et.al Gynecologic Oncology, Vol 140, Issue 1, January 2016, Pg 8-14

OBJECTIVES

In 2008 the largest validation trial on sentinel node (SN) procedure in cases of vulvar cancer conducted was GRONISS-V-I. They showed that application of the SN procedure is safe in patients of early stage vulvar cancer. The present study performed long term follow up of early stage vulvar cancer patients and evaluated the survival and recurrence rates.

METHODS

GRONISS-V-I included 377 patients (from 2000 to 2006) with unifocal squamous cell carcinoma of the vulva (T1 < 4 cm), depth of invasion > 1 mm, and no palpable, clinically suspected or proven pathologically inguinofemoral metastases. Multifocal disease patients were excluded from the study. These patients underwent radical excision of the primary tumour and the SN procedure. No further treatment was given to patients with negative SN on pathologic assessment and inguinofemoral lymphadenectomy was performed in cases of positive SN metastasis. The follow up of this study continued till March 2015.

RESULTS

The mean follow up period for this study was 105 months (ranging from 0-179 months). After receiving the primary treatment the overall local recurrence rate was 27.2% at 5 years and 39.5% at 10 years. The recurrence rate was 24.6 % and 36.4% for SN negative patients and 33.2 % and 46.4% for SN positive patients respectively (p=0.03). 39 out of 253 patients who were SN negative had to undergo an inguinofemoral lymphadenectomy because of a local recurrence. After a period of 5 years isolated groin recurrence was found in 2.5% of SN negative and 8 % of SN positive patients. Disease specific 10 year survival rate was 91% for SN negative patients whereas 69% for SN positive patients (p < 0.0001). Patients with a local recurrence had 10 year disease specific survival of 69% whereas it was 90 % for patients without local recurrence.

CONCLUSION

Recurrence is found in 36 % of patients with negative SN and 46 % of the patients with positive SN. This greatly reduces the disease specific survival rate of these patients significantly. This study also emphasizes the scientific importance of long term follow up in patients treated of vulvar cancer as these patients remain at high risk for recurrence even after 10 years of receiving primary treatment.

Loop electrosurgical excision procedure (LEEP)**Shivani Kothiyal, Nisha Singh, KGMU,**

Indications- Type 2 or 3 Transformation zone; Unsatisfactory colposcopy, CIN 2 or 3, cytology and histology discrepancy, Recurrent CIN

PRINCIPLE- The heat from a high-voltage electrical arc between the operating electrode and tissue allows cutting by vaporizing tissue (at 100 °C) or to coagulate by dehydrating tissue (above 100°C). The cutting electrodes are loops of very fine (0.2 mm) stainless steel or tungsten wire. Electrosurgical cutting settings lead to some coagulation by blending electrical currents, one with a cutting waveform and another with a coagulation waveform. This combination is called a blended cutting waveform.

Prerequisites

Informed and written consent. Pelvic inflammatory disease (PID), cervicitis, vaginitis anogenital ulcer or bleeding disorder excluded. At least 3 weeks postpartum, Hypertension controlled

Procedure**(See Pictures on Page 5)**

Local anesthesia is achieved in 30 seconds with 5ml of 1% xylocaine. Reduce the amount of bleeding by mixing vasopressin . The injections are given in a ring pattern 1-2 mm deep (at 3, 6, 9 and 12 o'clock positions) at the periphery of the lesion and transformation zone using a 25- to 27-gauge needle. The application of Lugol's iodine solution helps to outline lesion margins. An insulated vaginal speculum with an electrically insulating coating or a speculum covered with a latex condom should be used to avoid an electrical shock to the woman in the event that the activated electrode inadvertently touches the speculum. The aim of the LEEP procedure is to remove the lesions and the transformation zone in their entirety and send the affected tissue for histopathological examination.

The power setting used depends on the size of the tissue electrode being used for cutting and whether fulguration is being performed. The commonly used power settings for the different loop electrodes are as follows - 1.0 x 1.0 cm 30 watts ; 1.5 x 0.5 cm 35 watts ; 2.0 x 0.8 cm 40 watts ; 2.0 x 1.2 cm 50 watts.

Follow up Advice

Antibiotics for seven days.

Counseling for Brown or black discharge for a few days to two weeks

Report back if the discharge persists for more than 2 weeks or becomes malodorous; lower abdominal pain or profuse bleeding develops. Not to use a vaginal douche or tampons, or to have sexual intercourse for one month.

Routine follow up after 9-12 months. Biopsy of any persistent lesions

Complications

Severe perioperative bleeding (<2%), usually 4-6 days after treatment and often from the posterior lip of cervix. Can be controlled by fulguration, using a silver nitrate applicator stick. Rarely, placement of a suture at the bleeding site is necessary

Post-operative pain relieved by oral analgesics,

LEEP Instruments

Insulated speculum with suction tubing



Variety of Loops electrodes

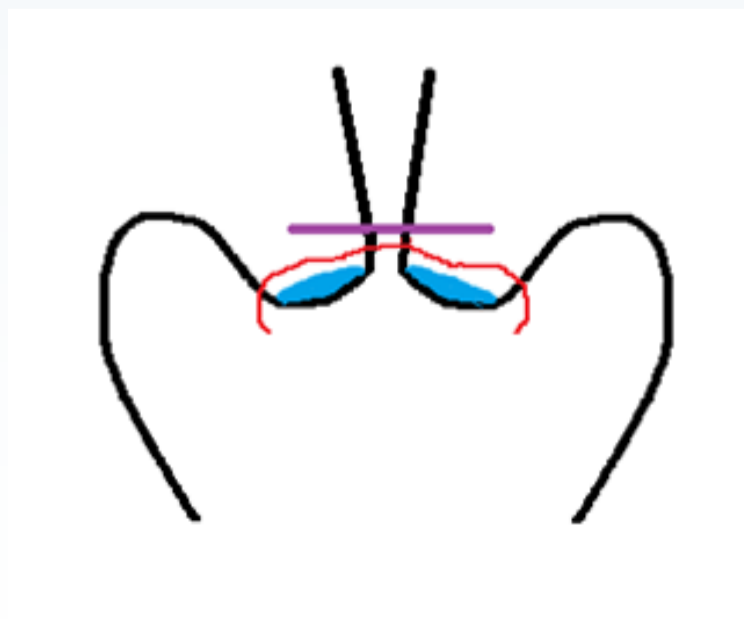


LEEP procedure



TYPES OF EXCISION

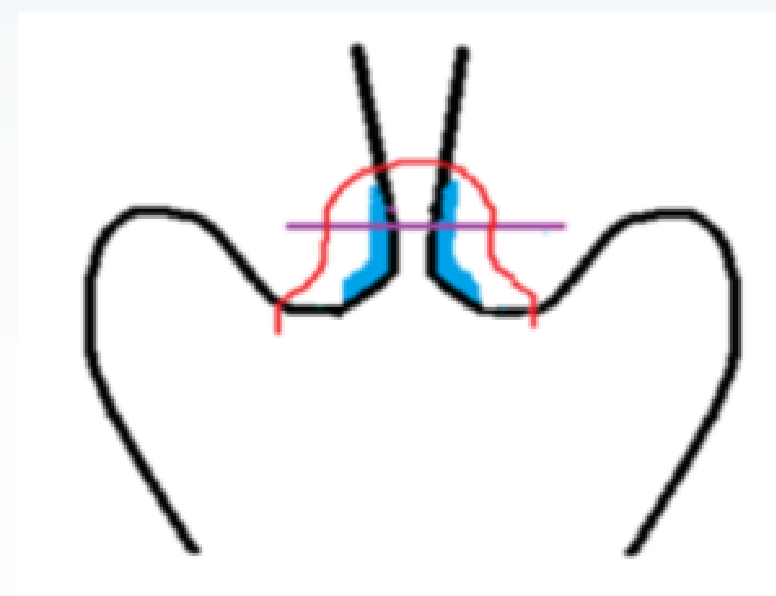
TYPE I



TYPE II



TYPE III





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Vision Statement

AOGIN India's vision is to reduce the burden of diseases caused by reproductive tract infections, especially Human Papillomavirus (HPV), in India. Furthermore, AOGIN India's **mission** is to work with governments, non-governmental organizations, learned societies, health care workers and the lay public, to communicate, cooperate and share information in India and neighboring countries pertaining to prevention, early detection and management of cervical cancer and other genital cancers.

AOGIN India GRANTS

AOGIN India announces 5 travel fellowships for AOGIN conference to be held in Singapore on 14-16th August 2016.

Interested members may please send abstract and full text of the paper (2500 words) by 30th April 2016 on info@aoginindia.org.

The covering letter should be marked to president AOGIN India with appropriate enclosures including letter from head of department, abstract and full text.

Forthcoming Conference

11th annual Conference of
ISCCP 2016
JODHPUR
2nd -3rd April 2016

Forthcoming Conference

7th Annual Conference of
AOGIN India 2016
PATNA
14-16th October 2016

Forthcoming Conference

AOGIN 2016
SINGAPORE
12-14th August 2016