Letter to the Editor

Comment on: Does the number of nodes removed impact survival in vulvar cancer patients with node-negative disease? Madeleine Courtney-Brooks, Paniti Sukumvanich, Sushil Beriwal, Kristin K. Zorn, Scott D. Richard, Thomas C. Krivak. Gynecological Oncology 117 (2010) 308–311

We read the study of Courtney-Brooks et al. with great interest. They concluded that removal of greater than 10 lymph nodes was associated with a significant improvement in DSS in patients with stage III node-negative vulvar carcinoma. The extent of the removal of lymph nodes in vulvar cancer remains controversial, and many countries have conflicting guidelines. The strength of the study of Courtney-Brooks et al. is that they include more than 1000 patients. However, some issues need clarification:

1. The authors identified patients with clinical stage I, II, and III vulvar squamous cell carcinoma from the SEER database that contains 26% of the annual registered 3580 new vulvar cancer patients in the United States. Inclusion of patients remains unclear: who are selected from the database? According to the information given, 15-year SEER registration will enclose approximately 14,000 patients. In the article, it is stated that 1030 patients were eligible for analysis, and subsequently, that 971 of 1135 patient with stage III disease were excluded. So what is the original group size? Who are included or excluded, and for what reason? It remains unclear what staging system is used by the authors; vulvar cancer is surgically staged, by the FIGO (1994?), TNM, or SJCC classification systems (the FIGO system changed significantly for vulvar cancer in 2009). In all 3 classifications, stage III cancer implies that either lymph nodes are positive or the primary tumor spreads to the lower urethra, the vagina, or the anus. In the study, 971 of the 1135 stage III patients were ineligible because they were lymph-node-positive or because data about the number of removed lymph nodes were lacking. Data of only 164 patients (14% of the total group) were available for analyses, suggesting that the included patients were in stage III because of their local tumor spread, in the absence of lymph node metastases. This is a major deficiency in the study and needs more clarification: what was the percentage of node-positive patients in stage III, and what was the percentage of missing data? What is the percentage of positive lymph nodes and missing data in the group with stage I and II disease?

2. In the publication, the authors only speak about patients and not about groins: midline vulvar cancer needs treatment of both groins. It is completely unclear for the readers of the study in how many patients midline tumor was present and bilateral groin dissection was performed. Was the number of removed lymph nodes calculated for each groin or per patient?

3. The number of lymph nodes retrieved during complete groins dissection does vary very much among patients [1]. But also the technique [2,3] of lymph node dissection varies between countries: debulking of bulky lymph nodes, superficial groin dissection, or superficial plus deep groin dissection. The number of lymph nodes removed varied in the database between 1 and 53. In stage I median 11, in stage II median 14, and in stage III median 15, lymph nodes were removed. This suggests that more women in stages II and III underwent a more radical lymph

node dissection. We would like to know what the differences in outcome are etween the groups with only superficial lymph node dissection compared with those with complete lymph node dissection.
4. Information about frequency and location of disease recurrence (inguinal node recurrence (INR) or vulvar recurrence (VR)) was also not available. While VR could easily be curable with surgery, the 5-year survival of INR is 0–15% [4]. Especially in stage III patients with advanced vulvar disease, in which it could be challenging to have clear surgical margins, the incidence of VR could be higher and, therefore, the association between the number of lymph nodes and the DSS is not justified.

We have the feeling that our issues should be addressed in order to assess the significance of the study correctly. Without answering the questions, this publication does not give an adequate answer on the question on required thoroughness in lymph node dissection.

Thank you very much in advance for answering our questions.

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