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HPV ASSOCIATED VULVA DISEASE IN A COHORT OF WOMEN LIVING WITH HIV

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ZSOG, 2024, HOLIDAY INN BULAWAYO

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Conflict of interest

- None

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Outline

- Clinical presentation
- Work-up and diagnosis
- Treatment outcomes in a cohort of WLWH
- Conclusion

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Aetiology

- HPV related cancers (40%-85% are HPV16+)

✓Usual type VIN- warty, basaloid or mixed types (25.8%)

✓Change of terminology- vulval HSIL

- Non- HPV related cancers

✓Differentiated type VIN (85.7%)

✓Lichen sclerosus (27.7%), squamous hyperplasia (31.7%)

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Other risk factors

- Sexual behaviour- HPV infection
- HIV infection
- Smoking
- Age

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Clinical features

- Vulval mass +- bleeding +- discharge
- Groin swelling
- Cervix, vagina and anus

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Diagnosis and referral

- Punch/incision biopsy (Keys or wedge biopsy)
- Excision biopsy may obstruct further treatment planning
- In case of multiple vulvar lesions, vulval mapping recommended
- Preoperative work-up should at least include clear documentation of the clinical exam (size of lesion, distance to the midline/clitoris/anus/vagina/urethra and palpation of lymph nodes). Picture or clinical drawing is advised

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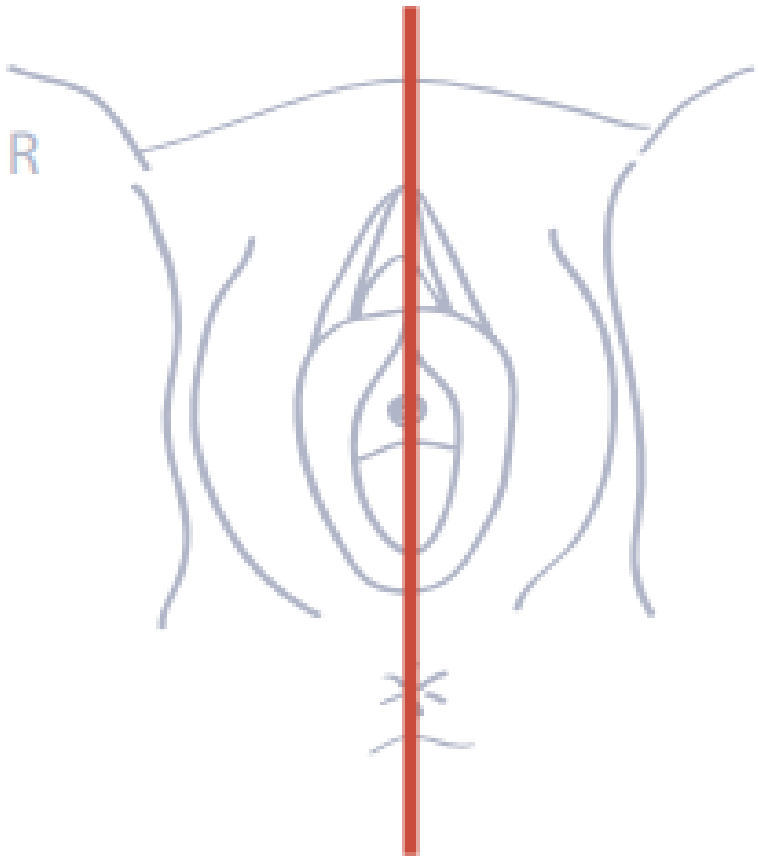
Diagnosis and referral



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PRE-TREATMENT IMAGING

- Evaluation of the cervix/vagina/anus is recommended
- Clinical examination and imaging of the groin, (USS, PET-CT, MRI) to identify potential LN metastases
- Suspicious LNs (at palpation and/or imaging) need FNA, or core biopsy when this would alter primary treatment
- Further staging with CT CAP recommended where there is a clinical suspicion of, or proven, (nodal) metastatic disease and/or advanced stage disease

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Surgical management

- Early 20th century- poorly developed surgical techniques- 5 yr SRs = 20-25%
- 1940s-1950s- Radical en bloc resection of the entire vulva and inguinal region- 5 yr SRs = 60-70%
- “The assumption that a lesion is “early” does not justify less than radical surgery. Conversely, the “advanced” lesion when geographically localized can be treated quite satisfactorily with pelvic exenteration”

Morley GW, Infiltrative carcinoma of the vulva: results of surgical treatment, Am J Obstet Gynecol 1976 Apr 15;124(8):874-88

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Paradigm shift

- Individualized- location, size of the tumour, age and PS & patient's wishes
- Tissue conserving approaches based on tumour margins
- Radical excision to deep fascia, sufficient to obtain at least 1 cm gross margins and appropriate LND (bulky lymph nodes need debulking only and use of SLN biopsy)
- Elimination of routine pelvic LND
- Pre or post-operative RT

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Treatment of primary tumour

- Radical wide local excision (radical hemivulvectomy, radical anterior vulvectomy, radical posterior vulvectomy)
- Radical vulvectomy in multifocal invasion arising on a background of extensive vulvar dermatoses
- In multifocal invasive disease, radical excision of each lesion as a separate entity may be considered
- It is acceptable to consider narrower margins where the tumour lies close to midline structures (clitoris, urethra, anus), and preservation of their function is desired
- +-Superficial resection of vulval HSIL or d-VIN

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Treatment of the groins

- Groin treatment should be performed for tumours > pT1a
- For unifocal tumours < 4 cm without suspicious groin nodes on clinical examination and imaging (any modality) the SLN biopsy is the SOC

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GROINSS V1

J Clin Oncol. 2008 Feb 20;26(6):884-9. doi: 10.1200/JCO.2007.14.0566.

Sentinel node dissection is safe in the treatment of early-stage vulvar cancer.

Van der Zee AG[1], Oonk MH, De Hullu JA, Ansink AC, Vergote I, Verheijen RH, Maggioni A, Gaarenstroom KN, Baldwin PJ, Van Dorst EB, Van der Velden J, Hermans RH, van der Putten H, Drouin P, Schneider A, Sluiter WJ.

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GROINSS V1

Gynecol Oncol. 2016 Jan;140(1):8-14. doi: 10.1016/j.ygyno.2015.09.077. Epub 2015 Sep 30.

Sentinel nodes in vulvar cancer: Long-term follow-up of the GROningen INternational Study on Sentinel nodes in Vulvar cancer (GROINSS-V) I.

Te Grootenhuis NC[1], van der Zee AG[1], van Doorn HC[2], van der Velden J[3], Vergote I[4], Zanagnolo V[5], Baldwin PJ[6], Gaarenstroom KN[7], van Dorst EB[8], Trum JW[9], Slangen BF[10], Runnebaum IB[11], Tamussino K[12], Hermans RH[13], Provencher DM[14], de Bock GH[15], de Hullu JA[16], Oonk MH[17].

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GROINSS VII

- IF radiotherapy is a safe alternative to IFL in patients with SN

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Treatment outcomes a cohort of WLWH

- A retrospective review of electronic medical records of patients with a diagnosis of VIN and VC between January 2020 & April 2024

- Sociodemographic and clinical profile, treatment & outcomes data was collected

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Sociodemographic and clinical profile

Variable	HSIL	VC
Number of women	50	37
Median age (yrs)	46	40
Median duration on ART (yrs)	11	6
HIV VL <50copies (%)	86.4	77.4
CD4 count >200 (%)	86.4	74.2
hrHPV type 16 (%)	69.4	75
Multiple hrHPV genotypes (%)	71	62.5

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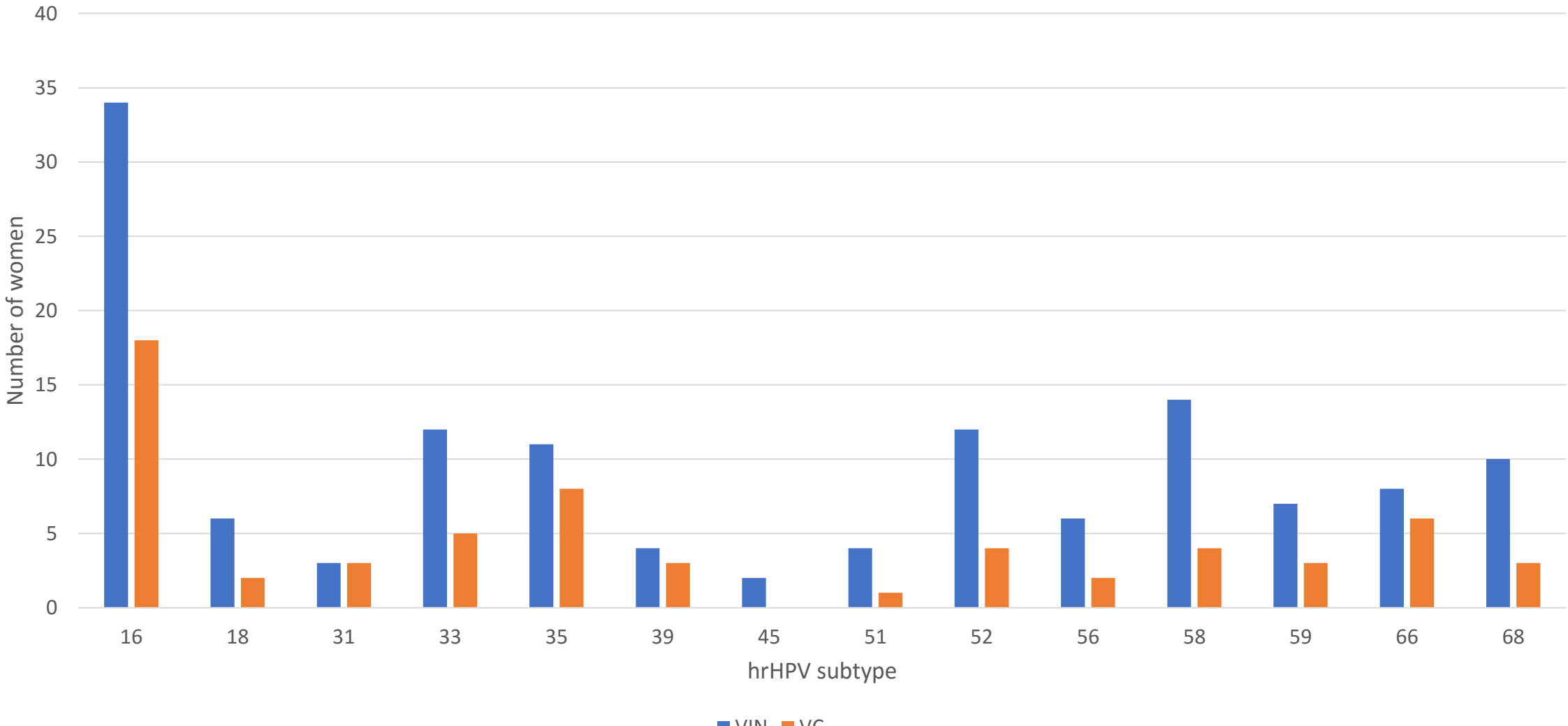
Prevalence of high-risk HrHPV



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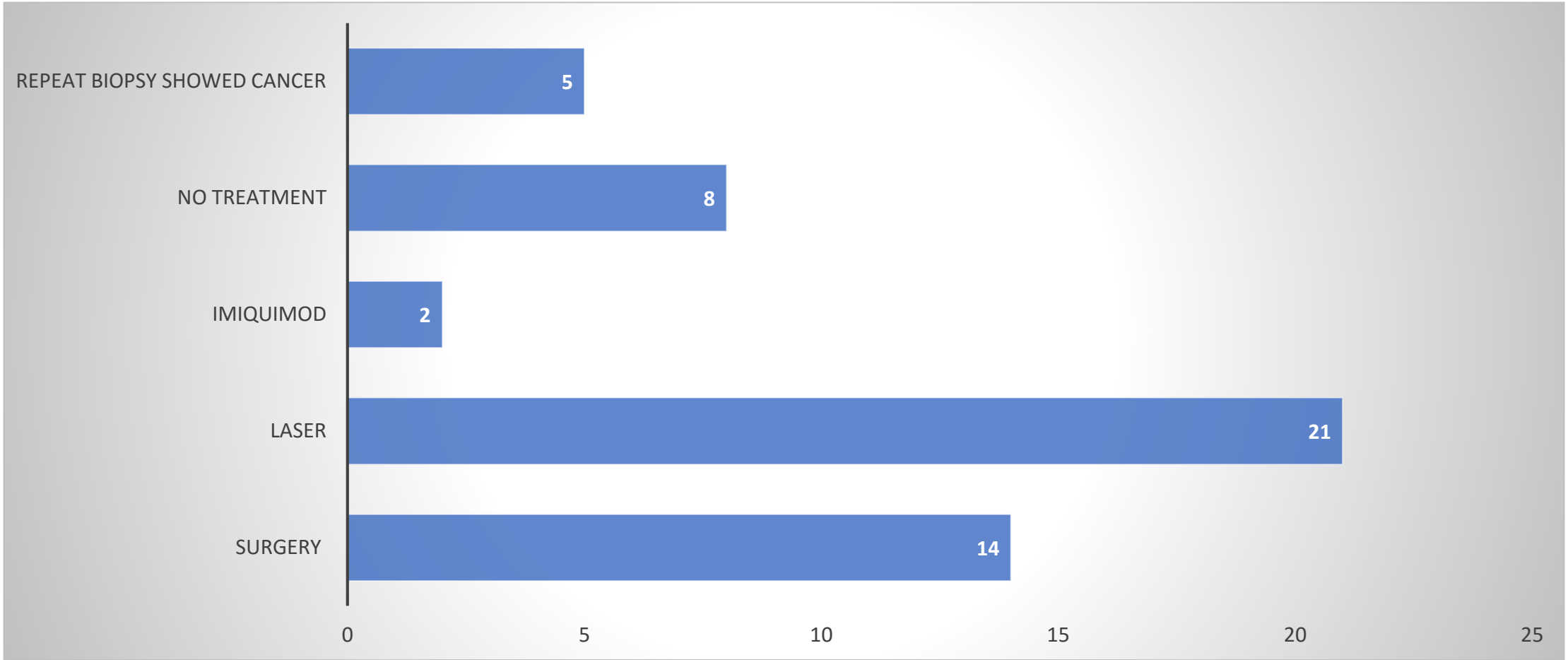
Treatment of patients with HSIL



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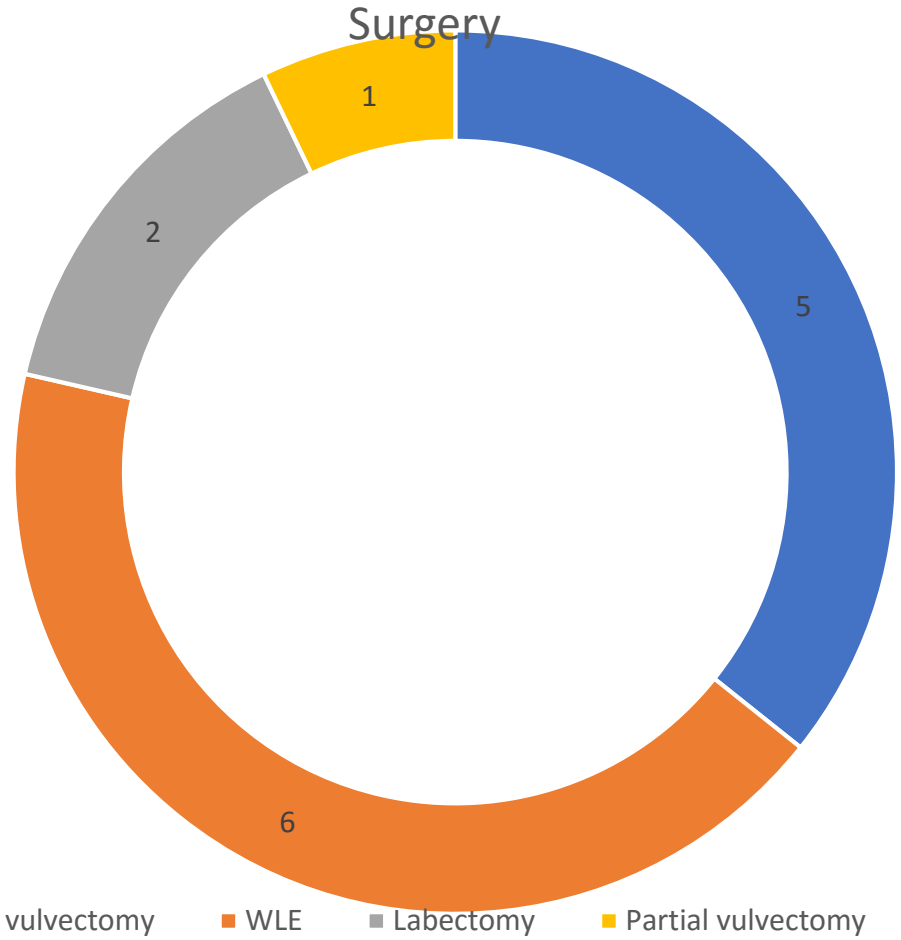
Treatment of patients with HSIL - Surgery



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Treatment of patients with HSIL

- 37/50 treated (surgery/laser/imiquimod), 18 (48.6%) required a second treatment

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FIGO Stage at presentation

Stage	Number of patients	Percentage
1	17	46
2	1	3
3	6	13
4	8	22
Stage unknown	5	13

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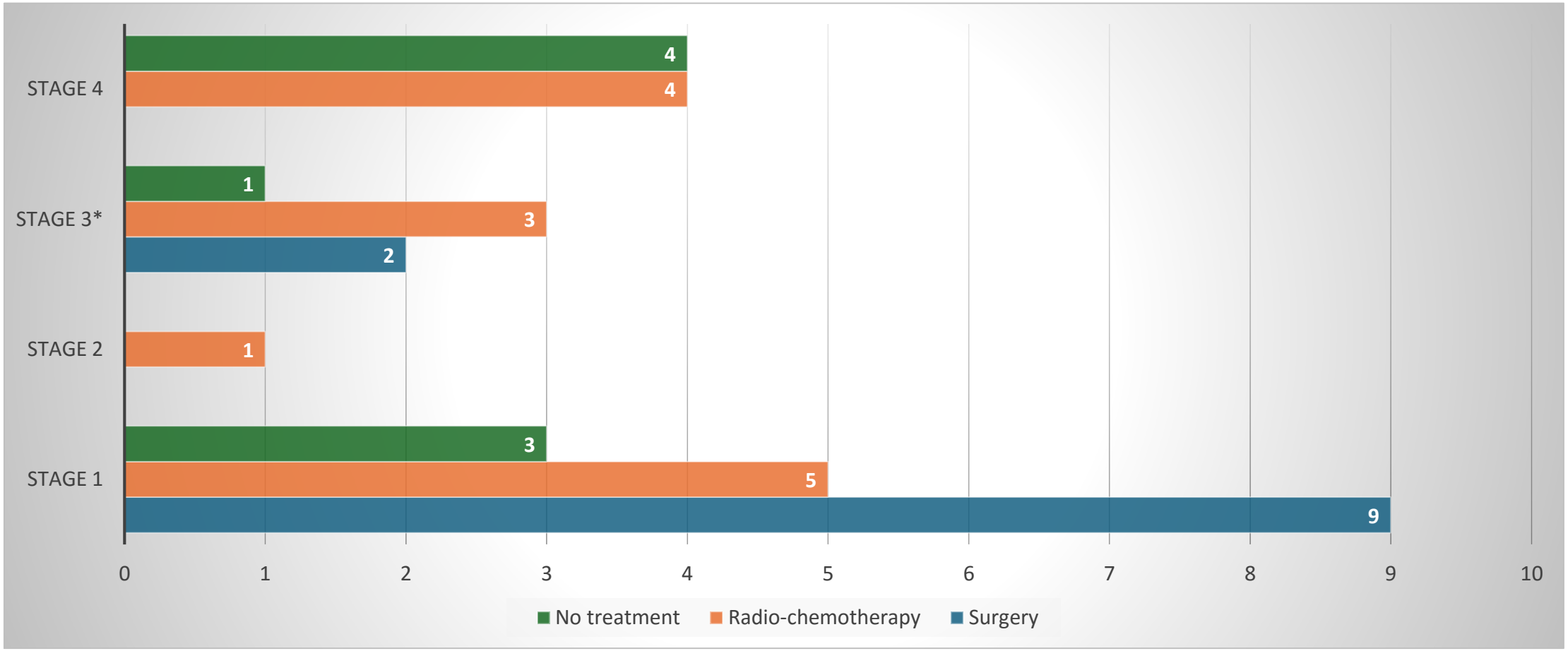
Treatment by stage



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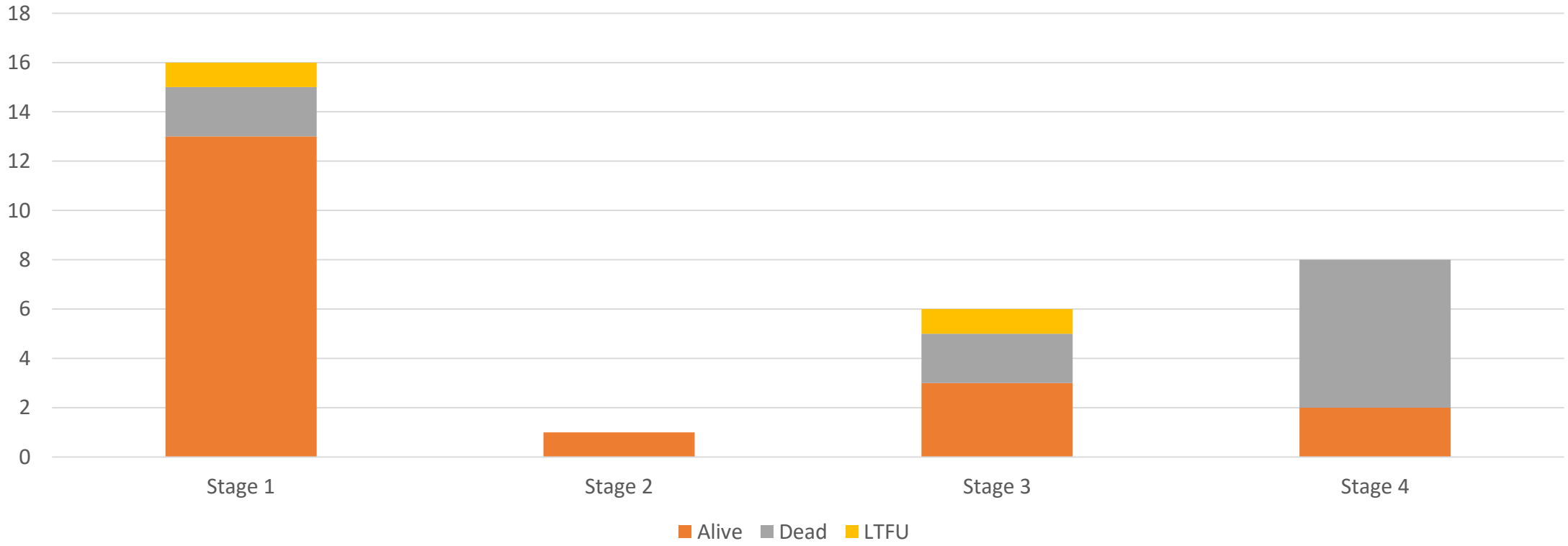
Outcome by stage



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Surgical treatment

SURGERY OFFERED	NUMBER OF PATIENTS	%
Radical anterior vulvectomy	4	36.4%
Wide Local Excision + BGND	4	36.4%
Radical vulvectomy + BGND	3	27.2%

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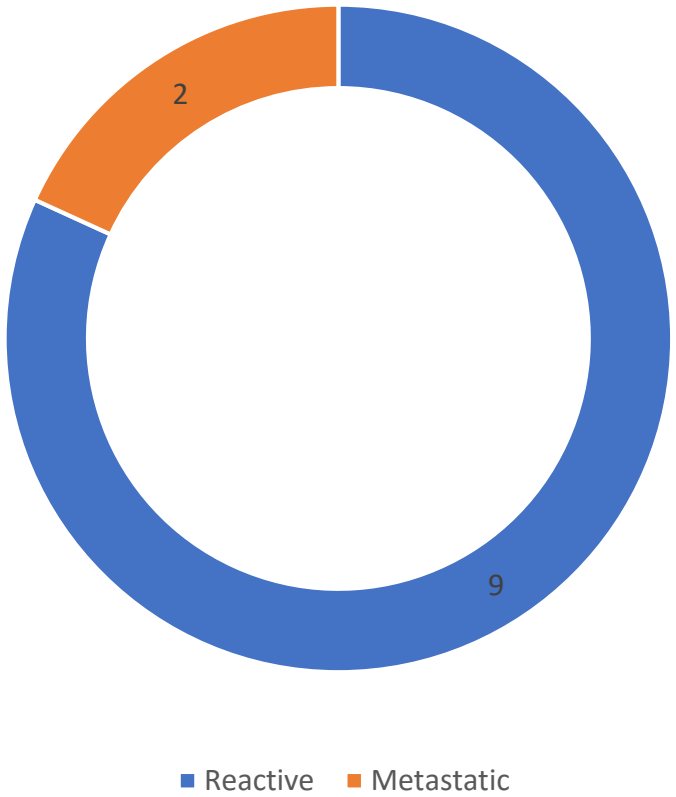
Lymph node status post-surgery



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Complications

Surgical site Infection	3
Lymphoedema	4
Wound dehiscence	1
DVT	2

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Conclusion

- Vulval cancer occurring in younger WLWH
- HPV 16/18 have the highest prevalence in HSIL and Cancer
- Risk of recurrence of HSIL requiring additional treatment is almost 50%
- Early stage disease has a good prognosis

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