Wednesday 25 June 10.30–11.45
Penile Cancer
Chairmen: T. Terry and K. Sethia

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Organ-preserving surgery for penile carcinoma: early follow-up data

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INTRODUCTION

Invasive tumours of the penis have traditionally been surgically treated with partial or radical penectomy. An alternative approach is an organ-sparing procedure aiming to preserve as much of the native anatomy and function as possible. We present our initial experience using this approach.

PATIENTS AND METHODS

A prospective analysis of 26 consecutive patients (21 newly diagnosed and five requiring salvage surgery for recurrences after radiotherapy; mean age 59 years, range 38–83) undergoing organ-sparing surgery for penile carcinoma was performed. All procedures were performed in a single centre by one surgeon over a 2-year period.

RESULTS

The disease stage included two Ta, nine T1, 13 T2 and two T3 tumours, with 10 G1, 11 G2 and five G3 tumours. The surgical approaches were partial glansectomy and primary repair in two, partial glansectomy and reconstruction in five, glansectomy and reconstruction in 15, and glansectomy, distal corporectomy and reconstruction in the remainder. There were no local recurrences; one patient required regrafting for partial graft loss.

CONCLUSION

These early results show that the organ-sparing approach used in appropriately selected cases is feasible, offering early oncological control equal to conventional surgery. Advantages include decreased psychological morbidity and potential for normal sexual function.

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Management of nodal disease in penile carcinoma: further results from the South Thames penile cancer audit

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INTRODUCTION

The management of nodal disease in squamous cell carcinoma of the penis remains controversial with no good evidence to guide treatment. The role of prophylactic block dissection, nodal sampling, external beam radiotherapy (EBRT) with or without chemotherapy are debated. A review of contemporary practice may be helpful establishing the current use of these techniques.

PATIENTS AND METHODS

The medical notes and histology reports of 207 cases of penile carcinoma diagnosed between 1989 and 1999 were reviewed retrospectively. Tumours stages were converted to the 1997 TNM classification.

RESULTS

In all, 158 (76%) squamous cell carcinomas were identified; 85 were recorded as N0 and 31 as Nx, with 42 (26%) of these having histologically confirmed nodal disease and 20 presenting as clinically node negative. Of these, half were G3 tumours and developed nodal recurrence after a median (range) of 7 (2–15) months. Prophylactic groin dissection was carried out in six patients, two of which were node-negative, and in three as treatment for recurrence. EBRT was used as the primary treatment for nodal disease in six cases, with chemotherapy in one.

CONCLUSION

The incidence of nodal involvement compares with other series (23–30%). These results suggest that nodal staging is often inadequate and that lymphadenectomy has been under-used. Many techniques are available for nodal staging including ultrasonography, CT, MRI and sentinel-node biopsy. EAU guidelines recommend modified or radical lymphadenectomy for ≥T2 and G3 disease; this would have involved an additional 64 dissections.

Funding: South Thames Specialist Audit Commission

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Current UK management of penile carcinoma: is it time for 'super-specialization'?

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INTRODUCTION

UK urologists see less than one new case of penile cancer per year. We used the BAUS Cancer Registry to evaluate current management practices in the UK.

METHODS

Newly presenting patients registered during 1998 (6-month pilot data collection) and 1999 were used as the starting population. Outcome data were requested from consultants, who had registered patients.

RESULTS

In all, 243 patients were registered with a date of diagnosis between 9 October 1997 and 24 December 1999. Outcome data was returned on 188 of these patients; 168 (89%) had squamous carcinoma, 69 (37%) were aged <60 years at diagnosis and 165 (88%) were treated with curative intent. Treatment options included local excision (7%), circumcision (13%), circumcision and radiotherapy (5%), partial penectomy (41%), radical penectomy (8%), radical penectomy plus radiotherapy (11%) and radiotherapy alone (8%). The median (range) follow-up was 29 (0–49) months. Survival was related to stage of disease, with deaths from penile cancer increasing from 5.8% for Stage 0 to 86% for Stage IV. Complications occurred in 31% of those having treatment and 40% of those having lymph node dissection.

CONCLUSIONS

We report a large cohort of contemporary patients with penile cancer. These data provide a benchmark to judge the outcome of future 'supra-network' MDT activity. The challenges will be to salvage more Stage III patients, reduce the complication rate and introduce trial activity.

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Lymphadenectomy for penile carcinoma: complications and management

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INTRODUCTION

The EAU has published guidelines on the management of inguinal lymph nodes in penile cancer. The aims of this study were to establish whether these guidelines are applicable in a contemporary series and assess the complications after lymphadenectomy in this difficult group of patients.

PATIENTS AND METHODS

Twelve patient (mean age 51.8 years, range 38–75) with penile squamous cell carcinoma underwent a total of 16 modified superficial/radical inguinal lymph node dissections. Preoperative staging included MRI; those with palpable nodes before surgery underwent intraoperative frozen section analysis.

RESULTS

The overall mean hospital stay was 6.8 days (5.5 for superficial, 11.3 for radical). Of the 16 lymphadenectomies 12 developed complications (nine lymphoceles, nine wound infections, two wound necrosis). Seven patients required intervention for complications, including re-admission for wound infection and/or aspiration of lymphocele. Only one patient had mild lymphoedema at follow up. Three of four patients with palpable lympadenopathy had positive nodes on histology. Overall, six patients had positive nodes. Of those node-positive five were grade G2/G3 on primary histology. Half of the T2/T3 tumours were node-positive. There were no detectable recurrences at follow up.

CONCLUSION

In agreement with EAU guidelines, the grade of the primary tumour appears to correlate with lymph node metastasis, with half the patients having positive nodes. However, until more accurate prognostic factors are identified, up to half of patients will undergo unnecessary lymphadenectomy, which has a high morbidity.

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Is the association between balanitis xerotica obliterans and penile cancer underestimated?

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INTRODUCTION

Balanitis xerotica obliterans (BXO) is a common penile disease that usually involves the prepuce and glans. There have been sporadic case reports of the association between BXO and penile carcinoma, although it is uncertain if there is a specific causal relationship. The reported incidence of penile carcinoma in patients with BXO is 2.6–5.8%, leading some to advocate circumcision in all cases, with close follow-up in those with persistent glans disease. This study was designed to determine the incidence of BXO in a consecutive series of penile carcinomas in one centre.

PATIENTS AND METHODS

All cases of penile cancer referred to the senior author (N.A.W.) over a 2-year period were analysed prospectively to determine the prevalence BXO.

RESULTS

In all, 52 cases of penile malignancy were reviewed, 14 of whom had BXO (27%), including eight cases of squamous cell carcinoma, five of carcinoma *in situ* and one of sarcoma. In nine cases, BXO and malignancy presented synchronously; in three others, cancer occurred in the background of chronic persistent BXO, two at 4 and 5 years after the initial diagnosis and treatment (circumcision). In only two cases was penile cancer truly metachronous, presenting 5 and 12 years after a curative circumcision for BXO.

CONCLUSION

A large proportion of patients with penile malignancy have a histological diagnosis of BXO, suggesting that the aggressive management of BXO recommended by some authors may be justified.