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Limiting the morbidity of inguinofemoral lymphadenectomy in vulvar cancer patients; a review

Anne-Floor W. Pouwer\textsuperscript{a}, Henriette J. Arts\textsuperscript{b}, Jacobus van der Velden\textsuperscript{c} and Joanne A. de Hullu\textsuperscript{a}

\textsuperscript{a}Department of Obstetrics and Gynaecology, Radboud university medical center, Nijmegen, The Netherlands; \textsuperscript{b}Department of Obstetrics and Gynaecology, University Medical Center Groningen, Groningen, The Netherlands; \textsuperscript{c}Department of Obstetrics and Gynaecology, Center for Gynaecologic Oncology Amsterdam (location: Academic Medical Center), Amsterdam, The Netherlands

\textbf{ABSTRACT}

\textbf{Introduction:} Inguinofemoral lymphadenectomy (IFL) is performed in the treatment for vulvar cancer. One or more complications after IFL is reported in up to 85\% of the patients. This review presents an overview of surgical techniques and peri- and post-operative care that has been studied in order to reduce the morbidity associated with IFL in vulvar cancer patients.

\textbf{Areas covered:} Current knowledge on post-operative complications after different surgical techniques and peri- and post-operative protocols were discussed. A systematic literature review was conducted using MEDLINE, EMBASE and the Cochrane library on 20 February 2017. In order to be eligible for inclusion, studies must report the associated post-operative morbidity per surgical technique, or peri- or post-operative care given after IFL in vulvar cancer patients.

\textbf{Expert commentary:} After the implementation of several new surgical techniques, the morbidity after IFL decreased but remains high and clinically meaningful. More research is needed on surgical techniques and peri- or post-operative care to further reduce the complication rates after IFL in vulvar cancer patients.

1. Introduction

Vulvar cancer is the fourth most common gynecologic cancer after endometrial, ovarian, and cervical cancer. Vulvar cancer is a rare disease with an incidence of 2.4 per 100,000 women [1]. Over the past few decades, the incidence of vulvar cancer increased [2]. Vulvar cancer mostly affects elderly women, with more than half of the patients being above the age of 70 years at the time of diagnosis. The most common histological type of vulvar cancer is squamous cell carcinoma (SCC), which accounts for over 80\% of the cases [3].

The dissemination of vulvar SCC may occur by three different routes: direct extension, lymphogenic spread, and hematogenic spread. The initial spread occurs usually to the inguinofemoral lymph nodes. As soon as the depth of infiltration is more than 1 mm, inguinofemoral lymph node metastases can already be present. Therefore, evaluation of inguinofemoral lymph nodes is crucial. The cornerstone in the treatment of primary vulvar SCC is surgery, consisting of both local tumor resection and inguinofemoral lymph node staging and/or dissection. The treatment for vulvar cancer has developed throughout the last decades. For years, radical vulvectomy with ‘en bloc’ bilateral inguinofemoral lymphadenectomy was a well-established treatment. In the last three decades, less radical surgery was introduced to decrease morbidity with comparable or improved prognosis. Nowadays, the standard treatment of early stage vulvar SCC consists of radical local excision of the tumor combined with a sentinel node (SN) procedure and/or inguinofemoral lymphadenectomy (IFL). The SN procedure is safe to perform instead of an IFL in patients with a unifocal tumor <4 cm without suspicious lymph nodes in the groins [4]. In patients with a larger tumor, multifocal disease and/or a positive SN and in patients with local recurrent disease without earlier IFL, an IFL is indicated. After the implementation of the SN, in approximately half of the patients with vulvar SCC an IFL is still indicated [5].

Unfortunately, IFL is associated with significant short- and long-term complications. The occurrence of one or more groin wound complications is reported in 66–85\% of the patients [6,7]. Wound breakdown, wound infection, lymphoceles, lymphedema, cellulitis, and erysipelas are the most reported complications. Because IFL will always have a place in the treatment of vulvar cancer, it is important to look for adjustments, which may reduce the associated morbidity.

The aim of this review is to create an up-to-date summary of surgical techniques and peri- and postoperative care that have been performed to reduce the morbidity of IFL in vulvar cancer patients.

2. Methods

2.1. Literature search

We performed a systematic search of the literature on 20 February 2016 using MEDLINE, EMBASE, and the Cochrane library. The following search (MeSH)terms and synonyms...
ware used for ‘lymphadenectomy’ combined with ‘vulvar cancer’ (lymphadenectomy, inguinal/inguinal lymphadenectomy, groin surgery, groin dissection, lymph node dissection, lymph node surgery, lymph node excision; vulvar cancer, vulvar tumor, vulvar carcinoma, vulvar neoplasm, vulvar squamous cell carcinoma). The search was restricted to the English and Dutch language.

2.2. Study selection

In order for an article to be eligible, the following predefined criteria had to be met [1]; (randomized) (un)controlled trial; controlled or uncontrolled prospective or retrospective study [2]; IFL for vulvar cancer patients aged >18 years; and [3] report the associated complication rate per studied surgical technique or peri- or postoperative care.

2.3. Outcome measures

Our primary outcomes of interest were

- Complication rate per surgical technique and/or peri-, or postoperative care
- Short-term complications <8 weeks after surgery
  - Wound breakdown
  - Wound infection
  - Lymphocele
- Long-term complications >8 weeks surgery
  - Cellulitis or erysipelas (recurrent)
  - Lower extremity lymphedema

Secondary outcome of interest was

- Quality of life

2.4. Data extraction and analysis

Relevant data on study population, study design, surgical technique, peri- or postoperative protocol, and the complication rates were extracted from the included studies. Similar complications were grouped together such as seroma and lymphocele, cellulitis and erysipelas, wound dehiscence and wound breakdown.

Quality of the included studies was categorized according to the levels for intervention studies of evidence of the Oxford Centre of Evidence Based Medicine [8]. Level one evidence included a systematic review of randomized controlled trials (RCT), level two evidence included a randomized trial, level three, a non-RCT, level four, case-series, case-control studies, or historically controlled studies.

The aim of this review was to create an up-to-date summary of all available evidence regarding surgical techniques and peri- and postoperative care protocols after IFL in vulvar cancer patients. Therefore, we included all published articles concerning this subject. As both controlled and uncontrolled trials were expected to include in this review, we planned not to perform meta-analyses.

3. Results

3.1. Literature search

The search yielded a total of 1988 articles, and after removal of duplicates, 1363. One author (AP) screened all titles and checked for relevant abstracts; 123 abstracts were found to be relevant and were retrieved in full text. The same author assessed the articles for eligibility using the predefined criteria as stated in our methods. A total of 36 studies were included in this review.

3.2. Study characteristics

The research designs of the included studies were mainly retrospective (23 studies), six were prospective uncontrolled studies, five RCTs, and two prospective controlled studies. Study populations ranged between 5 and 194 patients and were studied in the period from 1955 until 2016. The quality of the included studies was mainly level four evidence (31 studies). Two included RCTs were downgraded to level three evidence because they did not perform a sample size calculation and both included less than 15 patients [9,10] (See Table 1).

The following surgical interventions were studied: separate incisions or radical vulvectomy with ‘en bloc’ lymphadenectomy, unilateral IFL, sparing of saphenous vein, Sartorius transposition, dura mater for femoral vessel coverage, minimally invasive technique, preservation of fascia lata, harmonic scalpel or electrosurgery, plasmajet, VH fibrin sealant, lymphatic microsurgical venous anastomosis (LYMPHA technique), lymphatic flap, method of skin closure, anticoagulation, post-operative drainage and compression garments. None of the included studies reported data on quality of life. For an overview of the association of the above-described interventions on postoperative morbidity after IFL, see Table 2.

3.3. Modifications of surgery

3.3.1. Type of groin incision

The morbidity of IFL by type of groin incision was reported by ten included studies; both separate incisions and the ‘en bloc’ approach were described. See Table 3.

Only two retrospective studies studied postoperative complications after IFL by separate incisions versus the ‘en bloc’ approach [14,15]. Helm et al. [14] did report a reduction of patients with wound breakdown using separate incisions but this reduction was not statistically significant. The second study described a reduction of the wound breakdown rate and an increase in lymphoceles after using separate incisions, but did not perform any statistical tests [15]. Six other studies report the incidence of postoperative complications after the use of separate incisions without a control group. Overall, it can be concluded that the occurrence of wound breakdown, lymphocele, and cellulitis/erysipelas was reduced by using separate incisions with an increase in lymphoceles.

To determine further reduction of the morbidity associated by IFL using separate incisions, Manci et al. [30] compared skin
access above or below the inguinal ligament in a RCT and found an advantage for incision above the ligament; wound dehiscence in 32% versus 17%, lymphocele in 19% versus 6%, respectively, although there was no statistically significant difference.

### 3.3.2. Laterality of IFL

Unilateral IFL as an alternative to bilateral IFL was studied in a selected group of patients with lateralized tumors (tumor with medial margin >1 cm from the midline) without palpable groin lymph nodes. Two studies reported less complications in unilaterally treated patients [17,22]. The number of patients with wound dehiscence or lymphedema is significantly reduced by performing a unilateral IFL from 24% to 0% and 67% to 8%, respectively (p < 0.001) [22]. In conclusion, unilateral IFL does reduce morbidity but can only safely be performed in patients with early stage and lateralized vulvar cancer [17].

#### 3.3.3. Sparing of the saphenous vein

The classic description of IFL includes ligation of the saphenous vein. It was suggested that sparing the saphenous vein might reduce the complications associated with IFL. Four retrospective studies reported the complication rates after sparing versus ligation of the saphenous vein [20,23,26,27]. See Table 4 for an overview of the outcomes of these studies. There was a significant lower number of groins with wound infection [23,26], wound breakdown [20,23,26], lymphedema [23,26,27], and cellulitis/erysipelas [20,27] after sparing of the saphenous vein. There was no evidence of effect for the reduction of lymphoceles. It can be concluded that sparing of the saphenous vein reduces the postoperative wound complications after IFL.

#### 3.3.4. Coverage of femoral vessels

The transposition of the Sartorius was first introduced by Way as modification to protect the femoral vessels in case of

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**Table 1. Characteristics of included studies.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Patients</th>
<th>Intervention</th>
<th>Control</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burke 1995 [17]</td>
<td>1978–1994</td>
<td>Retrospective</td>
<td>76</td>
<td>Bilateral and/or unilateral IFL</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Zhang 2007 [27]</td>
<td>1989–2005</td>
<td>Retrospective</td>
<td>64</td>
<td>Ligation saphenous vein</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Madhuri 2011 † [9]</td>
<td>Not</td>
<td>RCT</td>
<td>18</td>
<td>Plasmajet</td>
<td>Not plasmajet</td>
<td>3</td>
</tr>
<tr>
<td>Li 2012 [33]</td>
<td>2004–2009</td>
<td>Retrospective</td>
<td>24</td>
<td>Modified triple incisions</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Soliman 2012 [34]</td>
<td>2002–2009</td>
<td>Retrospective</td>
<td>34</td>
<td>Separate incisions</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Morott 2013 [35]</td>
<td>2009–2011</td>
<td>Prospective</td>
<td>15</td>
<td>No LYMPHA (historical cohort)</td>
<td>No LYMPHA (historical cohort)</td>
<td>4</td>
</tr>
<tr>
<td>Li 2015 [36]</td>
<td>2007–2013</td>
<td>Prospective</td>
<td>58</td>
<td>Sartorius tendon transposition</td>
<td>Sartorius transposition</td>
<td>4</td>
</tr>
<tr>
<td>Wang 2015 [37]</td>
<td>2010–2013</td>
<td>Prospective</td>
<td>21</td>
<td>VEIL hypogastric subcutaneous approach</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Gentileschi 2016 [38]</td>
<td>Not</td>
<td>Prospective</td>
<td>5</td>
<td>Lymphatic flap</td>
<td>No lymphatic flap</td>
<td>4</td>
</tr>
<tr>
<td>Wu 2016 [39]</td>
<td>2011–2016</td>
<td>Prospective</td>
<td>37</td>
<td>VEIL lateral approach</td>
<td>*</td>
<td>4</td>
</tr>
<tr>
<td>Jain 2017 [40]</td>
<td>2011–2015</td>
<td>Retrospective</td>
<td>12</td>
<td>R-VEIL</td>
<td>*</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 2. Influence of intervention on the complication rate after IFL per level of evidence.

<table>
<thead>
<tr>
<th>Level of evidence</th>
<th>Decrease</th>
<th>Increase</th>
<th>No association</th>
<th>Unclear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Level 2</td>
<td>None</td>
<td>Fibrin sealant</td>
<td>Sartorius transposition</td>
<td>Skin access above or below the inguinal ligament</td>
</tr>
<tr>
<td>Level 3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Level 4</td>
<td>Separate incisions</td>
<td>‘en bloc’ approach</td>
<td>Cadaver dura mater</td>
<td>Plasmajet Prophylactic compression garment (R-) VEL Harmonic scalpel or electrosurgery Anticoagulation Duration of drainage Lymphatic flap</td>
</tr>
</tbody>
</table>

*: only lymphedema studied; (R-) VEL: (robot-assisted) video endoscopic inguinofemoral lymphadenectomy; IFL: inguinofemoral lymphadenectomy; LYPMA: lymphatic microsurgical preventive healing approach.

Table 3. Separate incisions versus ‘en bloc’ resection for inguinofemoral lymphadenectomy: complications in percentages.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Separate</th>
<th>En bloc</th>
<th>p-Value</th>
<th>Separate</th>
<th>En bloc</th>
<th>p-Value</th>
<th>Separate</th>
<th>En block</th>
<th>p-Value</th>
<th>Separate</th>
<th>En block</th>
<th>p-Value</th>
<th>Overall ≥1 complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘en bloc’ versus separate incisions per patient</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Helm 1992</td>
<td>64</td>
<td>-</td>
<td>-</td>
<td></td>
<td>19</td>
<td>34</td>
<td>NS</td>
<td>31</td>
<td>19</td>
<td>NS</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Lin 1992</td>
<td>82</td>
<td>-</td>
<td>-</td>
<td></td>
<td>22</td>
<td>53</td>
<td>-</td>
<td>15</td>
<td>0</td>
<td>-</td>
<td>22</td>
<td>16</td>
<td>NS</td>
<td>-</td>
</tr>
<tr>
<td>‘en bloc’ per patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Podratz 1983</td>
<td>175</td>
<td>85†</td>
<td>85†</td>
<td>-</td>
<td>22</td>
<td>53</td>
<td>-</td>
<td>15</td>
<td>0</td>
<td>-</td>
<td>22</td>
<td>16</td>
<td>NS</td>
<td>-</td>
</tr>
<tr>
<td>Separate incisions per patient</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaarenstroom 2003</td>
<td>101</td>
<td>35</td>
<td>39</td>
<td>-</td>
<td>17</td>
<td>40</td>
<td>-</td>
<td>28</td>
<td>-</td>
<td>66</td>
<td>-</td>
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<tr>
<td>Gould 2001</td>
<td>67</td>
<td>13</td>
<td>35</td>
<td>-</td>
<td>19</td>
<td>13</td>
<td>-</td>
<td>30</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hacker 1981</td>
<td>100</td>
<td>9</td>
<td>9</td>
<td></td>
<td>19</td>
<td>13</td>
<td>20</td>
<td>20</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hinten 2011††</td>
<td>164</td>
<td>29</td>
<td>29</td>
<td></td>
<td>19</td>
<td>29</td>
<td>49</td>
<td>49</td>
<td>34</td>
<td>-</td>
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<tr>
<td>Van der Zee 2008†</td>
<td>166</td>
<td>21</td>
<td>21</td>
<td></td>
<td>34</td>
<td>25</td>
<td>25</td>
<td>16</td>
<td>16</td>
<td>-</td>
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<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separate incisions per groin</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gaarenstroom 2003</td>
<td>187</td>
<td>27</td>
<td>27</td>
<td>-</td>
<td>11</td>
<td>27</td>
<td>-</td>
<td>21</td>
<td>-</td>
<td>-</td>
<td>52</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sollman 2012</td>
<td>64</td>
<td>3</td>
<td>10</td>
<td></td>
<td>10</td>
<td>13</td>
<td>-</td>
<td>5</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant.
†: including wound infection, wound breakdown and necrosis; ††: both en bloc and separate incisions; †: sentinel node procedure with subsequent inguinofemoral lymphadenectomy.
The effect of transposition of the Sartorius on the complication rate is reported in three studies, one RCT [24] and two retrospective studies [18,23]. Judson et al. [24] randomized for either sartorius transposition or not. They found a statistically significant increase of lymphocele formation in patients in the transposition group. Other outcomes, such as wound breakdown, wound infection, and lymphedema did not differ between those two groups of patients.

One retrospective study reported an increase in patients with lymphedema after transposition of the Sartorius, with statistical significance [23] and another study reported a reduction of wound infections after transposition [18]. These studies did not report significant differences between wound breakdown and lymphocele. See Table 5 for an overview of results.

Another explored surgical technique during IFL to cover the groin vessels is Sartorius tendon transposition versus Sartorius transposition as investigated by one case-control study [36]. Wound breakdown and chronic lymphedema were significantly reduced in the Sartorius tendon transposition group, 30% versus 3.6% \((p = 0.012)\) and 33.3 versus 7.1% respectively \((p = 0.022)\). However, none of the studies report the morbidity after tendon transposition versus no tendon or Sartorius transposition.

In conclusion, there is no evidence that covering the femoral vessels by transposition of the Sartorius or cadaver or artificial dura mater does reduce the complications after IFL in vulvar cancer patients.

### 3.3.5. Minimally invasive IFL

In the previous years, minimally invasive techniques were developed for IFL to reduce the postoperative complications. After the introduction in other malignancies such as penile cancer and melanoma, video endoscopic IFL (VEIL) was studied in vulvar cancer patients. Until now, there is limited English literature on vulvar cancer. Four studies concerning VEIL in vulvar cancer patients were included in this review [32,37,39,40]. These studies were published between 2011 and 2017, two were prospective and two retrospective. In total, 87 patients were included (75 patients from China and 12 patients from India). For results see Table 6.

Xu et al. used the abdominal approach for VEIL and reported no inguinal wound-related complications besides one patient with exhibited lymphorrhea through the drain orifice [32]. The second study used a hypogastric subcutaneous approach and reported only one patient with a lymphocele (5%); furthermore, no other inguinal wound complications were observed [37]. The third study used a 3-incision lateral approach to perform VEIL in 37 patients and was the largest published study in vulvar cancer patients. They described wound breakdown in 3% of the patients; no other complications such as wound infection, lymphocele, lymphedema, and cellulitis were reported in these patients [39]. The last study performed in India used robot-assisted VEIL (R-VEIL)
to perform IFL. Reported overall complication rate was 75% per patient and 60% per groin [40]. These overall complication rates reported after R-VEIL were even higher to those reported after open IFL by Gaarenstroom et al. of 66% per patient and 52% per groin, respectively [6]. Furthermore, it is unclear if (R-)VEIL is safe in vulvar cancer patients, given a groin recurrence rate as high as 6% in patients using VEIL [39] comparing to 2.5% after using the conventional procedure [42].

In conclusion, (R-)VEIL seems to be feasible for the approach of IFL as described in all studies, but it remains questionable if (R-)VEIL reduces the postoperative complications, and whether this procedure is oncologically safe or not.

### 3.3.6. Other modifications

More individual studies report modifications on the current surgical techniques of IFL. First of all, the preservation of the fascia lata. Two retrospective studies report after sparing of the fascia lata lower rates of lymphocele, lymphedema, wound infection, and wound breakdown compared to the literature [19,25] and overall short-term complication rate of 38% and long-term complication rate of 14% [25].

The device used during IFL is studied as a possible option to reduce the morbidity. Pellegrino et al. [29] investigated the differences in postoperative complications of using either the harmonic scalpel or conventional electrosurgery. They did not report significant differences between these two groups in the incidence of postoperative complication. In this study, only one patient had a postoperative complication in the harmonic scalpel group (including 22 patients) versus zero patients in the conventional electrosurgery group (including 20 patients). Another study regarding the surgical device used is performed by Madhuri et al. [9] using Plasmajet (a surgery system utilizing kinetic energy and highly controlled thermal effects to seal the tissue). In a conference abstract, they described a pilot RCT in 18 patients and concluded that Plasmajet may reduce the lymphocele formation but did not publish the full paper until now.

Another studied option is the sealing of lymph vessels during IFL, evaluated by Carlson et al. [28] in a RCT. They investigated the addition of VH fibrin sealant sprayed in the groin before sutured closure. Inguinal infections, wound breakdown, lymphoceles, and lymphedema did not significantly differ between the two groups. However, they reported a significant increase in the number of vulvar infections in patients treated by VH fibrin sealant (33% versus 14%, p = 0.0098). The overall complication rate for patients treated in the intervention group was 61% versus 59% in the control group. In conclusion, VH fibrin sealant in the groin did not reduce the groin complications after IFL and increased the vulvar wound complications.

The use of lymphatic microsurgical preventive healing approach (LYMPHA) in the prevention of lymphedema during IFL was described by one prospective study in 23 groins [35]. Before incision of the skin, blue dye was injected in the thigh muscles to identify the lymphatic vessels; anastomizes were made between lymphatics from the lower limb and one of the collateral branches of the femoral vein. They reported lymphedema in 8% of the groins after the LYMPHA technique and 36% in the cohort without LYMPHA technique after a mean follow-up of 16.7 (SD 6.2) months. Other groin wound
was associated with an increased risk for any short-term complication, \( p = 0.02 \) by using subcuticular suture compared to staples. Wound infection and wound breakdown were not influenced by the method of skin closure.

3.4. Modifications of perioperative care

In 1983, one study reported the influence of perioperative prophylactic anticoagulation as a possible cause of lymphocele after IFL. In patients receiving heparin, 42% developed a lymphocele versus 2% in patients receiving sodium warfarin, dextran, or no anticoagulation \( (p < 0.01) \). The influence of both treatment regimens on the risk of embolism in these patients is unclear. There are no other studies regarding prophylactic anticoagulation and the associated risk of complications after IFL besides this dated publication. Nowadays, the use of heparin is more and more replaced by the use of low-molecular-weight heparin during surgery and postoperative care. No reports about usage of low-molecular-weight heparin are published until now.

The usage of prophylactic intravenous antibiotics is widely accepted during perioperative care, but there were no publications about reducing postoperative (wound) complications.

3.5. Modifications of postoperative care

The postoperative care given might influence the morbidity after IFL. First of all, the postoperative drainage of the groin after IFL might reduce the morbidity. The optimal duration of lymph fluid drainage was studied by only two retrospective studies. Walker et al.\([31]\) reported complications in association with the duration of lymph fluid drainage. The main reason for removal of the drain was production of <50 ml per 24 hours.

Wound breakdown and lymphedema were significantly lower in the group of patients drained over 7 days compared to shorter drainage. There was no influence on the number of patients with a wound infection and lymphocele. Another retrospective study showed that higher drain production on the last day \textit{in situ} was associated with an increased risk for any short-term complication but there was no effect found on duration drain \textit{in situ} on the complication rate \([5]\). Prospective research is needed to determine the optimal duration of postoperative drainage in terms of reduction of complications after IFL.

The second studied modification of postoperative care was the use of prophylactic compression garments by Sawan et al.\([10]\) in 14 patients. Patients were randomly assigned for prophylactic compression garments or best supportive care without compression garments. There was no statistically significant difference in postoperative complication rate regarding wound breakdown, wound infection, lymphocele, and lymphedema. Further (larger) studies are needed to investigate the role of compression garments for reducing the morbidity of IFL.

4. Expert commentary

Where feasible we advise the implementation of separate incisions, unilateral IFL, sparing of the saphenous vein, preservation of the fascia lata, and continuous suture as the standard care for IFL in vulvar cancer patients. These surgical techniques appear to reduce the complication rates. The usage of perioperative fibrin sealant, the ‘en bloc’ approach, bilateral IFL (for lateralized tumors), and artificial dura mater should not be used as a standard surgical technique for IFL given the higher complication rates. Sartorius transposition, skin access above or below the inguinal ligament, and cadaver dura mater did not influence the complication rate and should not be implemented for IFL. Minimally invasive approach for IFL is promising in terms of reduced of complication rates, but the oncological safety remains unclear. Therefore, minimally invasive techniques for IFL should only be used within the protection of a prospective trial.

Regarding the postoperative care, there is no consensus about optimal drain management and it remains unclear if prophylactic compression garments do reduce the postoperative complication rates. Peri- and postoperative protocols should be studied more extensively before the implementation of new protocols.

Concerning the surgical technique in vulvar cancer patients, the implementation of separate incisions decreased...
the morbidity after IFL. A RCT comparing the ‘en bloc’ approach versus separate incisions investigating the oncologic safety is lacking. However, in a Cochrane review, all observational studies concerning separate incisions were pooled and they concluded that separate incisions were deemed to be oncologically safe [43].

Another surgical technique which appears promising in terms of reduction of postoperative morbidity is minimally invasive IFL. Recently, two reviews were published on this subject [44,45]. One review included ten studies including 236 procedures in 168 patients with penile, vulvar, or vaginal cancer or melanoma. They concluded that the number of wound infections, wound dehiscences, and lymphoceles appeared lower in patients operated by the VEIL technique (overall complication rate 4% of the groins) compared to the open technique [44]. The other systematic review reported an overall complication rate of 13% (lymphocele formation 3.6%, wound infection 1.2%, and lymphedema 0.4%) [45]. This review included nine studies, but only three out of these were published in English. One was included in our review [32], the others were excluded for this review (one study included also vaginal cancer patients and the other did not report data about postoperative complications). So far, no RCTs assessed this new minimally invasive surgical technique. Furthermore, none of the studies included Caucasian women. Moreover, the usage of an ultracision scalpel, which has proven to reduce the incidence of lymphoceles after axillary dissection in breast cancer patients [46], which is used during VEIL and not during the open procedure may partly explain the differences in complication rates. The results on decreasing the incidence of postoperative complications by using the minimally invasive approach are promising, but the oncologic safety of this technique is still unclear. The main concern is the high groin recurrence rate of 6.5% in patients with negative lymph nodes after VEIL [39]. The oncologic safety of pelvic lymph node dissection by laparoscopy is proven for other gynecological malignancies, no differences in number of lymph nodes removed, disease recurrence and survival were reported in several studies [47,48]. A large prospective trial with adequate follow-up of at least 2 years is needed to determine the oncologic safety of VEIL and the postoperative outcomes in Caucasian women with vulvar cancer.

IFL is also performed in patients with a melanoma or penis cancer. In order to reduce bias, in our review only studies including patients with vulva cancer were included. There were several reasons for excluding other indications for IFL than vulvar cancer. First of all, the median age of patients with melanoma is lower than in patients with vulvar cancer; older patients are faced with more comorbidity than younger patients which plays a role in the incidence of postoperative complications. Furthermore, the sex of a patient may influence the complication rate after IFL; therefore, studies on penis cancer, including only men, were excluded from this review. However, more studies on the complications after IFL for melanoma and after axillary dissection for breast cancer are published. Regarding the complications after IFL in melanoma patients, a review included seven studies described different surgical approaches for IFL; applying fibrin sealant in the wound bed, different incision techniques for separate incisions, local versus general anesthesia, early mobilization or postoperative bed rest were studied, but none of these interventions showed a statistically significant reduction in complication rates [49]. A review concerning seroma formation after axillary dissection in breast cancer patients reported a decrease in complications by using ultrasonic scissors, electrothermal bipolar vessel system, suture fixation techniques to reduce the dead space, volume-controlled suction drainage, and active shoulder exercise [50].

There are some limitations to this review. First of all, there is a lack of published studies with level one evidence. As vulvar cancer is a rare disease, it is hard and not realistic to perform a large number of RCTs in vulvar cancer patients. Therefore, this review was mainly based on data from retrospective or observational studies, which is a source of bias. Another limitation was the different definitions used for complications after IFL. An attempt should be made to standardize the definitions used for postoperative wound complications in vulvar cancer patients for this will improve the comparability between published studies in the future.

### 5. Five year view

Even though new surgical modifications were implemented, the complication rate after IFL in vulvar cancer patients remains high. In the near future, more research is expected to further reduce this morbidity. Besides research on reducing the complications after IFL, research will focus on new treatment regimens in order to limit the indication for IFL. Reducing the number of patients with an indication for IFL can be achieved by the introduction of a repeat SN procedure and/or radiotherapy on the groin. However, it should be kept in mind that the consequences of a groin recurrence are significant, with a 5-year survival rate of only 0–15% [51–53]. Therefore, determination of the lymph node status remains an important part in the treatment of vulvar cancer patients.

The safety of a SN procedure in patients with a local recurrence of vulvar SCC has not been proven yet [54]. As a consequence, patients with a local recurrence after an earlier negative SN do not perceive the benefits of the SN procedure in terms of the omission of an IFL. Research concerning the safety of a (repeat) SN procedure instead of an IFL in patients with recurrent vulvar SCC is expected within the upcoming years.

In 2018, results will be expected of the GROINSS-VII study that will provide more information on the safety and efficacy of radiotherapy instead of IFL in patients with micro-metastases in the sentinel lymph nodes.

Replacement of IFL by other treatment options with less treatment-related morbidity but the same effectiveness and safety will be a step forward in treating vulvar SCC patients. For patients who still have an indication for IFL, research is expected on minimally invasive techniques for IFL to determine the oncologic safety and the benefits in terms of reduced postoperative morbidity. Furthermore, the device used during surgery may be a key factor in preventing postoperative complications. Peri- and postoperative care may also play an important role and also affect the postoperative
Inguinofemoral lymphadenectomy (IFL) is a part of the treatment for approximately half of the patients with primary or recurrent vulvar squamous cell carcinoma.

IFL in vulvar cancer patients is associated with post-operative groin wound complications such as wound infection, wound breakdown, lymphocele, lymphedema and cellulitis or erysipelas in up to 85% of the patients.

This review is an up to date summary of surgical techniques and peri- and postoperative care protocols that have been studied to reduce this morbidity.

Surgical techniques such as separate incisions for IFL, unilateral IFL, sparing of the saphenous vein, preservation of the fascia lata and continuous skin suture do reduce the postoperative complications.

Peri- and postoperative care is described in a few publications; it remains unclear if peri-operative prophylactic anticoagulation or antibiotics influences the number of postoperative complications. The use of post-operative prophylactic compression garments does not reduce post-operative complications. There is no consensus on the optimal duration of drainage of the groin in order to prevent postoperative complications.

After the implementation of several new surgical techniques, the morbidity after IFL decreased but remains high and clinically meaningful.

More research is needed on surgical techniques and peri- or postoperative care to further reduce the complication rates after IFL in vulvar cancer patients.

Key issues

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8. Piver MS, Malfetano JH, Lele SB, et al. Prophylactic anticoagulation and peri- and postoperative care protocols that have been studied to reduce this morbidity. It remains unclear if peri-operative prophylactic anticoagulation or antibiotics influences the number of postoperative complications. The use of post-operative prophylactic compression garments does not reduce post-operative complications. There is no consensus on the optimal duration of drainage of the groin in order to prevent postoperative complications.
This study created insight of the predictors of complications after inguinofemoral lymphadenectomy in vulvar cancer patients.


• Systematic review on VEIL in vulvar cancer patients reporting a significant decrease of complications using VEIL.


