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Letter to the Editor

In response to Rydzewski NR et al. "Role of adjuvant external beam radiotherapy and chemotherapy in one versus two or more node-positive vulvar cancer: A National Cancer Database study"

Dear editor,

In response to Rydzewski NR et al. "Role of adjuvant external beam radiotherapy and chemotherapy in one versus two or more node-positive vulvar cancer: A National Cancer Database study". Radiotherapy and Oncology [1].

In this interesting study on the impact of adjuvant (chemo) radiotherapy in patients with vulvar cancer and positive lymph nodes, the authors conclude that "all patients with node positive disease benefited from adjuvant radiotherapy". This conclusion also implies that patients with a single positive lymph node would benefit from adjuvant radiotherapy. The last statement is definitely subject to debate. Conflicting data have been reported in the past about the value of adjuvant radiotherapy in this particular group of patients with a single positive lymph node.

As mentioned by the authors in the discussion section, a strength of this study is the large number of patients with a single positive node. However a significant flaw of this study is the lack of details about clinical, surgical and pathological variables in the group of patients with a single positive lymph node. For example the clinical N status of the nodes is important to know, because in GOG 37 adjuvant radiotherapy was beneficial for patients with 2 or more positive nodes and also for patients with a single clinical suspicious and positive lymph node, while a beneficial effect for a single occult nodal metastasis could not be shown [2]. The type of surgery is also important to know, because if only a superficial (inguinal) node dissection was carried out, without adjuvant radiotherapy we know that the groin recurrence rate is high because of residual lymph node metastasis in the deeper femoral nodes [3]. Performing a proper complete inguino femoral lymph node dissection (IFL) can prevent this and is therefore considered standard treatment. Do we know how many patients in this study with a single positive node maybe only had a nodal debulking of a clinical bulky positive node? These patients have a very poor prognosis, irrespective of radiotherapy and should not be included in a study like this [4]. Finally and probably most important, do we know the status of the capsule in the tumor positive lymph node? Extra capsular disease, even in a single tumor positive lymph node has a negative impact on the prognosis of the patient, while the patient with a single intracapsular metastasis has a relatively good prognosis [5–7]. All these variables are not available in the Rydzewski study.

In a case–control study, mentioned by Rydzewski et al. in the discussion section, Fons and coworkers could not show a beneficial effect of adjuvant radiotherapy in the group of patients with a single intracapsular positive node [7]. We feel that, taking all the before mentioned arguments into account, the statement that all patients will benefit from adjuvant radiotherapy is too strong and that an exception should be made for the patients with an occult single intracapsular metastasis after a proper inguino femoral lymph node dissection. This is more in line with the ESGO guideline in which postoperative radiotherapy to the groin is recommended for cases with >1 metastatic lymph node and/or presence of extracapsular lymph node involvement (grade B) [8].

Conflict of interest

None declared.

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