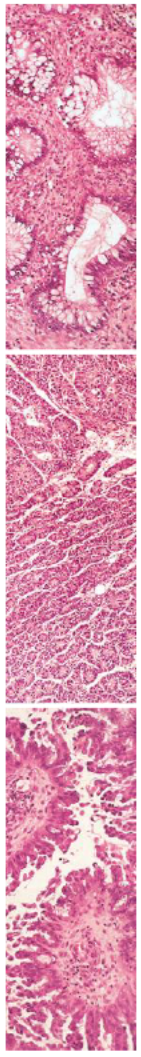

Vulvo Vaginal Melanoma

Stuart Salfinger

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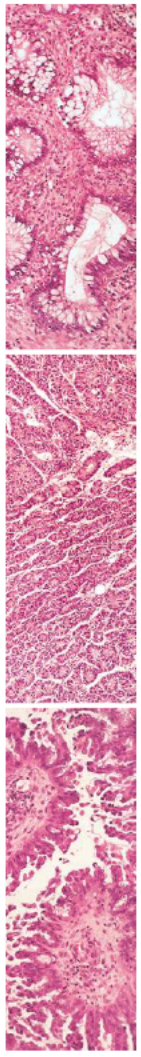
Gynaecologic Oncologist

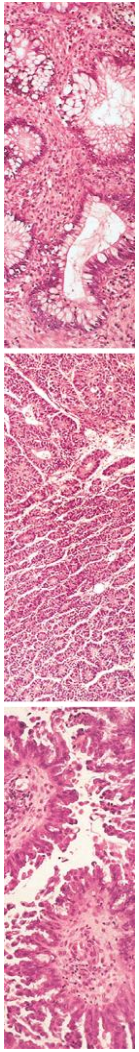
WESTERN AUSTRALIAN GYNAE&SURGERY



Female urogenital melanoma

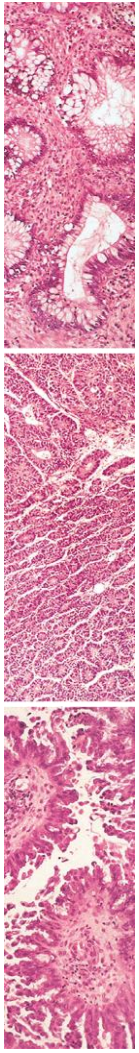
- Vulval melanoma – 95%
  - 10% malignant vulvar tumours
  - <1% all melanoma
- Vaginal melanoma – 3%

WESTERN AUSTRALIAN GYNAE&SURGERY



Symptoms

- Pruritus
- vaginal bleeding
- vaginal discharge
- Dyspareunia
- mass

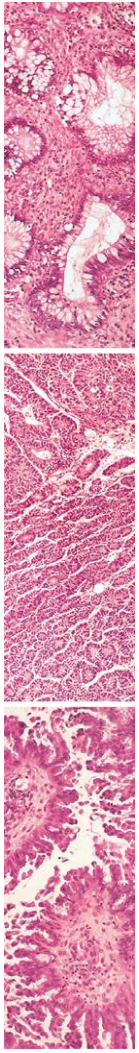


Vulvar melanoma

White population

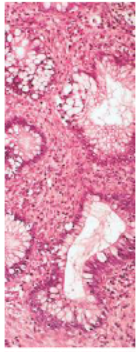
Late 60’s

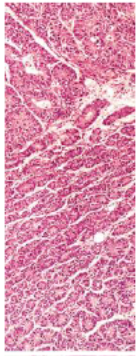
- A – asymmetric
- B – border irreg/scalloped
- C – colour – black (variegate RWB)
- D – diameter >6mm
- E – evolving

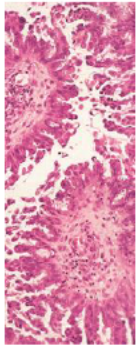


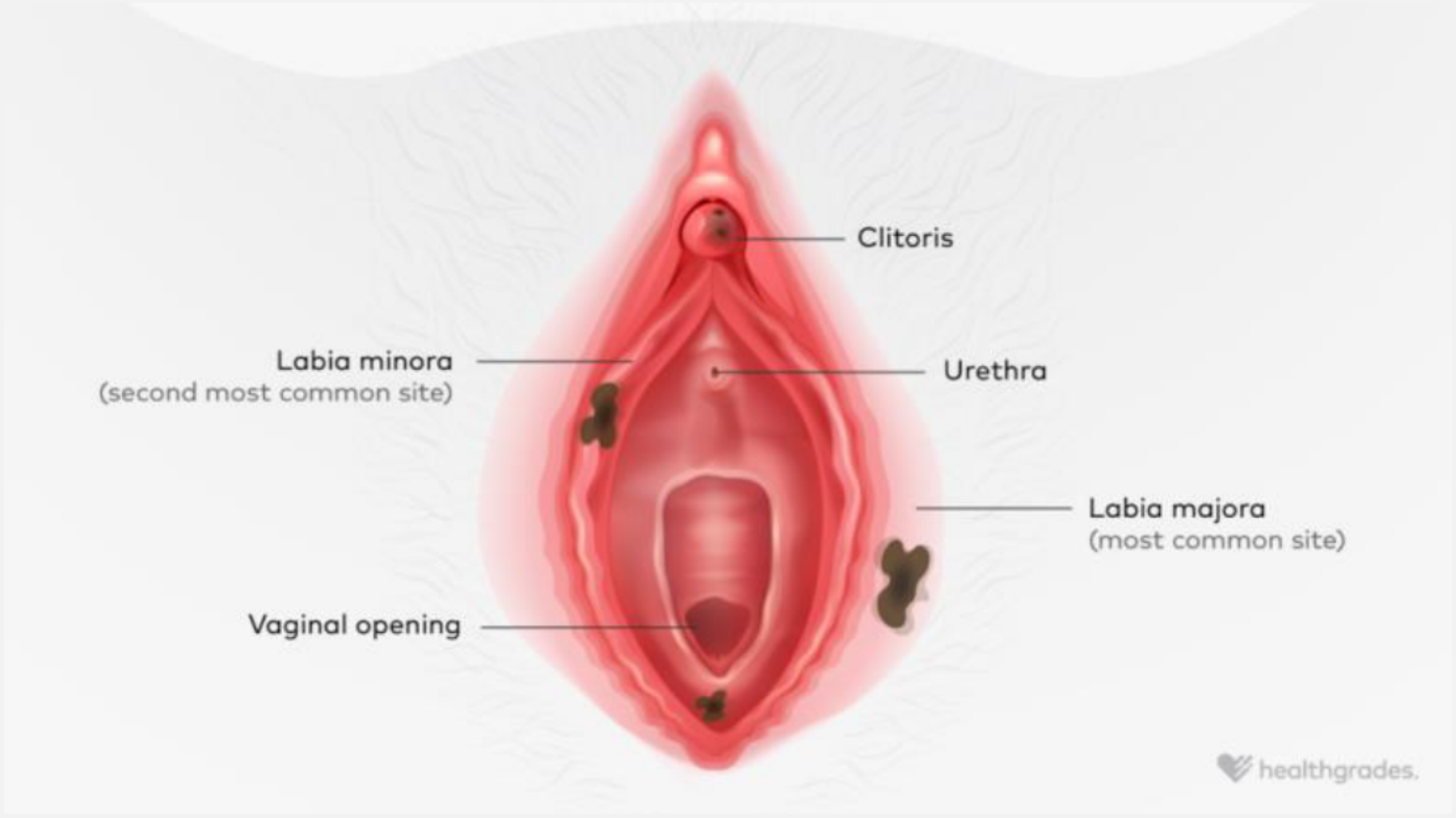
Other pigmented lesions

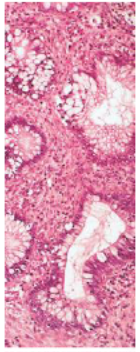
- Vulvar melanosis – 60-70 pigmented lesions
  - Poorly demarcated, asymmetric, younger women
- Melanocytic nevi - sharp margins, stable
- Varicosities
- Pigmented BCC
- Papillary hidradenoma
- Acanthosis nigrans

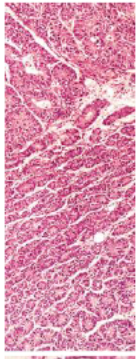


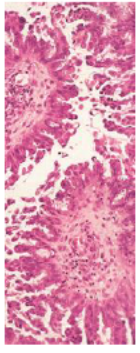


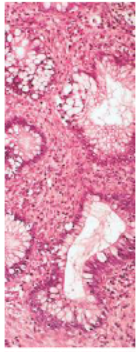


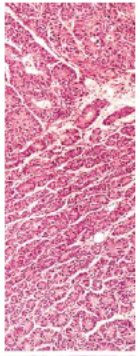

Clitoris
Labia minora
(second most common site)
Urethra
Labia majora
(most common site)
Vaginal opening
healthgrades.

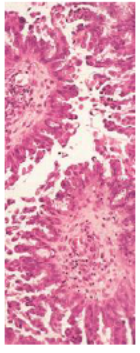


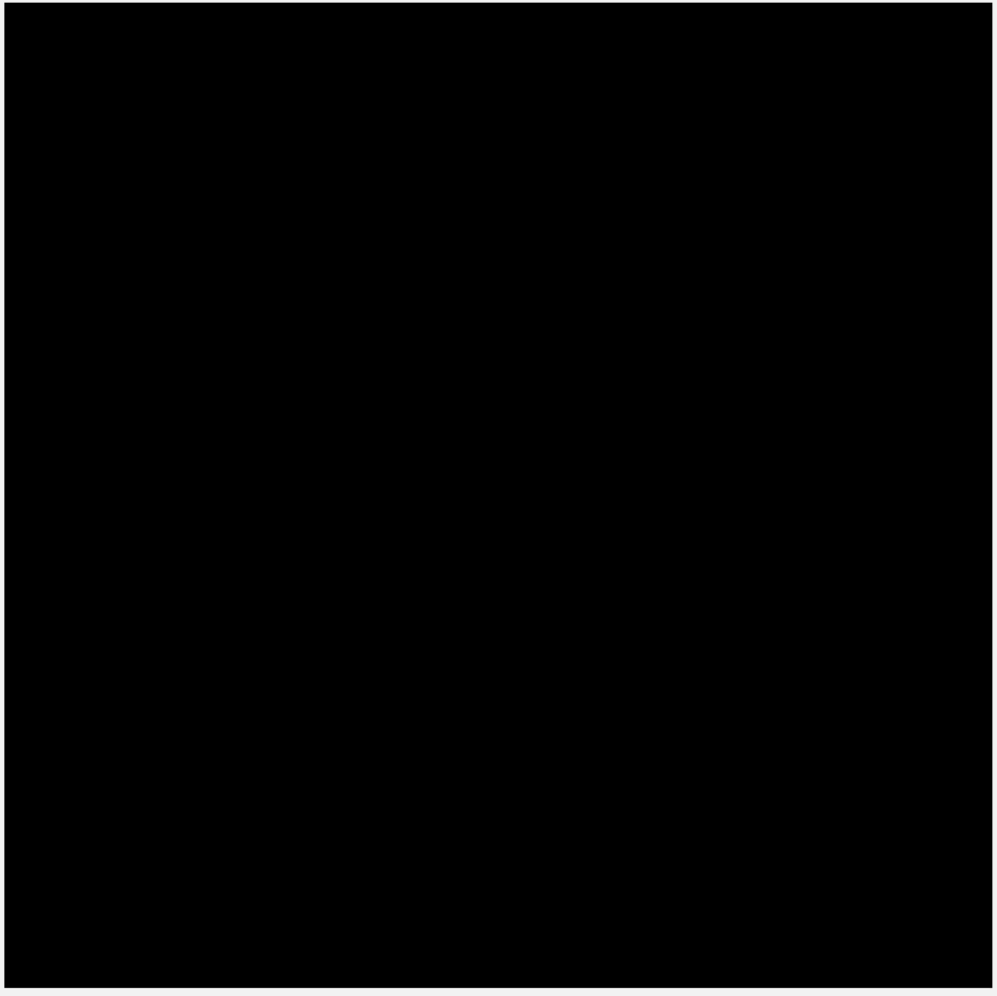


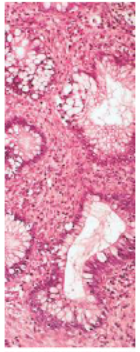


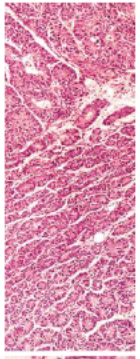


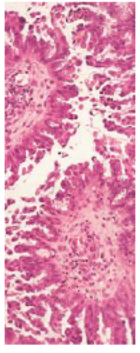


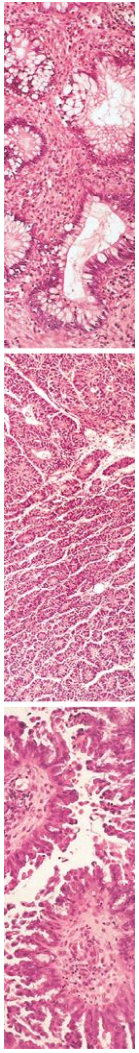








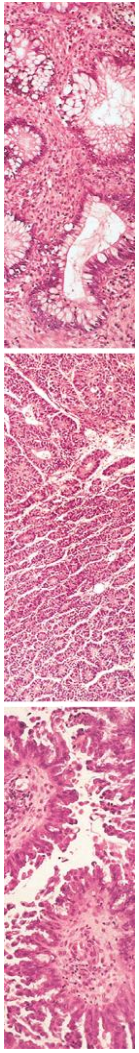




Diagnosis

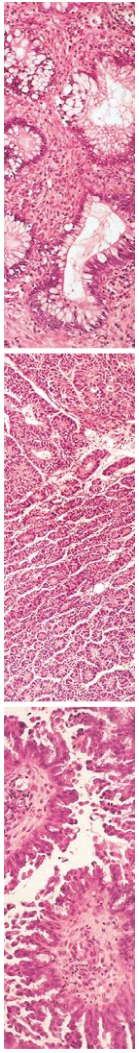
Biopsy

- LA infiltrate
- Keys punch biopsy, fine scissors and forceps.
- Silver nitrate or monsels, suture
- Good pathologist



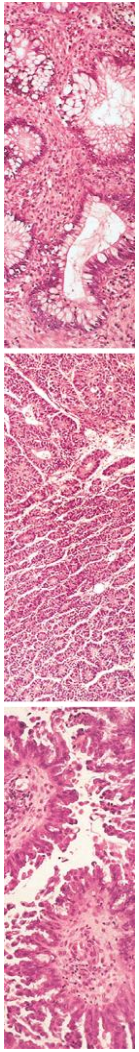
Risk factors

- Outer, nonglabrous hair bearing area labia majora (cf skin melanoma)
- Arise from contiguous nevi
- Chronic inflammation
- Viral infections
- Chemical irritants
- Genetic factors



Staging evaluation

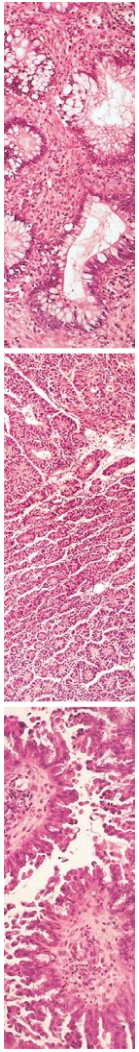
- Clinical assessment
- CT or MRI
- PET
- Imaging Chest/Abdo/Pelvis/CNS



Vulvar Survival by Staging - TNM

- Stage 0 – 77%
- Stage I – 70%
- Stage II – 50%
- Stage III – 48%
- Stage IV – 24%

AJCC > Clarks/Breslow/FIGO



Vaginal melanoma staging

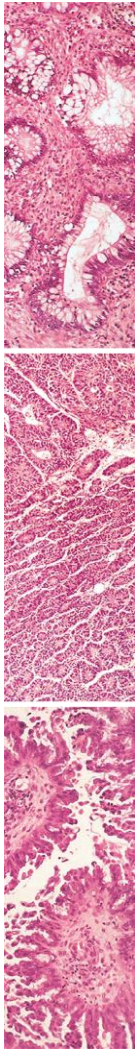
Simplified staging

- I – local disease
- II – locoregional mets
- III – distant mets

None useful for survival

Tumour size <3cm vs >3cm

Vaginal melanoma survival 5-25%

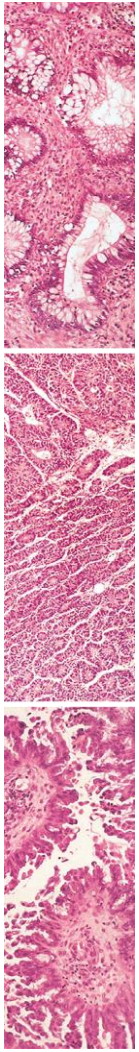


Vulvar melanoma - Treatment

- WLE
- Radical vulvectomy
- <1mm – 1cm margin
- >1mm 2cm margin

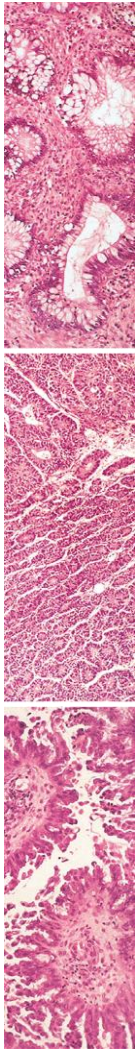
Balance radicality for local control with risk of distant mets

No diffence OS with more radical local excision



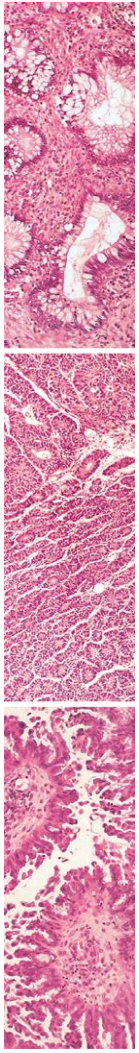
Vaginal melanoma treatment

- WLE if feasible
- Margins difficult – anatomic and multifocal nature
- Increased use adjuvant RT



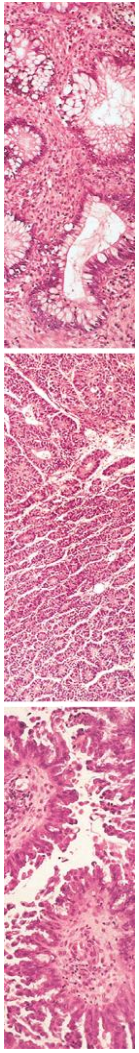
Lymph nodes

- Positive nodes – prognostic factor along with tumour thickness
- Radical vulvectomy and bilat inguino-femoral lymphadenctomy no benefit over WLE alone



Lymph Nodes

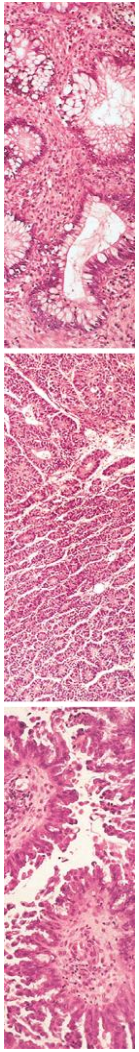
- Sentinel – identify locoregional mets – patients benefit from adjuvant systemic
- Elective regional lymphadenectomy – no survival benefit



Other therapies

For more advanced or metastatic disease, other options may be considered:

- •Immunotherapy: This has shown promise for some advanced vulvar melanomas.
- Targeted therapy: This may be an option for cases with specific gene mutations like BRAF or KIT.
- Radiation and chemotherapy: These may have a role as adjuvant (additional) treatment, but their benefit is still being studied.



Conclusions

- Rare tumors
- Need biopsy to assess
- Local treatment excision adequate margin
- Nodes – prognostic not therapeutic