



European Association of Urology

GUIDELINES ON PENILE CANCER*

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1 INTRODUCTION

The European Association of Urology (EAU) consensus group on penile cancer has prepared these guidelines¹ to help urologists assess the scientific evidence for the management of penile cancer and to incorporate recommendations into their clinical practice. References used in the text have been assessed according to the level of scientific evidence involved, as indicated by Table 1. Guideline recommendations have also been evaluated (Table 2), according to the Agency for Health Care Policy and Research (1).

Table 1: Levels of evidence

Evidence level	Type of evidence
1a	Evidence obtained from meta-analysis of randomized trials
1b	Evidence obtained from at least one randomized trial
2a	Evidence obtained from one well-designed controlled study without randomization
2b	Evidence obtained from at least one other type of well-designed quasi-experimental study
3	Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports
4	Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

Table 2: Grades of guideline recommendations (1)

Grade	Nature of recommendations
A	Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B	Based on well-conducted clinical studies, but without randomized clinical trials
C	Made despite the absence of directly applicable clinical studies of good quality

1.1 REFERENCE

1. Agency for Health Care Policy and Research.

Clinical Practice Guidelines Development: Methodological Perspectives. Washington DC: US Department of Health and Human Services, Public Health Service, 1992, pp. 115-127.

2 BACKGROUND

Penile carcinoma is an uncommon malignant disease, with an incidence of 0.1-7.9 per 100,000 males. In Europe, the incidence is 0.1-0.9 per 100,000, and in the USA, 0.7-0.9 per 100,000. In some areas of Asia, Africa and South America, the incidence is significantly higher at 19 per 100,000 (1); in these countries, penile carcinoma accounts for as many as 10-20% of male cancers.

Penile carcinoma essentially metastasizes via the lymphatic system and develops mainly through the embolization mechanism instead of lymphatic permeation. Distant metastases are very rare and are a result of vascular dissemination (2). Spreading essentially develops in stepwise fashion; inguinal lymphatic spread occurs first, followed by pelvic metastases, and lastly by distant metastases. As a consequence, it is extremely rare to observe patients with positive pelvic nodes or distant metastasis without inguinal lymph-node involvement.

The primary tumour is localized to the glans in 48% of cases, prepuce in 21%, both glans and prepuce in 9%, coronal sulcus in 6%, and less than 2% in the shaft (3). Palpable inguinal nodes are present at diagnosis in 58% of patients (range 20-96%) (4). Of these patients, 17-45% have nodal metastases, while the remaining patients have inflammatory disease secondary to an infection of the primary tumour (4-6: Evidence level 2a).

The likelihood of bilateral involvement is considerable because of the large number of penile lymphatics in the subcutaneous tissue. Pelvic nodal involvement is found in 22-56% of patients with metastases to two or more nodes (7-9: Evidence level 2b). About 20% of patients with non-palpable nodes harbour nodal micrometastases. The occurrence of nodal metastases is affected by the depth of invasion, tumour grade, vascular and lymphatic involvement, corpora cavernosa involvement and growth pattern and the associations of these factors (10-12: Evidence level 2a).

An overall 5-year survival rate of 52% has been reported. This ranges from 66% in patients with negative lymph nodes to 27% in patients with positive nodes (4,6,8, 13-15: Evidence level 2a), and 0-38.4% in patients with pelvic node involvement (4,8,9,16: Evidence level 2b). Most patients are elderly and the neoplasm has a slow growth rate. Death from cancer is usually a consequence of local complications, such as infection, haemorrhage of the ulcerated tumour or ulcerated inguinal metastases.

There are still many controversies regarding the management of penile cancer. Treatment of the primary tumour tends to be more organ-preserving, in order to maintain sexual function and a better quality of life (1,15,17-19: Evidence level 2b). There is also debate about the need and extent of lymphadenectomy in clinically node-negative patients (1,20). Social and cultural habits also seem to be important factors in penile cancer, as exemplified by the fact that 44-90% of patients suffer from phimosis at presentation (2) and the documented association between human papillomavirus (HPV) and penile carcinoma (21-23: Evidence level 2a).

All these factors, together with the low incidence rate in countries with good socio-economic conditions and the absence of large or randomized trials, have an important influence on the management of penile cancer.

2.1 Classification

2.1.1 Pathology

Squamous cell carcinoma (SCC) is by far the most common malignant disease of the penis, accounting for more than 95% of cases. Malignant melanomas and basal cell carcinoma are less common. The extent to which SCC is preceded by pre-malignant lesions (3,24: Table 3) is unknown. Although SCC is the most common penile neoplasia, it manifests in several different types and with varying growth patterns (24-26: Table 4).

Mesenchymal tumours are very uncommon (3), with an incidence rate of less than 3% (e.g. Kaposi's sarcoma, angiosarcoma, epithelioid hemangioendothelioma).

The penis is a very rare metastatic site, but bladder, prostate, renal and rectal tumours have been reported as primary tumours in cases of metastatic disease (3).

Table 3: Premalignant lesions

Lesions sporadically associated with SCC of the penis (3,24: Evidence level 2b)	
•	Cutaneous horn of the penis
•	Bowenoid papulosis of the penis
Lesions at high risk of developing SCC of the penis (up to one-third transform to invasive SCC (24: Evidence level 2a)	
•	Penile intraepithelial neoplasia (consider carcinoma <i>in situ</i>) (erythroplasia of Queyrat, Bowen's disease)
•	Balanitis xerotica obliterans

Table 4: Penile neoplasias (SCC)

Types of SCC	
•	Classic
•	Basaloid
•	Verrucous and its varieties (24):
•	Warty (condylomatous) carcinoma
•	Verrucous carcinoma
•	Papillary carcinoma
•	Hybrid verrucous carcinoma
•	Mixed carcinomas (warty-basaloid carcinoma, adeno-basaloid carcinoma)
•	Sarcomatoid
•	Adenosquamous
Growth patterns of SCC	
•	Superficial spread
•	Nodular or vertical-phase growth
•	Verrucous
Differentiation grading systems for SCC	
•	Broders system (25): traditionally used as a grading system
•	Maiche system score (26): currently seems to be the most suitable grading system

2.1.2 TNM staging

The 1997 and 2002 Tumour Node Metastasis (TNM) classification for penile cancer is shown in Table 5 (27).

Table 5: The 1997/2002 TNM (Tumor, Node, Metastasis) classification of penile cancer (27)

T - Primary tumour	
TX	Primary tumour cannot be assessed
T0	No evidence of primary tumour
Tis	Carcinoma <i>in situ</i>
Ta	Non-invasive verrucous carcinoma
T1	Tumour invades subepithelial connective tissue
T2	Tumour invades corpus spongiosum or cavernosum
T3	Tumour invades urethra or prostate
T4	Tumour invades other adjacent structures
N - Regional lymph nodes	
NX	Regional lymph nodes cannot be assessed
N0	No evidence of lymph node metastasis
N1	Metastasis in a single inguinal lymph node
N2	Metastasis in multiple or bilateral superficial lymph nodes
N3	Metastasis in deep inguinal or pelvic lymph nodes, unilateral or bilateral
M - Distant metastasis	
MX	Distant metastases cannot be assessed
M0	No evidence of distant metastases
M1	Distant metastases

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3 RISK FACTORS FOR PENILE CARCINOMA

Phimosis and chronic irritation processes related to poor hygiene are commonly associated with this tumour, whereas neonatal circumcision gives a protection against the disease (1: Evidence level 2a). There is strong evidence that HPV types 16 and 18 are associated with penile carcinoma in as many as 50% of cases, as well as to penile carcinoma *in situ*, basaloid and warty verrucous varieties in more than 90% of cases (1-3: Evidence level 2a).

The best prognostic factors related to survival are the presence of positive lymph nodes, the number and site of positive nodes and the extracapsular nodal involvement (4-9: Evidence level 2a). These are therefore important factors to consider when applying complementary therapies following lymphadenectomy pathological examination.

Predictive factors for the presence of lymph node metastasis have been assessed thoroughly. Important predictive factors include parameters from the primary tumour, i.e. location, size, tumour grade, corpora cavernosa invasion (10,11) and the association of some of these factors (12). These factors have been corroborated by multivariate analysis (7,8,13-15: Evidence level 2a), and have been used to define high-, intermediate- and low-risk groups for lymph node metastasis (9,11,12). These risk groups have been recently widely accepted in the literature (13,16,17) and prospectively validated (18: Evidence level 2a). Other important predictive factors with particular relevance in the intermediate-risk group include vascular, lymphatic invasion, depth of invasion and growth pattern of the primary tumour (19,20). All these factors have been taken into account when outlining the therapy recommendations given in these guidelines (see 5.2.1 Non-palpable nodes).

Molecular markers are under investigation as prognostic factors, but they currently have no use in clinical practice (21-23). More promising results have been reported with p-53 overexpression (22,24) and SCC antigen in predicting nodal involvement (25); nonetheless, these results need to be prospectively validated before they can be incorporated into clinical practice.

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4 DIAGNOSIS

In order to establish a rational diagnostic approach to penile cancer, it is important to take into account the primary lesion, regional lymph nodes and distant metastases, both initially and during follow-up.

4.1 Primary lesion

Patients with a suspicious penile lesion should undergo physical examination. This is often sufficient to determine the diagnosis and staging, as well as aiding therapeutic decision-making. It is important to record:

- Diameter of the penile lesion or suspicious areas
- Location(s) on the penis
- Number of lesions
- Morphology of the lesion, whether papillary, nodular, ulcerous or flat
- Relationship with other structures (e.g. submucosa, corpora spongiosa and/or cavernosa, urethra)
- Colour and boundaries of lesion.

Cytology or histological diagnosis is absolutely necessary before making treatment decisions. The aim is not only to confirm the pathological diagnosis, but also to determine the tumour grade. The information will assist in making therapeutic decisions concerning the primary tumour, as well as in establishing risk groups for regional therapeutic strategy (1). The preference of the pathologist should be taken into account when choosing the most suitable histological diagnostic method. The pathological diagnosis can be made by incisional biopsy, tissue core biopsy, fine-needle aspiration, or brush biopsy (like cervical cancer). Excisional biopsy can also be used as a conservative approach for a small lesion located in the prepuce or in another feasible area.

Diagnostic imaging, ultrasound or magnetic resonance imaging (MRI) can assist in identifying the depth of tumour invasion, particularly with regard to corpora cavernosa infiltration (2,3: Evidence level 3). However, penile ultrasound imaging is sometimes difficult to interpret and is an unreliable method for detecting microscopic infiltration (4).

4.2 Regional nodes

A careful inguinal physical examination is necessary, taking into account the following aspects.

4.2.1 Non-palpable nodes

There is no indication for imaging or histological examination if the nodes are non-palpable. If poor prognostic factors were observed with the primary tumour, it is advisable to perform pathological surgical inguinal nodal staging (*see later*). Nevertheless, sentinel node biopsy, as described by Cabanas (5), is not recommended because false-negative rates have been reported as high as 25% (range 9-50%) (6). However, there have been recent reports of a dynamic sentinel lymph-node biopsy, using isosulphan blue and/or ^{99m}Tc-colloid sulphur, which is a promising, new procedure (7,8). The preliminary results have been corroborated with a specificity of 100% and a sensitivity of 78-80% (9-12) and have recently been validated in a prospective study (13: Evidence level 2a). The sensitivity and specificity of this method need to be confirmed in randomized studies.

4.2.2 Palpable nodes

The following parameters should be recorded if palpable nodes are present:

- Diameter of node(s) or mass(es)
- Uni- or bilateral localization
- Number of nodes identified in each inguinal area
- Mobile or fixed nodes or masses

- Relationship to other structures (e.g. skin, Cooper ligament) with respect to infiltration, perforation, etc.
- Presence of oedema on leg and/or scrotum.

As many as 50% of palpable inguinal nodes at diagnosis are reactive nodes rather than metastatic. In contrast, nearly 100% of enlarged nodes that appear during follow-up are metastatic (14-16: Evidence level 2a). Thus, regional nodes should be evaluated a few weeks after treatment of the primary tumour, in order to allow the inflammatory reaction to subside.

The histological diagnosis involves fine-needle aspiration biopsy, tissue core biopsy, or open biopsy according to the preference of the pathologist (17,18: Evidence level 2b). In case of a negative biopsy and clinically suspicious nodes, a repeat biopsy or excisional biopsy should be performed. Imaging techniques (computed tomography (CT) scan, MRI) have been used. They continue to be widely used, but are very expensive and more useful for staging than for early detection. Positron emission tomography (PET) scan is under investigation (19).

4.3 Distant metastases

An assessment of distant metastases should only be performed in patients with proven positive nodes (20,21: Evidence level 2b). Pelvic/abdominal CT scanning is used in the identification of pelvic and/or retroperitoneal nodes in patients with inguinal metastases. Although this is not a reliable diagnostic method (22), the detection of pelvic masses has a considerable impact on therapy and prognosis (23,24). A chest radiograph should be performed on patients with positive lymph nodes. Routine blood determinations should be carried out only in patients with bulky inguinal masses and pelvis nodes, and in those with metastasis (25,26). A bone scan is recommended only in symptomatic cases (20). A diagnostic schedule is summarized in Table 6.

Table 6: Diagnosis schedule for penile cancer

Lesion level	Procedures		
	Mandatory	Advisable	Optional
Primary tumour	Physical examination Cytological or histological diagnosis	Ultrasound (if corpora cavernosa invasion suspected)	MRI (if ultrasound inconclusive)
Regional disease			
• Non-palpable nodes	Physical examination	Dynamic sentinel node biopsy ¹	
• Palpable nodes	Cytological or histological diagnosis		
Distant metastases		Pelvic CT (if inguinal nodes +ve) Abdominal CT (if pelvic nodes +ve) Chest radiography (if nodes +ve)	Bone scan (in symptomatic patients)

MRI = magnetic resonance imaging.

¹ Cabanas technique (5) is no longer advisable. Isosulphan blue or ^{99m}Tc-colloid sulphur is a promising new procedure (7-13).

4.4 Guidelines on diagnosis of penile cancer

Primary tumour

1. Physical examination is mandatory, recording morphological and characteristics of physical lesion (Grade B)
2. Cytological or histological diagnosis is also mandatory (Grade B)
3. Imaging: penile ultrasound is advisable to demonstrate corpora cavernosa invasion. In cases of inconclusive results, ultrasound or MRI is an optional method (Grade C)

Regional lymph nodes

1. Physical examination is mandatory (Grade B)
2. If nodes are non-palpable, there is no indication for imaging or histological examination. A new technique, dynamic sentinel node biopsy, is showing its predictive value in intermediate- and high-risk patients and is advisable (Grade B)
3. If nodes are palpable, it is mandatory to record nodal morphological and physical characteristics and to perform a histological diagnosis (Grade B)

Distant metastasis (only in patients with metastatic inguinal nodes) (Grade B)

1. A pelvic/abdominal CT scan (positive pelvic nodes) is advisable
2. A chest radiography is also advisable
3. Routine laboratory determinations are optional for specific conditions
4. A bone scan is only recommended in symptomatic cases

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5 TREATMENT

5.1 Primary lesion

5.1.1 Penile intraepithelial neoplasia

In cases of penile intraepithelial neoplasia, a penis-preserving strategy is strongly recommended.

The following therapies have been used successfully (1,2: Evidence level 3):

- laser therapy (carbon dioxide (CO₂)-laser or Neodymium:Yttrium-Aluminum-Garnet: Nd-YAG)
- cryotherapy
- photodynamic therapy
- topical imiquimod, 5%
- 5-fluorouracil (5-FU) cream
- local excision
- Mohs' surgery.

The therapeutic approach should be decided according to the preferences of the surgeon and patient and available technology.

5.1.2 Category Ta-1G1-2

For patients who can guarantee regular follow-up, a penis-preserving strategy is strongly recommended, i.e. laser therapy (3-7), local excision plus reconstructive surgery (8-10), radiotherapy or brachytherapy (11-16), glansectomy (10,17) (Evidence level 2a). With radiotherapy and laser therapy, the organ-preserving rate is 55-84%.

There is no difference in the local recurrence rates (15-25%) between micrographic surgery, external radiation therapy, interstitial brachytherapy and laser therapy. However, with traditional conservative surgery, the recurrence rate is more variable at 11-50% (10). A pathological assessment of surgical margins is essential in applying these procedures and to reduce the rate of local recurrence to 9-24% (9,18,19: Evidence level 2b). Meticulous follow-up is essential so that local disease recurrences can be treated as soon as possible.

Generally, a local recurrence need not have a negative impact on survival (12,20: Evidence level 3). In patients who do not comply with regular follow-up, partial amputation is an optional recommendation.

5.1.3 Category T1G3, T≥2

Partial or total amputation, or emasculation according to tumour extent, can be considered to be standard therapies (2,10,21,22: Evidence level 2a).

A conservative strategy is an alternative in very carefully selected patients with tumours encompassing less than half of the glans and in whom a close follow-up can be carried out (17,23: Evidence level 2b).

Chemotherapy induction courses within the context of a clinical trial, followed by conservative procedures in cases of complete or partial response, can be considered an investigational recommendation. Promising results have been reported with the latter procedure, even in cases of corpora cavernosa infiltration (12,24-26: Evidence level 3).

5.1.4 Local disease recurrence

For local recurrence after conservative therapy, a second conservative procedure is strongly advised if there is no corpora cavernosa invasion (7,20: Evidence level 2b). However, if there is a large or a deep infiltrating recurrence, partial or total amputation is strongly recommended.

5.1.5 Radiotherapy

External beam irradiation or brachytherapy can ensure excellent results in infiltrating tumours less than 4 cm in diameter. Late sequelae (e.g. meatal stenosis, skin necrosis) are not uncommon. The use of a single technique achieves better results than combined external beam irradiation and brachytherapy (11-16: Evidence level 2a).

5.2 Regional nodes

In penile carcinoma, the success of therapy is related to lymph node status and treatment. Lymphadenectomy is an effective therapy for patients with positive lymph nodes (21,22,27-29: Evidence level 2a). However, this procedure is associated with a high morbidity rate of 30-50% (2,30), even with modern technical modifications (31-33). This morbidity precludes its prophylactic use, although some controversy still surrounds this aspect (1,34). The rational use of lymphadenectomy requires a careful groin assessment and an awareness of predictive factors for positive lymph nodes (35-37).

5.2.1 Non-palpable nodes

Analysis (uni- and multivariate) of prognostic factors has identified three risk groups for developing nodal metastases (2,4,38,39: Evidence level 2a).

Low-risk group: In patients at low risk of developing nodal micrometastases (pTis, pTaG1-2 or pT1G1), a surveillance programme is strongly advised because the probability of occult micrometastases occurring in inguinal lymph nodes is less than 16.5% (38-40: Evidence level 2a). If patients are considered unreliable for follow-up, a 'modified' inguinal lymphadenectomy is an optional recommendation.

Intermediate-risk group: In cases of intermediate risk (T1G2), therapeutic decision-making should take into account vascular or lymphatic invasion and growth pattern (35-37: Evidence level 2a).

In patients with no vascular or lymphatic invasion, or a superficial growth pattern on the primary tumour, a surveillance programme is mandatory. However, modified lymphadenectomy is strongly recommended in cases of vascular or lymphatic involvement or of infiltrating growth pattern, unless patients can reliably receive regular follow-up. The current high reliability of dynamic sentinel node biopsy demonstrated in recent reports (41: Evidence level 2a) can replace the use of predictive factors in indicating the need for modified lymphadenectomy in this risk group.

High-risk group: In patients at high risk of nodal involvement (T (2 or G3), modified or radical inguinal lymphadenectomy is strongly recommended. In these patients, the incidence of occult metastases ranges between 68% and 73% (4,38-40: Evidence level 2a).

A modified lymphadenectomy can be extended to a radical lymphadenectomy if positive nodes are present on frozen sections.

5.2.2 Palpable nodes with positive histopathology

Positive palpable nodes: Bilateral radical inguinal lymphadenectomy is strongly recommended in cases of positive palpable nodes.

There is great controversy about when to perform pelvic lymphadenectomy. Immediate or delayed pelvic lymphadenectomy can be performed in cases where two or more positive inguinal lymph nodes or extracapsular invasion are found upon frozen section biopsies or standard pathology examination. In these cases, the incidence of positive pelvic nodes increases up to 30% (28: Evidence level 2b).

Overall, the probability of pelvic lymph nodes is 23% when 2-3 inguinal nodes are involved and 56% when more than 3 nodes are involved (42: Evidence level 2b). In these cases, metastases are often microscopic and offer the possibility of cure in 14-54% (28,43: Evidence level 2b).

In the contralateral inguinal area with no palpable nodes modified, lymphadenectomy can be considered initially and may be extended if positive nodes are present in frozen section biopsies.

Fixed inguinal masses or clinically positive pelvic nodes (CT scan or MRI): For patients with fixed inguinal masses or clinically positive pelvic nodes (CT scan or MRI), induction courses of chemotherapy can provide partial or complete clinical responses in 21-60% (35,42-51: Evidence level 2b). Subsequent radical ilio-inguinal lymphadenectomy is strongly recommended (4,34,42,44,51: Evidence level 2b). However, this strategy should be used as part of a clinical trial.

Another strategy is to use pre-operative radiotherapy (52-54), but the increased morbidity of lymphadenectomy after radiotherapy should be taken into account (22: Evidence level 3). Nevertheless, this approach is known to be beneficial with other types of cancer, e.g. rectal and SCC of head and neck regions.

Appearance of inguinal palpable nodes during follow-up: When inguinal palpable nodes appear during a surveillance programme, two treatments are strongly recommended.

- The first treatment is bilateral radical inguinal lymphadenectomy following similar criteria to that discussed above.
- The second treatment is inguinal lymphadenectomy, performed at the site of positive nodes, in the case of a long disease-free interval. The development of positive nodes in both inguinal areas after surveillance should appear synchronously, or within a very short interval in both inguinal areas. The probability of developing subsequent late lymph node metastases in the contralateral inguinal area after initial unilateral inguinal lymph-node recurrence is approximately 10% (55: Evidence level 3). Unilateral lymphadenectomy could be warranted in these cases, but a follow-up programme is advised. However, when there is more than one pathological lymph node in unilateral lymphadenectomy, the probability of occult contralateral involvement is approximately 30% and warrants an early bilateral inguinal lymphadenectomy (29: Evidence level 3).

Adjuvant therapy is advised when there are two or more positive nodes or extracapsular nodal involvement upon pathological examination, as these patients have a poorer prognosis than patients with a single positive lymph node (51-58: Evidence level 2a). The results of phase II trials suggest that adjuvant chemotherapy is beneficial for these patients (51,56-58: Evidence level 2b). However, these adjuvant programmes should be performed as part of controlled clinical trials. Fewer data are available on adjuvant radiotherapy (52,54: Evidence level 3).

5.3 GUIDELINES ON TREATMENT OF PENILE CARCINOMA

5.3.1 Recommendations for therapy of primary lesion

Penile intraepithelial neoplasia

- Penis-preserving strategy is strongly recommended (Grade B)

Category Ta-1G1-2

- Penis-conservative strategy is strongly recommended
- In patients who do not comply with regular follow-up, partial amputation is an optional alternative (Grade B)

Category T1G3, T_≥2

- Partial or total amputation or emasculation according to tumour extent can be considered as standard therapy (Grade B)
- Conservative therapies in very carefully selected patients (Grade B)
- Chemotherapy followed by conservative procedures is an investigational option (Grade C)

Local disease recurrence following conservative therapy

- A second conservative procedure is strongly advised if there is no corpora cavernosa invasion (Grade B)
- If there is a large or infiltrating recurrence, partial or total amputation is strongly recommended (Grade B)

5.3.2 Recommendations for regional node therapy if non-palpable nodes

Low risk of occult metastases (pTis, pTaG1-2, pT1G1)

- Surveillance programme is strongly advised.
- For patients considered unreliable for surveillance, modified lymphadenectomy is an optional recommendation (Grade B)

High risk of occult metastases (pT_≥2 or G3)

- Modified or radical lymphadenectomy is strongly recommended (Grade B)

Intermediate risk of occult metastases (pT1G2)

- Therapeutic decision-making can be aided by considering the vascular or lymphatic invasion and growth pattern (Grade B)
- Strict surveillance is an option in patients without such findings and suitable for reliable and regular follow-up (Grade B)
- Modified lymphadenectomy is an option in patients with poor histological findings (Grade B)
- A dynamic sentinel lymph node biopsy with isosulphan blue or/and ^{99m}Tc-colloid sulphur is an alternative method for indicating lymphadenectomy when technology is available
- Modified lymphadenectomy can be enlarged to a radical lymphadenectomy if positive nodes are present (Grade B)

5.3.3 Recommendations for regional node therapy if palpable pathological positive nodes

- Bilateral radical inguinal lymphadenectomy is the standard recommendation (Grade B)
- Pelvic lymphadenectomy could be performed in cases with at least two positive inguinal nodes or extracapsular invasion (Grade B).
- Modified lymphadenectomy can initially be considered on the contralateral inguinal area with no palpable nodes (Grade B)
- Patients with fixed inguinal masses or clinically positive pelvic nodes (CT or MRI) are good candidates for induction chemotherapy followed by radical ilio-inguinal lymphadenectomy (Grade B). Another strategy is to use pre-operative radiotherapy, but this has possible harmful complications (Grade C)
- When inguinal palpable nodes appear during a surveillance programme, there are two possible recommendations:
 - bilateral radical inguinal lymphadenectomy
 - inguinal lymphadenectomy at the site of positive nodes, according to the disease-free interval and if less than two positive lymph nodes were found on the specimen (Grade B). Adjuvant chemotherapy is an advisable recommendation when there are at least two positive nodes or extracapsular nodal involvement; another option is adjuvant radiotherapy (Grade C)

5.4 Integrated therapy

In patients presenting with a primary tumour together with positive nodes, both problems should be managed simultaneously. In patients presenting initially with positive pelvic nodes, induction chemotherapy can be administered first. Radical or palliative surgery or radiotherapy is indicated according to the tumour response.

5.5 Distant metastases

Chemotherapy or palliative therapy can be tried, according to the patient's age, performance status and preference. Because of the poor efficacy of chemotherapy in metastatic disease, this approach is only optionally recommended in selected patients for whom prolonged survival may be important, or in symptomatic patients with good performance status, in combination with palliative procedures.

5.6 Quality of life

Although penile carcinoma is a malignant disease with a high probability of cure, it has a high degree of therapeutic morbidity.

There is no consensus regarding the impact of partial penectomy on quality of life, probably because of the different patient attitudes in Europe and South America (59). However, a negative impact has been observed in Europe on general health, anxiety, social problems and sexual function domains (60-62: Evidence level 2a).

With regard to quality of life, the therapeutic decision-making process should take into account the patient's age, performance status, socio-economic factors and geographic location, sexual function, patient motivation and psychological condition, the morbidity of different procedures and tumour biology.

5.7 Technical aspects

5.7.1 Primary lesion

The most important factors in the choice of conservative strategy are the simplicity and morbidity of the procedures and the surgeon's experience. Formal circumcision is mandatory before brachytherapy.

5.7.2 Partial amputation

Partial amputation traditionally required removal of 2 cm tumour-free margins. Although this is probably more than is necessary, it is essential to achieve free tumour margins with pathological confirmation. A surgical margin of 10 mm would be safe (63); this should be 1.5 cm for G3 (64: Evidence level 2b).

5.7.3 Radical inguinal lymphadenectomy

Radical inguinal lymphadenectomy should include the following anatomical landmarks: inguinal ligament, adductor muscle, sartorius muscle with the femoral vein and artery as floor of dissection.

5.7.4 'Modified' inguinal lymphadenectomy

The saphenous vein should be preserved and there should be 1-2 cm reduction of the lateral and inferior boundaries. With these modifications, it is a safe procedure, with complications and morbidity rates lower than radical ilio-inguinal lymphadenectomy (31-34: Evidence level 2b).

5.7.5 Lymphadenectomy

Morbidity from lymphadenectomy for penile cancer remains high, despite improvements in surgical techniques, including:

- thicker and less extensive skin flaps to reduce skin necrosis
- femoral vessels protected by coverage with the sartorius muscle
- improved lymphatics control and preservation of the saphenous vein to decrease leg oedema
- anticoagulation both during and after surgery to prevent deep venous thrombosis and pulmonary embolism.

At the MD Anderson Cancer Center, prophylactic and therapeutic dissections were associated with a lower incidence of complications compared with palliative dissections, and major complications were more frequent in the palliative group (30).

5.7.6 Pelvic lymphadenectomy

Pelvic lymphadenectomy includes the external iliac lymphatic chain and ilio-obturator chain with the following borders:

- proximal boundary: iliac bifurcation
- lateral boundary: ilio-inguinal nerve
- medial boundary: obturator nerve.

5.8 Chemotherapy

The chemotherapy regimen should be discussed with the medical oncologist. However, the following can be used as guidelines.

5.8.1 Adjuvant chemotherapy

Adjuvant chemotherapy with two courses of cisplatin and 5-FU may be sufficient or vincristine, methotrexate and bleomycin may be administered once a week for 12 weeks on an out-patient basis (57). This regimen following radical resection of lymph-node metastases achieved 82% 5-year survival in 25 consecutive patients as compared to only 37% in 31 consecutive historical controls treated with radical surgery alone (57). A more accurate analysis of two series allowed identification of interesting risk factors: none of the category pN1 patients relapsed, independently of adjuvant or no adjuvant chemotherapy; and relapses occurred after adjuvant chemotherapy (50%) only in patients with bilateral and/or pelvic metastases (51,58,65: Evidence level 2b).

5.8.2 Neoadjuvant chemotherapy for fixed inguinal nodes

Induction chemotherapy comprised of three to four courses of cisplatin and 5-FU with appropriate doses and sequence. In Pizzocaro's series (51,57), among 16 patients treated with neoadjuvant chemotherapy for fixed inguinal nodes, 9 (56%) of the 16 patients could be radically resected following primary chemotherapy, and 5 (31%) have probably been cured. The authors observed that cisplatin plus 5-FU achieved the best results. This was also corroborated in a compilation of 29 patients with similar characteristics, with a clinical response rate of 66%. Radical rescue surgery was performed in 38% of patients. 17% were probably cured (46,48,65,66: Evidence level 2b). Overall, when combining all reported series, the response rate is 68.5%, radical surgery rate is 42.8% and survival rate is 23% (42,50).

5.8.3 Chemotherapy for advanced disease

Chemotherapy for advanced disease has not been widely used in penile cancer. The most commonly used combinations are cisplatin and 5-FU (48,65) and cisplatin, bleomycin and methotrexate (46,47), Kattan et al. (66) used several cisplatin-based chemotherapy combinations. Results in patients with widespread disease are usually modest, with 32% complete and partial response rate and 12% treatment-related deaths in the most recent study (47). The response rate is similar in patients treated with cisplatin plus 5-FU, but tolerability of this regimen is much better with no treatment-related deaths (48,65). Intra-arterial chemotherapy in locally advanced or recurrent SCC of the penis is promising (49,67), both as palliative treatment and neoadjuvant therapy.

5.9 Radiotherapy

5.9.1 Primary tumour

External beam radiotherapy or brachytherapy have produced a complete response rate of 56% and 70%, respectively. Although local failure rates were 40% and 16%, respectively, salvage surgical resection can restore local control. A comparison of these methods is difficult because of selection bias due to the exclusion of patients with large volume disease (> 4 cm) from radiotherapy. Common complications include meatal stenosis in 15-30%, urethral strictures in 20-35%, and telangiectasias in greater than 90%. Post-radiation changes include necrosis that is clinically difficult to differentiate from persistent tumour (42).

5.9.2 Prophylactic radiotherapy

Prophylactic radiotherapy in clinically negative lymph nodes is not recommended because radiotherapy fails to prevent the development of metastatic lymph nodes (53,54). Furthermore, all patients will be exposed to the complications of radiotherapy (22,29) and patient follow-up is more difficult due to radiation-related fibrotic changes, which make physical examination unreliable. There seems to be no role for radiotherapy as a primary treatment in patients with pathological nodes since the 5-year survival rate with radiotherapy is half the 5-year survival rate obtained with surgery (29).

5.9.3 Pre-operative radiotherapy

Pre-operative radiotherapy in patients with fixed nodes can render them operable but it is unknown if the fixation is caused by inflammatory reactions or by cancerous growth (22,29,54). More recently, reports suggest that this strategy should be possibly replaced by chemotherapy (4).

5.9.4 Adjuvant radiotherapy

Adjuvant radiotherapy in cases of metastatic nodes may be used to reduce local recurrence (8,14). A therapeutic schedule for penile cancer is shown in Table 7.

Table 7: Therapeutic schedule for penile cancer

Lesion therapy	Therapy	Recommendations		
		Strong	Optional	Investigational
Primary tumour	Conservative therapy	Primary/recurrent Tis, Ta-1G1-2	T1G3, T 2 limited to < 50% of glans (fit patients for surveillance)	After chemotherapy, according to tumour response
	Total/partial amputation	Primary/recurrent T1G3, T ≥ 2	Primary or recurrent Ta-1G1-2 (conservative therapy not feasible),	
	Radiotherapy	T1-2 < 4cm	amputation refusal	In combination with chemotherapy
Regional (non-palpable nodes)	Surveillance	Tis, TaG1-2, T1G1, T1G2 Superficial growth, vascular (-ve) or negative dynamic sentinel node biopsy	T2G2-3 (Preference and fit patients for close follow-up)	
	Modified LND ¹	T1G2 nodular growth or vascular (+ve) or positive dynamic sentinel node biopsy, T1G3 or any T2	T1G2 vascular (-ve) flat growth or negative dynamic sentinel node biopsy (patients unfit for follow-up)	
Regional (palpable nodes)	Radical LND ²	Positive nodes at presentation	Plus adjuvant chemotherapy ³ or radiotherapy ⁴ (> 1 positive node)	
		Positive nodes after surveillance	Unilateral LND on nodal site (disease-free interval > 6 months and < 3 positive nodes)	
	Chemotherapy ³ +/- LND	Fixed inguinal masses, pelvic nodes (fit patients for chemotherapy)		
	Radiotherapy ⁴ +/- LND		Fixed masses (patients unfit for chemotherapy)	

Distant metastases	Chemotherapy ³ or palliative therapy (according to performance status, age, etc.)
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LND = lymphadenectomy.

¹ Modified LND can be extended to radical in cases where there are positive nodes.

² If unilateral non-palpable nodes on the opposite side, modified LND can be carried out. Pelvic LND should be done for more than one positive inguinal node only.

³ Chemotherapy should be discussed with medical oncologist and preferably be given in the context of clinical trials.

⁴ Radiotherapy has inconsistent results and high morbidity associated with surgery.

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6 FOLLOW-UP

Penile carcinoma is one of the few solid tumours in which lymphadenectomy can provide a high cure rate even when lymph nodes are involved. This is related to its particular biology, as the disease essentially develops in a stepwise fashion. However, penectomy and inguinal node dissection are associated with important morbidity. Urologists are therefore faced with the dilemma of reaching an appropriate balance between decreasing the morbidity by using conservative procedures and disease control. In this context, follow-up is crucial in order to achieve similar survival rates to those achieved with early radical surgery. Moreover, most relapses occur during the first 2 years; late recurrences, though uncommon, may occur. As penile carcinoma is associated with poor socio-economic conditions, close surveillance cannot always be performed.

6.1 Why follow-up?

With respect to the primary lesion, the local disease recurrence rate is extremely variable according to the type of therapy carried out. With partial or total penectomy, the incidence of local recurrence ranges from 0% to 7%; with conservative therapies, this might increase to 50% (1). Nevertheless, local recurrence does not have a negative impact on cause-specific survival, provided an early diagnosis is carried out (2,3).

Controversy remains as to whether early or delayed lymphadenectomy should be carried out in patients with initially non-palpable inguinal lymph nodes. Some authors achieve similar survival rates with both approaches (1,4). However, a surveillance programme implies a close follow-up as late diagnosis seems to be a negative prognostic factor.

In summary, the potential development of local recurrence and inguinal lymph node metastasis in patients treated with conservative approaches, as well as the possibility of curing patients following the early detection of relapse, does justify the need for follow-up in patients with penile carcinoma.

6.2 How to follow-up?

As the penis and inguinal lymph nodes are externally situated areas, follow-up in patients with penile carcinoma is based essentially on inspection and physical evaluation. In patients with initially palpable inguinal nodes, the reliability of physical evaluation compared to pathological examination ranges from 47-86% (5,6). Moreover, in patients with non-palpable lymph nodes initially, the development of palpable nodes during follow-up means metastases in 100% of cases.

CT scan and chest radiographs can be additional tests used to identify pelvic lymph nodes or distant metastases, particularly in categories equal or more than N2, as the tumour spreads mainly in these areas. Other appropriate diagnostic tests should be used in symptomatic patients.

6.3 When to follow-up?

The follow-up interval and strategies for patients with penile cancer are directly related to the initial treatment of the primary lesion and regional lymph nodes.

6.3.1 Primary tumour

If the primary lesion was treated with conservative therapy (local resection, laser therapy, brachytherapy, Mohs' procedure, associated therapies), a follow-up interval of 2 months for 2 years and then every 3 months for a further year is recommended, because most local recurrences occur in this period. Long-term follow-up is also recommended every 6 months because late local recurrences have been observed (7). Patient self-evaluation is also advisable and patients should be informed about the possible warning signals. This follow-up schedule is advised because the disease recurrence rate is high and follow-up increases the chance of improving the cure.

For patients treated with partial or total penectomy, a follow-up appointment every 4 months for 2 years, then at 6-monthly intervals for 1 year, and annually thereafter, is recommended. For the latter period, no hard data are available to suggest a specific interval. This schedule is recommended because local disease recurrence, although infrequent, usually occurs very early and because an early diagnosis is necessary because of the aggressive behaviour of the tumour (8).

6.3.2 Regional areas

If a surveillance programme has been implemented after removal of the primary tumour, it is recommended that a groin evaluation be carried out every 2 months for 2 years, then every 3 months during the next year, and then every 6 months for a further 2 years, (9,10). No CT scan and chest radiographs are necessary. The rationale for this scheme is based on the fact that most inguinal lymph node recurrences are detected during the first 2 years. Moreover, when recurrences develop their growth is very quick and the prognosis is related to the number, size and bilateralism of the lymph nodes (11,12). Very close follow-up is therefore advisable.

If inguinal lymphadenectomy has been performed and no tumour has been found upon pathological examination of the specimen, a physical evaluation is recommended every 4 months for 2 years and then every 6 months for the next year; subsequently, it is not completely necessary to carry out follow-up. In these cases, a local or distant relapse is rare if a radical procedure and extensive pathological examination have been performed. The follow-up is focused essentially on the quality of life for these patients as inguinal lymphadenectomy has a high morbidity rate.

If inguinal lymphadenectomy has been performed and positive lymph nodes have been observed upon pathological examination, specific follow-up cannot be recommended because of the many variables involved including:

- Number of positive lymph nodes (uni- or bilaterally)
- Whether pelvic lymphadenectomy was performed, with or without positive lymph nodes
- Type of adjuvant therapy carried out and the scheme used.

In relation to these variables, each institution should define the physical examination, CT scan, chest radiograph and the appropriate intervals between them.

Bone scan and other tests are only recommended in symptomatic patients. A quality-of-life assessment should essentially encompass sexual activity and lymphadenectomy morbidity (lymphoedema). The follow-up schedule is summarized in Table 8.

Table 8: Follow-up schedule for penile cancer

Lesion level	Therapy	Interval			Examinations	
		Years 1 and 2	Year 3	Years 4 and 5	Mandatory	Advisable
Primary tumour	Conservative therapy	2 months	3 months	6 months	Physical/self exam/QOL	
	Partial/total penectomy	4 months	6 months	Yearly	Physical/self exam/QOL	
Regional approach	Surveillance	2 months	3 months	6 months	Physical exam/QOL	Cytology or biopsy if unclear clinical findings
	LND (pN0)	4 months	6 months	Not necessary	Physical/self exam/QOL	
	LND (pN+)	Institutional protocol ¹	Institutional protocol ¹	Institutional protocol ¹	Physical/self exam/QOL/CT scan/chest radiograph	Bone scan (symptoms)

LND = lymphadenectomy; QOL = quality of life (physical and sexual); CT = computed tomography.

¹ Based on the therapeutic approach applied. It is advisable, however, to carry out follow-up every 2-3 months for 2 years, then every 4-6 months during the third year and every 6-12 months thereafter.

6.4 GUIDELINES FOR FOLLOW-UP IN PENILE CANCER

Primary tumour

- Patients treated with conservative therapies: follow-up every 2 months for 2 years, then every 3 months for 1 more year; long-term follow-up is also recommended every 6 months. Physical and self-examination should be performed (Grade C)
- Patients treated with partial or total penectomy: follow-up every 4 months for 2 years, twice during the third year and then annually is recommended (Grade C)

Regional nodes and distant metastasis

- If a surveillance programme was decided after the primary tumour was removed, a groin evaluation every 2 months for 2 years, then every 3 months for 1 more year and every 6 months for the next 2 years, is recommended (Grade C)
- If an inguinal lymphadenectomy was performed (pN0), physical evaluation is recommended every 4 months for 2 years, then every 3 months for 1 more year. After this, it is not mandatory to carry out follow-up (Grade C)
- If inguinal lymphadenectomy was performed (pN1-3), specific follow-up cannot be recommended. Physical examination, CT scan, chest radiography and the appropriate intervals between them should be defined by each institution (Grade C)
- Bone scan and other tests are only recommended in symptomatic patients (Grade B)

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7 ABBREVIATIONS

CT	computed tomography
HPV	human papillomavirus
MRI	magnetic resonance imaging
Nd-YAG	Neodymium:Yttrium-Aluminum-Garnet
PET	positron emission tomography
SCC	squamous cell carcinoma
TNM	tumour, node, metastasis
5-FU	5-fluorouracil

¹ *These EAU Guidelines on Penile Cancer are endorsed by all members of the EAU Oncological Urology Group (Chairman: C. Abbou). Members of the Oncological Urology Group are the EAU Working parties on: Bladder Cancer, Renal Cancer, Prostate Cancer, Testis Cancer and Penile Cancer.*