National Institute for Health and Clinical Excellence

879 – Endoscopic radical inguinal lymphadenectomy

Consultation Comments table

IPAC date: Thursday 14th April 2011

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 Specialist Adviser	**1**	satisfactory provisional recommendations	Thank you for your comment.
2	Consultee 2 NHS Professional	**1**	The traditional open operation has a significant morbidity rate both in the short term due to wound complications and also in the long term due to the development of lower limb lymphoedema. Surgeons who have laparoscopic or robotic training and who routinely perform the open procedure will have teh necesary skills to undertake this surgery.	Thank you for your comment. Section 1.3 in the guidance indicates who should perform the procedure: "This procedure should be carried out only in centres that treat cancer patients requiring radical inguinal lymphadenectomy as part of their management, and by surgeons with training and experience in this type of endoscopic surgery."
3	Consultee 1 Specialist Adviser	**2.1**	There is no standard procedure for radical inguinal node dissection. It is different with respect to clinically node negative (prophylactic) patients and clinically node positive patients. The dissection is different for different tumour types (anal ,vulval and penile have potentially a more localised dissection, versus melanoma with a wide dissection. Most importantly, there is a no good evidence of the optimal incision for groin dissection and certainly different incisions will have different wound associated complication rates. With this lack of existing data, comparison of groups will be very difficult.	Thank you for your comment.

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4	Consultee 2 NHS Professional	**2.1**	For patients with penile cancer, the role of chemotherapy or radiotherapy is now reserved for cases deemed inoperable. Therefore the primary treatment options is open surgery.	Thank you for your comment. Section 2.1.2 of the guidance states “The standard method for radical inguinal lymphadenectomy is an open operation through an incision in the groin.”
5	Consultee 1 Specialist Adviser	**2.3**	Failure to adequately treat the groin at the first operation can result in devastating problems of regional recurrence requiring more complex revision surgery and likely reduced survival. I would urge that the initial trials be performed on clinically node negative patients where the outcome could be compared with the known complication rate of sentinel node biopsy.	Thank you for your comment.
6	Consultee 2 NHS Professional	**2.3**	The shorter period of having a drain in situ means that there is less risk of wound infection and prolonged lymphatic drainage. Even with these initial studies, the wound complication rates are much less when compared with the data available in the literature.	Thank you for your comment.
7	Consultee 2 NHS Professional	**2.4**	Although these initial trials are small, the increased availability of robotic surgery will allow this to be developed and offered as a more routine option.	Thank you for your comment.

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8	Consultee 2 NHS Professional	**2.5**	The morbidity associated with a radical inguinal node dissection is high as shown in several studies(ref 1-4). 23-62% of patients develop skin necrosis or lymphoedema. The burden on allied health care professionals who manage the wounds and the long term lymphoedema can be reduced if the technique is modified such that these complications are reduced. In terms of surgical technique the only evolution is the use of minimally invasive techniques to avoid a large groin incision and accurately ligate and seal the lymphatics. Refs 1. Johnson, D. E. and Lo, R. K.: Complications of groin dissection in penile cancer. Experience with 101 lymphadenectomies. Urology, 24: 312, 1984. 2. Ravi, R.: Morbidity following groin dissection for penile carcinoma. Br J Urol, 72: 941, 1993. 3. Ornellas, A. A., Seixas, A. L., and de Moraes, J. R.: Analyses of 200 lymphadenectomies in patients with penile carcinoma. J Urol, 146: 330, 1991. 4. Bevan-Thomas, R., Slaton, J. W., and Pettaway, C. A.: Contemporary morbidity from lymphadenectomy for penile squamous cell carcinoma: the M.D. Anderson Cancer Center Experience. J Urol, 167: 1638, 2002.	Thank you for your comment. All the studies referenced in this comment describe an open rather than endoscopic procedure and did not therefore form part of the evidence base on the procedure.