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Characteristics of vulvar cancer recurrence

Yakubbekova Sahibaxon Sadik qizi – Associate Professor of the Department of Oncology
Andijan, Uzbekistan

Abstract: The article discusses The frequency and timing of vulvar cancer (VC) recurrence depend on the stage of the disease and the depth of tumor invasion. The incidence of VC recurrence increases with increasing disease stage. Based on the timing of recurrence, it follows that the first 3 years after completion of treatment require particular vigilance for recurrence, which, according to our data, occurred in 73.19% of patients. Therefore, regular follow-up at least every 3 months is essential.
Key words: recurrence, vulvar cancer, stage, treatment

Relevance. Vulvar cancer is a highly aggressive disease, with a pronounced tendency toward rapid growth, early metastasis, and recurrence. According to literature data, the five-year survival rate for patients after various treatment methods ranges from 24.5% to 55.9%. Equally challenging is the treatment of recurrent vulvar cancer, which, according to literature data, occurs in 30% to 60% of patients within the first five years. Due to the anatomical and topographic structure of the external genitalia with an extremely richly developed network of lymphatic vessels, cancer in this location is a highly aggressive disease, with a pronounced tendency toward rapid growth, early metastasis, and recurrence [7] .

Among gynecological tumors, vulvar cancer is characterized by a unique clinical course, late recurrence, low efficacy of combination treatment, and frequent local recurrences. According to researchers, more than half of cases are diagnosed at stage III-IV. Most patients with invasive vulvar cancer are elderly. Nearly 80% of invasive vulvar cancer cases are diagnosed in women over 55, and 30% in women over 75. The average age of patients with vulvar cancer is 65-70 years.

Due to increasing life expectancy, vulvar cancer is not only a gynecological but also a geriatric problem. Given the average age of patients and numerous complications, surgical treatment outcomes are unsatisfactory. Furthermore, treatment of this category of patients is complicated by the frequent occurrence of both local and regional recurrences [5,6] . Recurrences of vulvar cancer are characterized by a higher degree of malignancy, worse treatment indications, and often cause anatomical damage to the site of origin, compared to primary tumors. At the same time, recurrence of the disease is very often the cause of death in patients with vulvar cancer. The question of the etiology of vulvar cancer remains important due to its increasing incidence, low therapeutic efficacy and frequent recurrences. Currently, the authors have identified two pathogenetic mechanisms of vulvar cancer, one of which is associated with the presence of human papillomavirus (HPV) in patients. Most patients with this type of vulvar carcinoma are younger, and the tumors are characterized by multifocality and low keratin content. The second form of the disease is not associated with HPV infection. It typically occurs in elderly and senile women and is associated with degenerative processes and long-term immunosuppression. In connection with the above, it seems interesting to investigate the presence or absence of human papillomavirus carriage in patients with vulvar cancer, especially in the context of the increase in the proportion of middle-aged and young patients over the past decade [2,4] .

Thus, the problems of diagnosis, prevention, and treatment of vulvar cancer remain complex. Furthermore, frequent recurrences of tumors in this location significantly impact the survival and quality of life of this group of patients. A detailed study of vulvar cancer recurrences, their frequency, average duration, and relapse-free survival in these patients, as well as analysis of certain biochemical and immunological characteristics, are necessary to identify prognostic factors for vulvar cancer recurrence, early diagnosis, timely treatment, and, ultimately, increase the life expectancy of this category of patients [8] .

According to the literature, the overall 5-year survival rate for patients with vulvar cancer does not exceed 50%. Equally challenging is the treatment of recurrent vulvar cancer, which occurs within the first 5 years in 30 to 60% of cases. The main causes of death are late diagnosis and incomplete treatment, and patients typically die from relapses and metastases [1,4,6,7,8,9,10].

Objective: To study the frequency and timing of vulvar cancer (VC) recurrence depending on the stage of the disease and the depth of tumor invasion.

Material and methods. Data from 809 patients with varicose veins treated at the Andijan Regional Oncology Center over a 20-year period were analyzed. Recurrence of varicose veins was detected in 203 (25.1%) of the 809 patients. All patients had squamous cell carcinoma of varying degrees of differentiation.

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Results. Analysis of the frequency and timing of RV relapses depending on the disease stage showed the following: at stage I, relapse occurred in 30 (18.3%) of 164 patients, at stage II – in 49 (20.5%) of 239, at stage III – in 87 (26.7%) of 326, and at stage IV – in 37 (46.3%) of 80. Most often, relapses occurred in the first year after completion of complex or combined treatment: in 39.7%, from 1 to 3 years – in 33.5%, over 3 years – in 13.4%, over 5 years – only in 12.3%. Depending on the disease stage, one year after completion of treatment, relapse occurred in 10% of patients with stage I, in 8.5% with stage II, in 45% with stage III, and in 97.3% with stage IV. At stage I, relapse occurred on average after 59.4±6.2 months, at stage II – after 46.9±3.4 months, at stage III – after 16.9±0.9 months, at stage IV – after 7.2±0.3 months. Depending on the depth of tumor invasion, the following data were obtained: at stage I with invasion of 1-2 mm, the average time for the occurrence of RV relapses is 74±4.5 months, at 3-4 mm – 49.3±3.7, over 5 mm – 17.8±2.7 months ($p<0.05$). A similar pattern is observed at stages II and III of the disease.

Extensive tumor resection is very important, and if indicated, inguinal lymphadenectomy is performed. Recurrent vulvar cancers are often unresectable. Furthermore, they are refractory to chemoradiation. Resistant to chemoradiotherapy. To improve treatment outcomes, all patients with tumor recurrence received chemotherapy before surgery. Platinum-based chemotherapy was administered with cyclophosphamide, doxorubicin, or a combination of platinum-based drugs and bleomycin. Some patients required two or three courses of chemotherapy before surgery was possible. All patients underwent surgery after chemotherapy.

Conclusions. The incidence of recurrent vulvar cancer clearly increases with increasing disease stage. Based on the timing of recurrence, it follows that the first three years after completion of treatment require particular vigilance for recurrence, which, according to our data, occurred in 73.19% of cases. Therefore, regular follow-up at least every three months is essential. The depth of tumor invasion is also an important prognostic factor in vulvar cancer patients: the greater the depth of invasion, the shorter the time to recurrence. In case of recurrence of vulvar cancer, chemotherapy is indicated.

Chemotherapy with attempted surgical intervention to resect the maximum possible tumor volume, followed by chemoradiation, significantly increases the risk of recurrence. Chemotherapy with attempted surgical intervention to resect the maximum possible tumor volume, followed by chemoradiation, significantly increases the patient's life expectancy.

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