PENILE LESIONS II
PENILE CANCER

RARE, MOST COMMON IN MEN 50-70 YEARS MAJORITY: SQUAMOUS CELL CARCINOMA (SqCC)
RISK FACTORS: PHIMOSIS, SMOKING, UNCIRCUMCISED, HPV (16,18, 31, 33), CHRONIC INFLAMMATION
MOST COMMON METASTASIS TUMORS TO PENIS: Bladder, prostate, colorectal. May PRIAPISM
LOCATION: Glans (50%), Shaft (30%), prepuce (20%) DX: BIOPSY!!!!

T		
Tis	Carcinoma in situ	5-FU, imiquimod, laser CO2, laser YAG, resurfacing
Ta	Non-invasive verrucous carcinoma	G1,G2: Excision, co2, YAG, resurfacing, glansectomy, RT <4cm
T1	Subepithelial connective tissue	
	T1a NOT lymphovascular NOT poorly different.	T1a G1-2: Excision, CO2, YAG, resurfacing, glansectomy, RT <4cm
	T1b WITH lymphovascular inv or poorly different.	T1b (G3): Excision, glansectomy, RT <4cm
T2	Corpus spongiosum +/- urethra	Excision, glansectomy, RT <4cm
T3	Corpus cavernosum +/- urethra	Partial amputation, RT <4cm. Urethra invasion: partial/total penect
T4	Other	Chemo + surgery in responders / palliative RT
N		**Palpable: perform CT/PET. If N+: SYSTEMIC STAGING**
N0	No palpable or visible LN	Tis, Ta G1, T1G1: surveillance > T1G2: BILATERAL MODIFIED INGUINAL LYMPH. or dynamic sentinel node biopsy. IF+: RADICAL IPSILATERAL
cN1	Palpable mobile UNILATERAL (inguinal)	RADICAL INGUINAL LYMPHADENECTOMY
cN2	Palpable mobile MULTIPLE or BILATERAL	RADICAL INGUINAL LYMPHADENECTOMY
cN3	Fixed mass or pelvic, unilateral or bilateral	NEOAD CHEMO + RADICAL INGUINAL LYMPHADENECT. responders
pN0	No + LN	
pN1	1 or 2 LN	IPSILATERAL PELVIC LYMPHADENECTOMY: If 2or+ inguinal+ (pN2) or pN3 (extracapsular)
pN2	MORE THAN 2 or BILATERAL	
pN3	PELVIC, EXTRANODAL	pN2/pN3: ADYUVANT CHEMO: cisplatin+taxane + 5-fluorouracil or ifosfamide
M		**IF SYSTEMIC DISEASE: perform a bone scan**
M1	Metastasis	Palliative chemotherapy
G		
G1	Well differentiated	GOOD PROGNOSIS: Verrucous, Papillary, Warty Pseudohyperplastic
G2	Moderately differentiated	INTERMEDIATE: SqCC, Mixed, Pleomorphic of warty carcinoma
G3	Poorly differentiated	BAD: Basaloid, Sarcomatoid adenosquamous
G4	Undifferentiated	

Ta/Tis/T1G1 → LOW RISK
T1G2 → INTERMEDIATE RISK
T1G3 o T2-T4 → HIGH RISK

Unilateral LN: Ipsilateral superficial +deep + contralateral superficial (if +---deep contralateral).
INGUINAL SUPERFICIAL: ANTERIOR TO FASCIA LATA DEEP: POSTERIOR TO FASCIA LATA, medial to the femoral vein
NODE OF CLOQUET: MOST SUPERIOR (also most distal external iliac, femoral canal)
1/3 clinical LN: negative 25% positive inguinal LN---pelvic +

ILND	SUPERIOR	MEDIAL	LATERAL	SAPHENOUS	SARTORIUS
CLASSIC	Inguinal ligament	Adductor longus	Sartorius	Resection?	Transposition?
MODIFIED	Inguinal ligament	Adductor longus	Femoral artery	Preservation	No

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