PREOPERATIVE DIAGNOSIS: , Clinical stage III squamous cell carcinoma of the vulva.,POSTOPERATIVE DIAGNOSIS: , Clinical stage III squamous cell carcinoma of the vulva.,OPERATION PERFORMED:, Radical vulvectomy (complete), bilateral inguinal lymphadenectomy (superficial and deep).,ANESTHESIA: , General, endotracheal tube.,SPECIMENS: , Radical vulvectomy, right and left superficial and deep inguinal lymph nodes. ,INDICATIONS FOR PROCEDURE: , The patient recently presented with a new vaginal nodule. Biopsy was obtained and revealed squamous carcinoma. The lesion extended slightly above the hymeneal ring and because of vaginal involvement was classified as a T3/Nx/Mx on clinical examination. Of note, past history is significant for pelvic radiation for cervical cancer many years previously.,FINDINGS: , The examination under anesthesia revealed a 1.5 cm nodule of disease extending slightly above the hymeneal ring. There was no palpable lymphadenopathy in either inguinal node region. There were no other nodules, ulcerations, or other lesions. At the completion of the procedure there was no clinical evidence of residual disease.,PROCEDURE:, The patient was brought to the Operating Room with an IV in place. She was placed in the low anterior lithotomy position after adequate anesthesia had been induced. Examination under anesthesia was performed with findings as noted, after which she was prepped and draped. The femoral triangles were marked and a 10 cm skin incision was made parallel to the inguinal ligament approximately 3 cm below the ligament. Camper's

fascia was divided and skin flaps were elevated with sharp dissection and ligation of vessels where necessary. The lymph node bundles were mobilized by incising the loose areolar tissue attachments to the fascia of the rectus abdominis. The fascia around the sartorius muscle was divided and the specimen was reflected from lateral to medial. The cribriform fascia was isolated and dissected with preservation of the femoral nerve. The femoral sheath containing artery and vein was opened and vessels were stripped of their lymphatic attachments. The medial lymph node bundle was isolated, and Cloquet's node was clamped, divided, and ligated bilaterally. The saphenous vessels were identified and preserved bilaterally. The inferior margin of the specimen was ligated, divided, and removed. Inguinal node sites were irrigated and excellent hemostasis was noted. Jackson-Pratt drains were placed and Camper's fascia was approximated with simple interrupted stitches. The skin was closed with running subcuticular stitches using 4-0 Monocryl suture.,Attention was turned to the radical vulvectomy specimen. A marking pen was used to outline the margins of resection allowing 15-20 mm of margin on the inferior, lateral, and anterior margins. The medial margin extended into the vagina and was approximately 5-8 mm. The skin was incised and underlying adipose tissue was divided with electrocautery. Vascular bundles were isolated, divided, and ligated. After removal of the specimen, additional margin was obtained from the right vaginal side wall adjacent to the tumor site. Margins were submitted on the right posterior, middle,

and anterior vaginal side walls. After removal of the vaginal margins, the perineum was irrigated with four liters of normal saline and deep tissues were approximated with simple interrupted stitches of 2-0 Vicryl suture. The skin was closed with interrupted horizontal mattress stitches using 3-0 Vicryl suture. The final sponge, needle, and instrument counts were correct at the completion of the procedure. The patient was then awakened from her anesthetic and taken to the Post Anesthesia Care Unit in stable condition.