

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Penile Cancer

Version 3.2015

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* Peter E. Clark, MD ☞ Chair
Vanderbilt-Ingram Cancer Center

* Philippe E. Spiess, MD, MS ☞ Vice chair
Moffitt Cancer Center

Neeraj Agarwal, MD ‡
Huntsman Cancer Institute
at the University of Utah

Stephen A. Boorjian, MD ☞
Mayo Clinic Cancer Center

Thomas W. Flaig, MD †
University of Colorado Cancer Center

Richard E. Greenberg, MD ☞
Fox Chase Cancer Center

Noah Hahn, MD †
The Sidney Kimmel Comprehensive
Cancer Center at Johns Hopkins

Harry W. Herr, MD ☞
Memorial Sloan Kettering Cancer Center

Brant A. Inman, MD, MSc ☞
Duke Cancer Institute

A. Karim Kader, MD, PhD ☞
UC San Diego Moores Cancer Center

Timothy M. Kuzel, MD ‡
Robert H. Lurie Comprehensive Cancer Center
of Northwestern University

Subodh M. Lele, MD ≠
Fred & Pamela Buffett Cancer Center at
The Nebraska Medical Center

Jeff Michalski, MD, MBA §
Siteman Cancer Center at Barnes-
Jewish Hospital and Washington
University School of Medicine

Jeffrey S. Montgomery, MD, MHSA ☞
University of Michigan
Comprehensive Cancer Center

Lance C. Pagliaro, MD †
The University of Texas
MD Anderson Cancer Center

Sumanta K. Pal, MD †
City of Hope Comprehensive Cancer Center

Anthony Patterson, MD ☞
St. Jude Children's Research Hospital/
University of Tennessee Health Science Center

Daniel Petrylak, MD †
Yale Cancer Center/Smilow Cancer Hospital

Elizabeth R. Plimack, MD, MS †
Fox Chase Cancer Center

Kamal S. Pohar, MD ☞
The Ohio State University Comprehensive
Cancer Center - James Cancer Hospital
and Solove Research Institute

Michael P. Porter, MD, MS ☞
Fred Hutchinson Cancer Research Center/
Seattle Cancer Care Alliance

Jerome P. Richie, MD ☞
Dana-Farber/Brigham and Women's
Cancer Center

Wade J. Sexton, MD ☞
Moffitt Cancer Center

William U. Shipley, MD § ☞
Massachusetts General Hospital Cancer Center

Eric J. Small, MD † ☞
UCSF Helen Diller Family
Comprehensive Cancer Center

Guru Sonpavde, MD †
University of Alabama at Birmingham
Comprehensive Cancer Center

Donald L. Trump, MD †
Roswell Park Cancer Institute

Jonathan Tward, MD, PhD §
Huntsman Cancer Institute
at the University of Utah

Geoffrey Wile, MD ☐
Vanderbilt-Ingram Cancer Center

Timothy G. Wilson, MD ☞
City of Hope Comprehensive Cancer Center

NCCN
Mary Dwyer, MS
Courtney Smith, PhD
Sarika Trikha, PharmD

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☞ Urology
† Medical oncology
‡ Hematology/Hematology oncology
§ Radiotherapy/Radiation oncology
☐ Diagnostic radiology
≠ Pathology
* Writing committee member



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Clinical Trials: NCCN believes that the best management for any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN member institutions, [click here: nccn.org/clinical_trials/physician.html](#).

NCCN Categories of Evidence and Consensus: All recommendations are Category 2A unless otherwise specified.

See [NCCN Categories of Evidence and Consensus](#).

[Staging \(ST-1\)](#)

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NCCN Guidelines Version 3.2015 Updates

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Summary of the changes in the 3.2015 version of the Guidelines for Penile Cancer from the 2.2015 version include:

[MS-1](#)

- The discussion section has been updated to reflect changes in the algorithm.

Summary of the changes in the 2.2015 version of the Guidelines for Penile Cancer from the 1.2015 version include:

[Principles of Chemotherapy](#)

[PN-C 1 of 2](#)

- Second-line therapy, 2nd bullet was revised from “Depending on first-line therapies, palliative options include single-agent therapy such as capecitabine, carboplatin, docetaxel, 5-FU, methotrexate, and paclitaxel. Strongly consider a clinical trial.” to “A clinical trial is preferred. The evidence to support the palliative use of second-line therapy is limited. In select patients, paclitaxel or cetuximab may be considered, especially if not previously treated with a similar class of agent.”

Summary of the changes in the 1.2015 version of the Guidelines for Penile Cancer from the 1.2014 version include:

[PN-4](#)

- “Bilateral” was added to “Unilateral or *bilateral* lymph nodes <4 cm” for clarification.
- For a low-risk primary lesion, “FNA” was replaced with “lymph node biopsy.”

[PN-5](#)

- For both “unilateral; mobile” and “multiple or bilateral inguinal lymph nodes; mobile or fixed,” the “FNA” was replaced with “needle biopsy.”
- For unilateral; mobile, after treatment, if ≥ 2 nodes positive or extranodal extension, the option of PLND was changed from a category 2B to a category 2A.
- Footnotes
 - ▶ Footnote “r” was revised by removing the category 2B from “Consider adjuvant chemotherapy (~~category 2B~~).”
 - ▶ Footnote “s” was revised as, “Consider postoperative radiotherapy (~~category 2B~~) or chemoradiotherapy.”
 - ▶ Footnote “t” was revised as, “Consolidation surgery consists of bilateral superficial and deep ILND and ~~possible unilateral/bilateral~~ PLND.”

[Principles of Radiotherapy](#)

[PN-B](#)

- For postoperative adjuvant radiotherapy, the category for positive inguinal lymph node was changed from a category 2B to a category 2A.

[Principles of Chemotherapy](#)

[PN-C 1 of 2](#)

- Second-line therapy, 2nd bullet, “panitumumab” was removed.

[PN-C 2 of 2](#)

- Radiosensitizing agents and combinations (For radiotherapy with concurrent chemotherapy), the alternate option “capecitabine” was clarified as “for palliation.”
- Reference #4 was updated, “Di Lorenzo G, Buonerba C, Federico P, et al. Cisplatin and 5-fluorouracil in inoperable, stage IV squamous cell carcinoma of the penis. *BJU Int* 2012;110(11 Pt B):E661-6.”



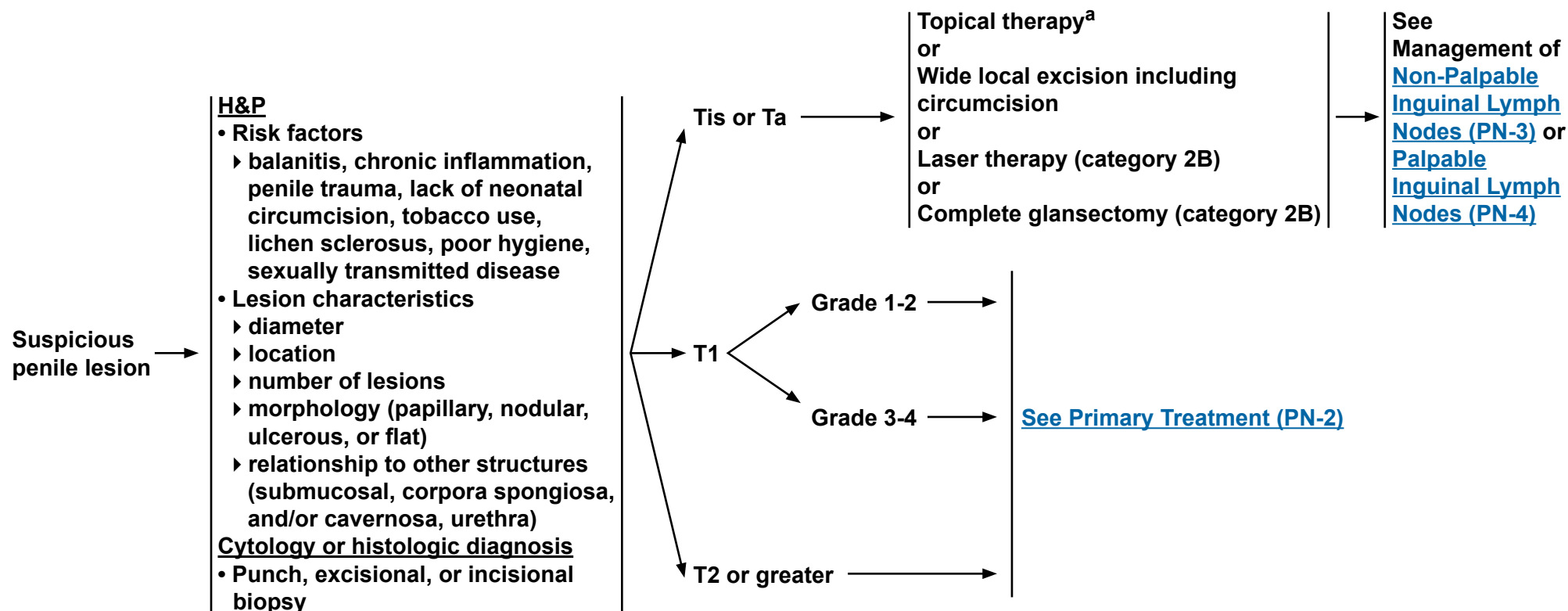
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Penile Cancer

PRIMARY EVALUATION

CLINICAL DIAGNOSIS

PRIMARY TREATMENT



If recurrent disease, [see PN-7](#) or
if metastatic disease, [see PN-8](#)

^aTopical therapy may include topical imiquimod (5%) or 5-fluorouracil (5-FU) cream.

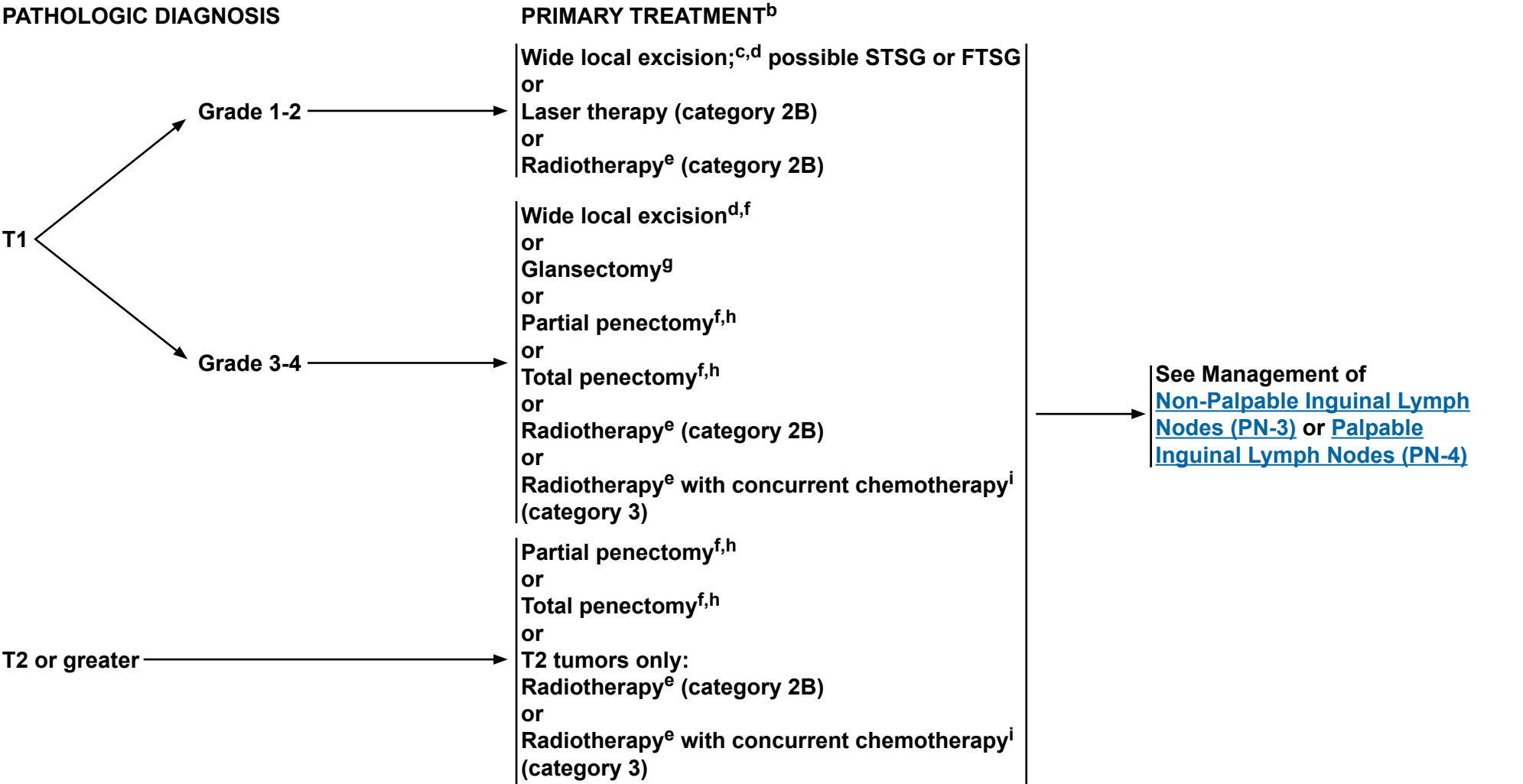
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^bSee [Principles of Surgery \(PN-A\)](#).

^cMoh's surgery is an option.

^dComplete excision of the skin with a wide negative margin with skin grafting is needed. STSG = split-thickness skin graft; FTSG= full-thickness skin graft.

^eSee [Principles of Radiotherapy \(PN-B\)](#).

^fRecommend intraoperative frozen sections to achieve negative margins.

^gAppropriate with proven negative margins for tumors involving the glans only.

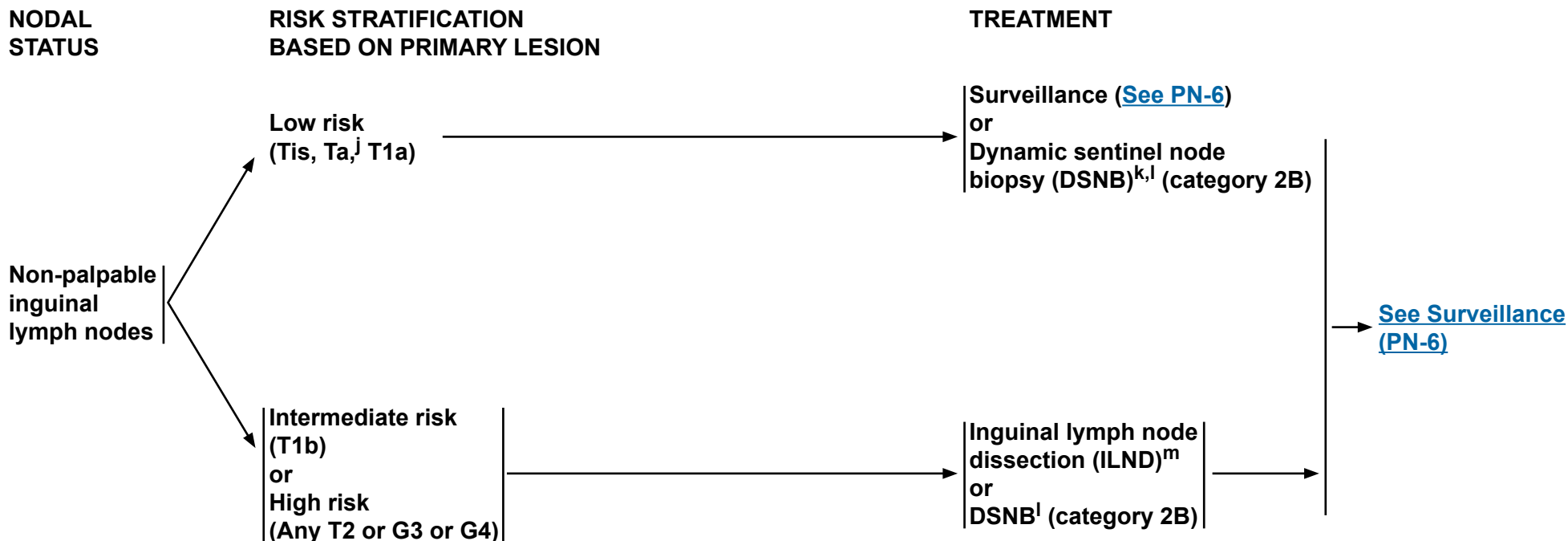
^hWhen it is necessary to dissect into the corpora cavernosum to achieve a negative margin, a partial or total penectomy is performed.

ⁱSee [Principles of Chemotherapy \(PN-C\)](#).

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MANAGEMENT OF NON-PALPABLE INGUINAL LYMPH NODES



^jTa verrucous carcinoma is by definition a well-differentiated tumor and would require surveillance alone of inguinal lymph nodes.

^kDSNB is recommended provided the treating physician has experience with this modality.

^lIf positive lymph nodes are found on DSNB, ILND is recommended.

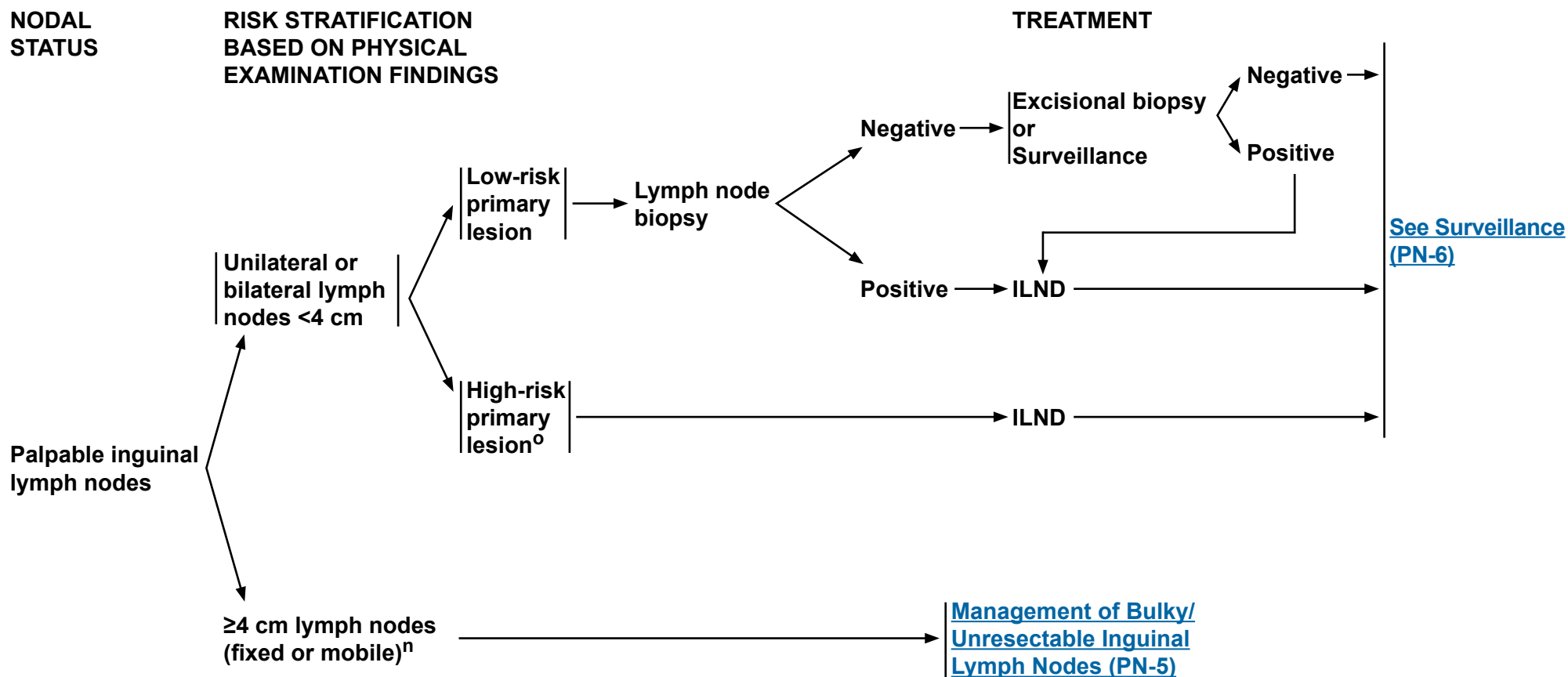
^mA modified/superficial inguinal dissection with intraoperative frozen section is an acceptable alternative to stage the inguinal lymph nodes.

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MANAGEMENT OF PALPABLE INGUINAL LYMPH NODES



ⁿImaging to assess regional nodes and distant metastases.

^oHigh-risk primary lesion: T1, high-grade, LVI, >50% poorly undifferentiated.

Note: All recommendations are category 2A unless otherwise indicated.

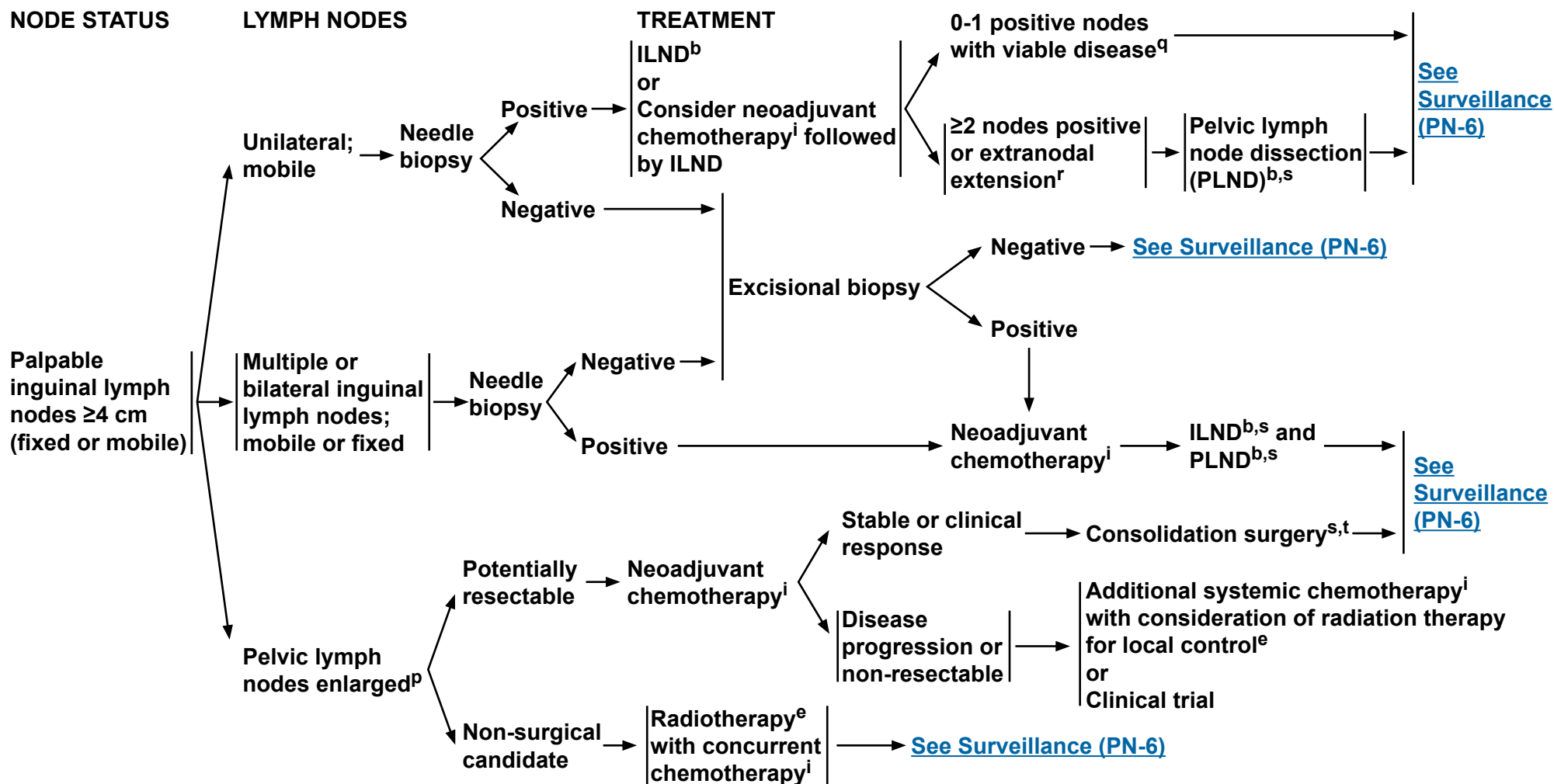
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Penile Cancer

MANAGEMENT OF BULKY/UNRESECTABLE INGUINAL LYMPH NODES


^bSee Principles of Surgery (PN-A).

^eSee Principles of Radiotherapy (PN-B).

ⁱSee Principles of Chemotherapy (PN-C).

^pOn CT or MRI, not pathologic stage.

^qFor viable disease post-chemotherapy, consider PLND.

^rConsider adjuvant chemotherapy.

^sConsider postoperative radiotherapy or chemoradiotherapy.

^tConsolidation surgery consists of bilateral superficial and deep ILND and unilateral/bilateral PLND.

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Penile Cancer

ANATOMIC SITE	INITIAL TREATMENT	SURVEILLANCE
Primary lesion	<ul style="list-style-type: none"> • Topical therapy • Laser therapy • Radiation therapy • Wide local excision including circumcision 	Clinical exam: ^{v,w} year 1-2, every 3 mo then year 3-5, every 6 mo then year 5-10, every 12 mo
	<ul style="list-style-type: none"> • Partial penectomy • Total penectomy 	Clinical exam: ^{v,w} year 1-2, every 6 mo then year 3-5, every 12 mo
Lymph nodes	Nx ^u	Clinical exam: ^{v,w} year 1-2, every 3 mo then year 3-5, every 6 mo
	N0, N1	Clinical exam: ^{v,w} year 1-2, every 6 mo then year 3-5, every 12 mo
	N2, N3	Clinical exam: ^v year 1-2, every 3-6 mo then year 3-5, every 6-12 mo Imaging: <ul style="list-style-type: none"> • Chest (CT or x-ray) <ul style="list-style-type: none"> ▸ year 1-2, every 6 mo • Abdominopelvic (CT or MRI) <ul style="list-style-type: none"> ▸ year 1, every 3 mo then ▸ year 2, every 6 mo
For patients with recurrence at either local or distant sites, see Management of Recurrent Disease (PN-7) .		

^uPatients on active surveillance of clinically negative nodes and at low risk for inguinal metastases.

^vClinical exam includes examination of the penis and inguinal region.

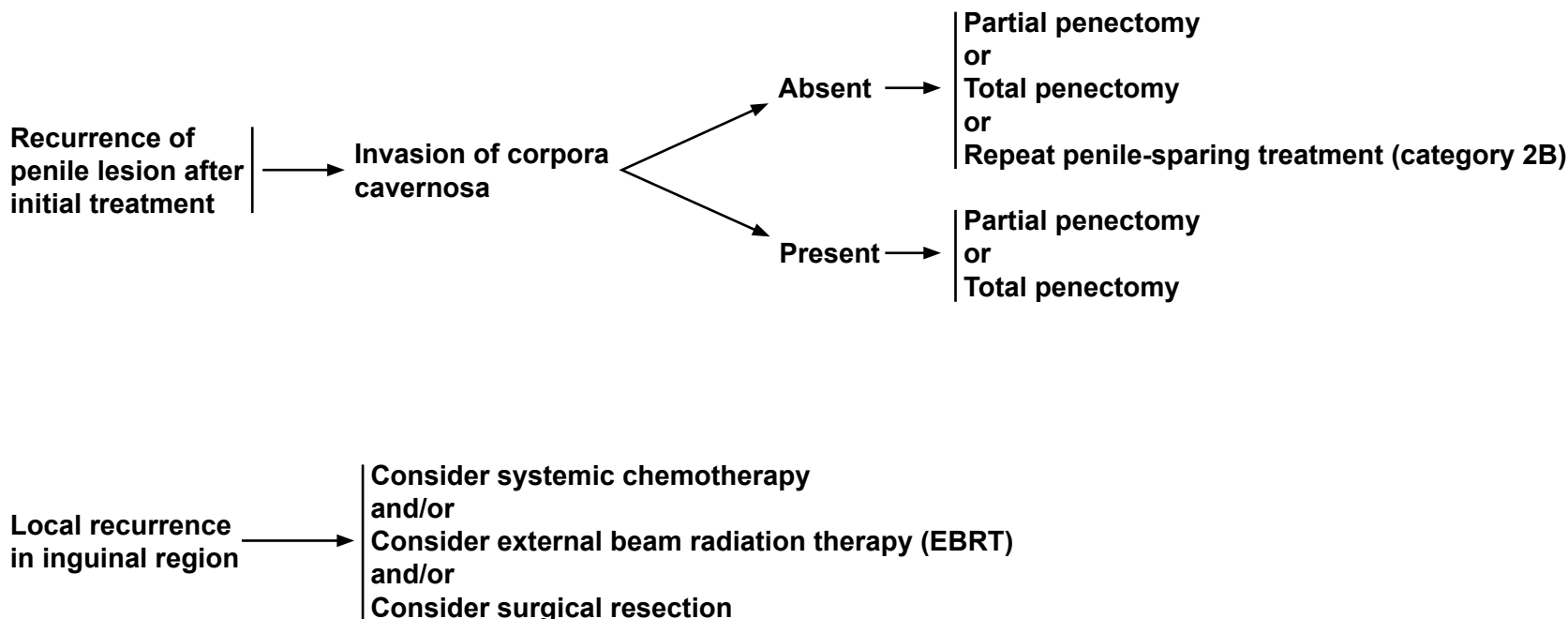
^wIf an abnormal clinical exam, obese patient, or prior inguinal surgery, then ultrasound, CT, or MRI of the inguinal region can be considered.

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MANAGEMENT OF RECURRENT DISEASE

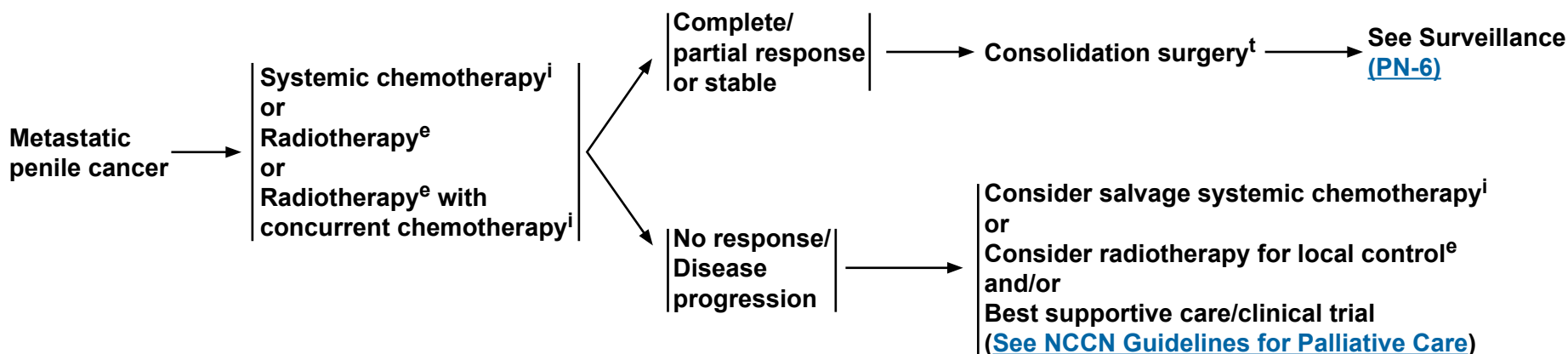


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MANAGEMENT OF METASTATIC DISEASE



^e[See Principles of Radiotherapy \(PN-B\).](#)

ⁱ[See Principles of Chemotherapy \(PN-C\).](#)

^tConsolidation surgery consists of bilateral superficial and deep ILND and possible bilateral PLND.

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PRINCIPLES OF SURGERY¹

- **Tis, Ta penile cancer lesions may be amenable to conservative penile organ-sparing approaches, including: topical therapy, local excision, circumcision, laser therapy (category 2B), or glansectomy (category 2B).**
- **Partial penectomy should be considered the standard for high-grade primary penile tumors, provided a functional penile stump can be preserved and negative margins are obtained.**
- **Standard or modified ILND or DSNB (category 2B) is indicated in patients with penile cancer in the absence of palpable inguinal adenopathy if high-risk features for nodal metastasis are seen in the primary penile tumor:**
 - ▶ **Lymphovascular invasion**
 - ▶ **≥pT1G3 or ≥T2, any grade**
 - ▶ **>50% poorly differentiated**
- **PLND should be considered at the time of ILND in patients with ≥2 inguinal nodes (on frozen section) on the ipsilateral ILND site or in a delayed procedure in patients with extranodal extension.**

¹See Discussion for further details regarding ILND and PLND.

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PRINCIPLES OF RADIOTHERAPY

Primary Radiation Therapy (category 2B) (Penile Preservation)

T1-2, N0

If tumor <4 cm

- Circumcision followed by either:

- ▶ Brachytherapy alone (preferred approach)^{1,2} (should be performed with interstitial implant);
or

- ▶ EBRT with or without chemotherapy:³ Total dose 65-70 Gy with conventional fractionation using appropriate bolus to primary penile lesion with 2 cm margins.

If tumor ≥4 cm

- Circumcision followed by either:

- ▶ EBRT with chemotherapy:³ 45-50.4 Gy to a portion of or whole penile shaft depending upon bulk and extent of lesion plus pelvis/inguinal nodes, then boost primary lesion with 2 cm margins EBRT (total dose 60-70 Gy);
or

- ▶ Brachytherapy (in select cases and with careful post-treatment surveillance)

T3-4 or N+ (surgically unresectable)

- Circumcision followed by:

- ▶ EBRT with chemotherapy:³ 45-50.4 Gy to whole penile shaft, pelvic lymph nodes, and bilateral inguinal lymph nodes, then boost primary lesion with 2 cm margins and gross lymph nodes (total dose 60-70 Gy).

Postoperative Adjuvant Radiotherapy

- Inguinal Lymph Node Positive

- ▶ Inguinal and pelvic lymph node EBRT to 45-50.4 Gy (strongly consider concomitant chemotherapy³).
- ▶ Boost gross nodes and areas of extracapsular extension to a total dose of 60-70 Gy.
- ▶ Treat primary site of disease if positive margin.

- Primary Site Margin Positive

- ▶ Primary site of disease and surgical scar EBRT to 60-70 Gy (for close margin consider radiation treatment vs. observation).
- ▶ Treat bilateral inguinal lymph nodes and pelvic lymph nodes if no or inadequate lymph node dissection.
- ▶ Brachytherapy (in select cases)

¹Crook J, Ma C, Grimard L. World J Urol 2009;27:189-196.

²de Crevoisier R, Slimane K, Sanfilippo N, et al. Int J Radiat Oncol Biol Phys 2009;74:1150-1156.

³For potential radiosensitizing agents and combinations, see [Principles of Chemotherapy \(PN-C 2 of 2\)](#).

Note: All recommendations are category 2A unless otherwise indicated.

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PRINCIPLES OF CHEMOTHERAPY

Neoadjuvant

- Neoadjuvant, cisplatin-based chemotherapy should be considered the standard (prior to ILND) in patients with ≥ 4 cm inguinal lymph nodes (fixed or mobile), if FNA is positive for metastatic penile cancer.¹
 - ▶ Patients with initially unresectable (T4) primary tumors may be downstaged by response to chemotherapy.
- A Tx, N2-3, M0 penile cancer can receive 4 courses of neoadjuvant paclitaxel, ifosfamide, and cisplatin (TIP).² Stable or responding patients should then undergo consolidative surgery with curative intent.
 - ▶ The phase II response rate was 50% in the neoadjuvant setting.
 - ▶ The estimated rate of long-term progression-free survival for intent to treat was 36.7%.
 - ▶ Improved progression-free and overall survival times were associated with objective response to chemotherapy.

Adjuvant

- There are no sufficient data to form conclusions about the use of adjuvant chemotherapy. By extrapolation from the neoadjuvant data, it is reasonable to give 4 courses of TIP in the adjuvant setting if it was not given preoperatively and the pathology shows high-risk features. ([See Management of Bulky/Unresectable Inguinal Lymph Nodes, PN-5](#)) Adjuvant EBRT or chemoradiotherapy can also be considered for patients with high-risk features, which include any of the following:
 - ▶ Pelvic lymph node metastases
 - ▶ Extranodal extension
 - ▶ Bilateral inguinal lymph nodes involved
 - ▶ 4 cm tumor in lymph nodes

Metastatic

- TIP is a reasonable first-line treatment for patients with metastatic penile cancer, including palliative treatment of patients with distant metastases.²
- 5-FU + cisplatin has been used historically for metastatic penile cancer and can be considered as an alternative to TIP.³ It appears to be effective for some patients, although the toxicities may be limiting and require dose reductions.⁴
- Bleomycin-containing regimens are associated with unacceptable toxicity⁵ and are no longer recommended.
- There are no randomized clinical trials due to the rarity of penile cancer in industrialized countries.

Second-line

- No standard second-line systemic therapy exists.
- A clinical trial is preferred. The evidence to support the palliative use of second-line therapy is limited.⁶ In select patients, paclitaxel⁷ or cetuximab⁸ may be considered, especially if not previously treated with a similar class of agent.

[Continued on PN-C 2 of 2](#)

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[References on PN-C 2 of 2](#)



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Penile Cancer

PRINCIPLES OF CHEMOTHERAPY

Preferred combination chemotherapy regimens

TIP²

Paclitaxel 175 mg/m² IV over 3 hours on Day 1
Ifosfamide 1200 mg/m² IV over 2 hours on Days 1-3
Cisplatin 25 mg/m² IV over 2 hours on Days 1-3
Repeat every 21 days

5-FU + cisplatin⁴ (category 2B)

Continuous infusion 5-FU 1000 mg/m²/d IV on Days 1-5
Cisplatin 100 mg/m² IV on Day 1
Repeat every 3 to 4 weeks

Radiosensitizing agents and combinations⁹ (For radiotherapy with concurrent chemotherapy)

• Preferred

‣ **Cisplatin alone, or in combination with 5-FU**

• Alternate options

‣ **Mitomycin C in combination with 5-FU**
‣ **Capecitabine (for palliation)**

References

1. Pettaway CA, Pagliaro L, Theodore C, Haas G. Treatment of visceral, unresectable, or bulky/unresectable regional metastases of penile cancer. *Urology* 2010;76:S58-65.
2. Pagliaro LC, Williams DL, Daliani D, et al. Neoadjuvant paclitaxel, ifosfamide, and cisplatin chemotherapy for metastatic penile cancer: a phase II study. *J Clin Oncol* 2010;28:3851-3857.
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4. Di Lorenzo G, Buonerba C, Federico P, et al. Cisplatin and 5-fluorouracil in inoperable, stage IV squamous cell carcinoma of the penis. *BJU Int* 2012;110(11 Pt B):E661-6.
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8. Carthon BC, Ng CS, Pettaway CA, Pagliaro LC. Epidermal growth factor receptor-targeted therapy in locally advanced or metastatic squamous cell carcinoma of the penis. *BJU Int* 2014;113:871-877.
9. Pagliaro LC, Crook J. Multimodality therapy in penile cancer: when and which treatments? *World J Urol* 2009;27:221-225.

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Penile Cancer

Table 1
**American Joint Committee on Cancer (AJCC)
TNM Staging System for Penile Cancer (7th ed., 2010)**
Primary Tumor (T)

TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Ta	Noninvasive verrucous carcinoma*
Tis	Carcinoma in situ
T1a	Tumor invades subepithelial connective tissue without lymph vascular invasion and is not poorly differentiated (i.e., grade 3-4)
T1b	Tumor invades subepithelial connective tissue with lymph vascular invasion or is poorly differentiated
T2	Tumor invades corpus spongiosum or cavernosum
T3	Tumor invades urethra
T4	Tumor invades other adjacent structures

*Note: Broad pushing penetration (invasion) is permitted; destructive invasion is against the diagnosis

Regional Lymph Nodes (N)

Clinical Stage Definition*

cNX	Regional lymph nodes cannot be assessed
cN0	No lymph node metastasis
cN1	Palpable mobile unilateral inguinal lymph node
cN2	Palpable mobile multiple or bilateral inguinal lymph nodes
cN3	Palpable fixed inguinal nodal mass or pelvic lymphadenopathy unilateral or bilateral

Pathologic Stage Definition*

pNX	Regional lymph nodes cannot be assessed
pN0	No regional lymph node metastasis
pN1	Metastasis in a single inguinal node
pN2	Metastasis in multiple or bilateral inguinal lymph nodes
pN3	Extranodal extension of lymph node metastasis or pelvic lymph node(s) unilateral or bilateral

*Note: Pathologic stage definition based on biopsy or surgical excision.

Distant Metastasis (M)

M0	No distant metastasis
M1	Distant metastasis

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ANATOMIC STAGE/PROGNOSTIC GROUPS

Stage 0	Tis	N0	M0
	Ta	N0	M0
Stage I	T1a	N0	M0
Stage II	T1b	N0	M0
	T2	N0	M0
	T3	N0	M0
Stage IIIA	T1-3	N1	M0
Stage IIIB	T1-3	N2	M0
Stage IV	T4	Any N	M0
	Any T	N3	M0
	Any T	Any N	M1



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Penile Cancer

Discussion

NCCN Categories of Evidence and Consensus

Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.

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Overview

Squamous cell carcinoma (SCC) of the penis is a rare disease, representing 0.4% to 0.6% of all malignant neoplasms among men in the United States and Europe.¹ In 2015, the estimated number of new cases of penile and other male genital cancers in the United States was 1820, with 310 predicted cancer-specific deaths.² Incidence is higher (up to 10%) among men in the developing countries of Asia, Africa, and South America.³ The most common age of presentation is between 50 and 70 years.⁴ Early diagnosis is of utmost importance, as this is a disease that can result in devastating disfigurement and has a 5-year survival rate of approximately 50% (over 85% for patients with negative lymph nodes and 29%–40% for patients with positive nodes, with the lowest survival rates at 0% for patients with pelvic lymph node [PLN] involvement).⁵ As the rarity of this disease makes it difficult to perform prospective, randomized trials, the NCCN Panel relied on the experience of penile cancer experts and the best currently available evidence-based data to collectively lay down a foundation to help standardize the management of the malignancy.

Literature Search Criteria and Guidelines Update Methodology

Prior to the update of this version of the NCCN Guidelines for Penile Cancer, an electronic search of the PubMed database was performed to obtain key literature published between August 21, 2013 and August 21, 2014, using the following search term: penile cancer. The PubMed database was chosen as it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.⁶

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article

types: Clinical Trial; Guideline; Meta-Analysis; Randomized Controlled Trial; Systematic Reviews; and Validation Studies.

The PubMed search resulted in 23 citations and their potential relevance was examined. The data from key PubMed articles as well as articles from additional sources deemed as relevant to these Guidelines and discussed by the panel have been included in this version of the Discussion section (eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel's review of lower-level evidence and expert opinion.

The complete details of the Development and Update of the NCCN Guidelines are available on the NCCN [webpage](#).

Risk Factors

In the United States the median age of diagnosis is 68 years, with an increase in risk for males older than 50 years.⁷ Early detection is assisted by the ability to do a good physical exam. Phimosis may hinder the capability to properly inspect the areas of highest incidence—the glans, inner preputial layer, coronal sulcus, and shaft. Men with phimosis carry an increased risk for penile cancer of 25% to 60%.^{4,8,9} A review of penile SCC in the United States showed that 34.5% of patients had the primary lesion on the glans, 13.2% on the prepuce, and 5.3% in the shaft, with 4.5% overlapping and 42.5% unspecified.⁷ Other risk factors include balanitis, chronic inflammation, penile trauma, tobacco use, lichen sclerosus, poor hygiene, and a history of sexually transmitted disease(s), especially HIV and HPV.⁴ Overall, about 45% to 80% of penile cancers are related to HPV, with a strong correlation with types 16 and 18.^{4,8,10,11} There is an 8-fold increased risk for patients with HIV, which may correspond to a higher incidence of HPV among males with HIV.¹² Cigarette smokers are noted to be 3 to 4.5 times more likely



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to develop penile cancer.^{10,13} Patients with lichen sclerosus are noted to have a 2% to 9% risk of developing penile carcinoma.¹⁴⁻¹⁶ Psoriasis patients undergoing psoralen plus ultraviolet A (PUVA) treatment have an increased penile cancer incidence of 286 times compared to the general population. Therefore, they should be shielded during treatment and any penile lesion should be closely monitored.¹⁷ A study of men with advanced penile SCC receiving systemic therapy identified visceral metastases and an ECOG performance score greater than or equal to 1 as poor prognostic factors for both overall survival and progression-free survival.¹⁸ Studies remain limited on predictive factors of prognosis in this patient population.

Clinical Presentation

Most often penile SCC presents as a palpable, visible lesion on the penis, which may be associated with penile pain, discharge, bleeding, or a foul odor if the patient delays seeking medical treatment. The lesion may be characterized as nodular, ulcerative, or fungating, and may be obscured by phimosis. The patient may exhibit signs of more advanced disease, including palpable nodes and/or constitutional symptoms (eg, fatigue, weight loss).

Characterization and Clinical Staging

SCC is the most common variant of penile cancer. Penile intraepithelial neoplasia (PIN) is a premalignant condition at high risk of developing into SCC of the penis.¹⁹ The AJCC recognizes four subtypes of SCC: verrucous, papillary squamous, warty, and basaloid.²⁰ The verrucous subtype is felt to be of low malignant potential, while other variants reported—adenosquamous and sarcomatoid variants—carry a worse prognosis.^{21,22} The primary lesion is further characterized by its growth pattern with superficial spread, nodular or vertical-phase growth, and verrucous pattern. In addition to the penile lesion, evaluation of lymph

nodes is also critical, as involvement of the inguinal lymph nodes (ILNs), the number and site of positive nodes, and extracapsular nodal involvement provide the strongest prognostic factors of survival.^{5,23}

The AJCC Tumor, Nodes, and Metastasis (TNM) system for penile carcinoma has been used for staging, with the most recent update published in 2010. It was initially introduced in 1968 and was subsequently revised in 1978, 1987, and 2002.^{20,24-27} In the 2010 update, the AJCC has made the distinction between clinical and pathologic staging while eliminating the difference between superficial and deep inguinal metastatic nodes.²⁰ Other changes to the 2010 TNM system include: T1 subdivided into T1a and T1b as determined by the presence or absence of lymphovascular invasion or poorly differentiated cancers; the T3 category is now limited to urethral invasion and T4 is limited to prostatic invasion; and stage II grouping includes T1b N0M0 as well as T2-3 N0M0 (see staging tables in the algorithm). A grading system for SCC of the penis based on degree of cell anaplasia is defined as: grade 1, well differentiated (no evidence of anaplasia); grade 2, moderately differentiated (<50% anaplasia); and grade 3, poorly differentiated (>50% anaplastic cells).²⁸ According to the AJCC, if no grading system is specified, a general system should be followed: GX, grade cannot be assessed; G1-3 as previously mentioned above; and G4, undifferentiated.²⁰ The overall degree of cellular differentiation with high-risk, poorly differentiated tumors is an important predictive factor for metastatic nodal involvement.²⁹ The AJCC also recommends collection of site-specific factors, including: the distinction between corpus spongiosum and corpus cavernosum involvement, the percentage of tumor that is poorly differentiated, the depth of invasion in verrucous carcinoma, the size of the largest lymph node metastasis, and HPV status.²⁰



Management of Primary Lesions

Diagnosis

Evaluation of the primary lesion, regional lymph nodes, and distant metastasis will dictate the appropriate and adequate management of SCC of the penis, beginning with the first evaluation at presentation and then throughout follow-up. Vital to the initial management is a good physical exam of the penile lesion(s) that remarks on the diameter of the lesion(s) or suspicious areas; location(s) on the penis; number of lesions; morphology of the lesion(s); whether the lesion(s) are papillary, nodular, ulcerous, or flat; and relationship with other structures including submucosal, urethra, corpora spongiosa, and/or corpora cavernosa. To complete the initial evaluation, a histologic diagnosis with a punch, excisional, or incisional biopsy is paramount in determining the treatment algorithm based on a pathologic diagnosis.^{20,30} This will provide information on the grade of the tumor, and will assist in the risk stratification of the patient for regional lymph node involvement.³⁰ MRI or ultrasound can be used to evaluate the depth of tumor invasion.³¹ For the evaluation of lymph nodes, see *Management of Regional Lymph Nodes*.

NCCN Recommendations

Tis or Ta

For patients with penile carcinoma *in situ* or noninvasive verrucous carcinoma, penis-preserving techniques may be utilized, including topical imiquimod (5%) or 5-FU cream, circumcision and wide local excision such as Mohs surgery, laser therapy (category 2B) using carbon dioxide or neodymium:yttrium-aluminum-garnet, and complete glansectomy (category 2B). Among these, topical therapy³²⁻³⁴ and excisional organ-sparing surgery³⁵ are the most widely used. Retrospective studies of laser therapy reported local recurrence rates of

around 18%, comparable to that of surgery, with good cosmetic and functional results.^{36,37} Glansectomy, removal of the glans penis, has also been studied with no recurrence observed in some cases.³⁸⁻⁴¹

T1G1-2

Careful consideration should be given to penile-preserving techniques if the patient is reliable in terms of compliance with close follow-up. These techniques include wide local excision as well as Mohs surgery as an option plus reconstructive surgery,⁴² laser therapy (category 2B),⁴³ and radiotherapy delivered as external beam radiation therapy (EBRT) or brachytherapy with interstitial implant (category 2B).⁴⁴⁻⁴⁸ Emphasis is placed again on patient selection and close follow-up, as the 2-year recurrence rate may reach up to 50%.⁴⁹ Studies have shown that surgical margins of 5 to 10 mm are as safe as 2-cm surgical margins, and 10- to 20-mm margins provide adequate tumor control.⁵⁰ Circumcision should always precede radiation therapy (RT) to prevent radiation-related complications.

T1G3-4 or T≥2

These lesions typically require more extensive surgical intervention with partial or total penectomy depending on the characteristics of the tumor and depth of invasion.³⁰ Intraoperative frozen sectioning is recommended to achieve negative surgical margins. If the tumor encompasses less than half of the glans and the patient agrees to very close observation, then a more conservative approach such as wide local excision or glansectomy may be considered. The patient should understand that there is an increased risk for recurrence and potential for a repeat wide local excision should a local recurrence be noted, provided there is no invasion of the corpora cavernosa.^{37,41} A clear and frank discussion should be had with the patient that a partial or total penectomy will likely be required should a larger or more invasive lesion be present.



The tumor size is an important factor when choosing RT as treatment. As the average length of the glans is about 4 cm, this serves as a cutpoint to reduce the risk of under-treating cavernosal lesions. In a study of 144 patients with penile cancer restricted to the glans treated by brachytherapy, larger tumors, especially those over 4 cm, are associated with higher risk of recurrence.⁵¹ A high, 10-year, cancer-specific survival rate of 92% was achieved in this series.

There was nonuniform consensus among NCCN Panelists on the use of RT as primary therapy due to scant data. RT alone is a category 2B recommendation, while RT with concurrent chemotherapy is a category 3 recommendation. RT should be given after circumcision has been performed.

For tumors smaller than 4 cm, brachytherapy with interstitial implant is preferred, but EBRT with or without chemotherapy is a viable option. Consider prophylactic ILN irradiation if selecting EBRT. For tumors 4 cm or larger, EBRT combined with chemotherapy may be used. Brachytherapy may still be appropriate in select cases, but careful monitoring is necessary as the risks of complications and failures increase.⁵² Crook and colleagues reported a 10-year cause-specific survival of 84% in 67 patients with T1-2 (select cases of T3) penile lesions treated with primary brachytherapy.⁴⁸

Post-surgical RT to the primary tumor site may be considered for positive margins.

Management of Regional Lymph Nodes

Evaluation and Risk Stratification

The presence and extent of regional ILN metastases has been identified as the single most important prognostic indicator in determining long-term survival in men with invasive penile SCC.²³

Evaluation of the groin and pelvis is an essential component of the metastatic workup of a patient. The involvement of the ILN can be clinically evident (ie, palpable vs. non-palpable), adding to the difficulty in management. Clinical exam for ILN involvement should attempt to evaluate and assess for palpability, number of inguinal masses, unilateral or bilateral localization, dimensions, mobility or fixation of nodes or masses, relationship to other structures (eg, skin, Cooper's ligaments), and edema of the penis, scrotum, and/or legs.^{53,54}

Crossover drainage from left to right and vice versa does occur and is reproducible with lymphoscintigraphy.^{5,55} The physical exam should describe the diameter of node(s) or mass(es), unilateral or bilateral localization, number of nodes identified in each inguinal, and the relationship to other structures, particularly with respect to the mobility or fixation of the node(s) or mass(es) to adjacent structures and/or involvement of the overlying skin. Imaging for palpable disease by CT or MRI may be used to assess the size, extent, location, and structures that are in close proximity to the ILN, as well as the presence of pelvic and retroperitoneal lymph nodes and distant metastasis. CT and MRI are limited in patients with non-palpable disease.^{53,56} While studies have looked at the use of nanoparticle-enhanced MRI, PET/CT, and 18F-fluorodeoxyglucose (FDG) PET/CT, the small sample sizes require validation in larger prospective studies.⁵⁷⁻⁶⁰ When considering one imaging modality to evaluate the stage of the primary lesion and lymph node status, MRI appears to be the best choice to enhance the physical exam in patients where the inguinal region is difficult to assess (eg, morbidity, previous chemotherapy/radiotherapy).^{57,61}

Consideration needs to be given to whether or not the primary lesion demonstrated any adverse prognostic factors. If one or more of these high-risk features is present, then pathologic ILN staging must be performed. Up to 25% of patients with non-palpable lymph nodes harbor



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micrometastases.²⁸ Therefore, several predictive factors have been evaluated to help predict the presence of occult lymph node metastasis.^{49,62} Slaton et al²⁸ concluded that patients with pathologic stage T2 or greater disease were at significant risk (42%–80%) of nodal metastases if they exhibited greater than 50% poorly differentiated cancer and/or vascular invasion, and therefore should be recommended to undergo an inguinal lymph node dissection (ILND).^{5,28} These factors can then further define patients into low-, intermediate-, and high-risk groups for lymph node metastasis.^{21,63,64} The European Association of Urology determined risk stratification groups for patients with non-palpable ILNs, and validated this in both uni- and multivariate analyses of prognostic factors. Patients can be stratified based on stage and/or grade into risk groups based on the likelihood of harboring occult node-positive disease, with the low-risk group defined as patients with Tis, Ta, or T1a disease, the intermediate group as those with T1b disease (lymphovascular invasion), and the high-risk group as those with T2 or G3/G4 disease.^{54,63}

There is a paucity of data regarding the predictive value of lymph node removal. A singular study suggests that disease-specific survival following radical lymphadenectomy can be predicted by the lymph node count and lymph node density.⁶⁵ Removal of greater than or equal to 16 lymph nodes in patients with pathologic negative nodes was associated with a significantly longer disease-specific survival rate ($P < 0.05$). Furthermore, the 5-year disease-free survival in patients with pathologic positive nodes was 81.2% in patients with lymph node density greater than 16% compared to 24.4% in patients with less than 16% lymph node density ($P < 0.001$).⁶⁵ Although this study suggests that lymph node count and density may be useful in predicting disease-specific survival, a larger validation study is necessary to support these preliminary data.

Dynamic Sentinel Node Biopsy

The work by Cabanas used lymphangiograms and anatomic dissections to evaluate the sentinel lymph node drainage for penile cancer with non-palpable ILNs.⁶⁶ This technique has been shown to have false-negative rates as high as 25%; therefore, it is no longer recommended.^{54,67} Advancements have been made with the dynamic sentinel node biopsy (DSNB) technique developed for penile cancer by the Netherlands Cancer Institute using lymphoscintigraphy and performed with technetium-99m–labeled nanocolloid and patent blue dye isosulfan blue.^{68,69} Initially, this technique was associated with a low sensitivity and high false-negative rate (16%–43%).⁷⁰⁻⁷³ Refinement of the technique to include serial sectioning and immunohistochemical staining of pathologic specimens, preoperative ultrasonography with and without fine needle aspiration (FNA) cytology, and exploration of groins in which no sentinel node is visualized on intraoperative assessment decreased the false-negative rate from 19% to only 5%.^{68,74} Using FNA with ultrasound can increase the diagnostic yield in metastases greater than 2 mm in diameter.^{56,75} Crashaw et al⁷⁶ used ultrasound with DSNB and noted improved accuracy in identifying patients with occult lymph node metastases. With modification of the NCI protocol, Hadway et al⁷⁷ were able to achieve a similar false-negative rate (5%) with an 11-month follow-up. A recent observational cohort study of 1000 patients treated between 1956 and 2012, suggests that DSNB can improve 5-year survival in patients with clinically node-negative groins.⁷⁸ Data in this study showed that patients treated prior to 1994 (the year DSNB was incorporated into treatment) had an 82% 5-year survival compared to the 91% 5-year survival seen in patients treated between 1994 and 2012 ($P = 0.021$). However, there are several limitations of this study including the possibility that improved staging resulted in more patients being grouped in a higher risk group. Therefore, incorporation of DSNB into treatment guidelines should be



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limited to centers with experience. Secondary to the technical challenges associated with DSNB, to be accurate and reliable, it is recommended that DSNB be performed at tertiary care referral centers where at least 20 procedures are done per year.^{68,79} It should be noted that DSNB is not recommended in patients with palpable ILNs.⁵³

Inguinal Lymph Node Dissection

The most frequent sites of metastasis from penile cancer are the ILNs, typically presenting as palpable inguinal lymphadenopathy. The management of ILNs by ILND has been fraught with great fears of surgical morbidity.^{54,80} Early treatment of lymph node involvement has been shown to have a positive impact on survival, except if the patient has bulky nodal spread or other sites of metastases.^{81,82} Palpable lymphadenopathy at the time of diagnosis does not warrant an immediate ILND. Of the patients with palpable disease, 30% to 50% will be secondary to inflammatory lymph node swelling instead of metastatic disease.⁶² Although the distinction between reactive lymph nodes and metastatic disease has traditionally been done with a 6-week course of antibiotics, percutaneous needle biopsy is becoming the favored approach among many penile cancer experts for patients with palpable nodes.^{5,53} In this setting, antibiotics are useful if the patient has a suspected underlying cellulitis at the site of palpable inguinal lymphadenopathy and future site of ILND.^{5,53,83}

The boundaries of the standard, full-template ILND (ie, Daseler's quadrilateral area) are: superiorly, the inguinal ligament; inferiorly, the fossa ovalis; laterally, the medial border of sartorius muscle; and medially, the lateral edge of adductor longus muscle.⁸³ Historically, it has been recommended to keep the patient on bed rest for 48 to 72 hours, especially after myocutaneous flaps or repair of large skin defects, although the necessity for this is debatable and not

corroborated with rigorous scientific data. Closed suction drains are placed at surgery and are typically removed when drainage is less than 50 to 100 mL per day.^{83,84} Consideration should be given to keeping the patient on a suppressive dose of an oral cephalosporin (or other gram-positive, broad-spectrum antibiotic) for several days to weeks postoperatively in an attempt to decrease the risk of wound-related issues and minimize the risk for overall complications. However, the data supporting this treatment approach are very limited.⁸³

Modified Template Lymphadenectomy

In attempts to decrease the morbidity associated with standard ILND, a modified template lymphadenectomy has been proposed that uses a shorter skin incision, limiting the field of inguinal dissection by excluding the area lateral to the femoral artery and caudal to the fossa ovalis, with preservation of the saphenous vein and elimination of the need to transpose the sartorius muscle while providing an adequate therapeutic effect. This technique is commonly reserved for patients with a primary tumor that places them at increased risk for inguinal metastasis but with clinically negative groins on examination.^{83,85} The modified technique has shown a decrease in complications. Contemporary modified ILND should include the central and superior zones of the inguinal region, as these sections were not included in the dissection leading to a false-negative rate of 15%.^{86,87} It is important to note that if nodal involvement is detected on frozen section, the surgical procedure should be converted to a standard, full-template lymphadenectomy. A standard full-template lymphadenectomy should be considered in all patients who have resectable inguinal lymphadenopathy. However, studies would favor neoadjuvant chemotherapy prior to proceeding with surgery, particularly in patients with bulky ILN metastases (ie, fixed nodes or nodal diameter ≥ 3 cm).^{88,89} Generally, ILND is performed within 4 to 6 weeks following the completion of systemic chemotherapy to allow



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patient recovery while minimizing the risk of cancer progression post-chemotherapy.

Delayed Inguinal Lymphadenectomy

Since data exist that suggest men with clinically negative groins undergoing immediate ILND have better survival outcomes than men undergoing delayed ILND once their groins are clinically positive, it is recommended that in most circumstances men with high-risk penile tumors should undergo immediate ILND. However, patients with lower-risk tumors who are undergoing active surveillance or high-risk men who refuse immediate ILND may experience an inguinal nodal recurrence at some time point during follow-up. The median time to inguinal recurrence after treatment of the primary penile tumor is approximately 6 months, with 90% occurring by year 3 and 100% by year 5.⁹⁰⁻⁹²

Unilateral Versus Bilateral Lymphadenectomy

In patients with high-risk features that do not have palpable lymph nodes, bilateral lymphadenectomy is generally performed, because it is not possible to predict the laterality of inguinal nodal metastasis based on the location of the tumor on the penis. Similarly, in patients who have a unilateral palpable node, about 30% will have contralateral positive nodes that are not palpable.⁹³ Therefore, bilateral lymphadenectomy should be considered the standard of care in patients undergoing immediate ILND for high-risk penile tumors or because of palpable nodes. When there is a delayed (>1 year after treatment of the primary penile tumor) inguinal recurrence of cancer, it is usually unilateral, and some authors have suggested that ipsilateral ILND is adequate while others have advocated for bilateral ILND in this circumstance.⁵

Pelvic Lymphadenectomy

Approximately 20% to 30% of patients with positive ILNs will also have cancer within PLNs. Interestingly, penile tumors do not appear to metastasize to the PLNs without first affecting the inguinal node echelon (ie, no skip lesions).^{66,92} Patients who have only one positive inguinal node have a risk of pelvic nodal involvement of less than 5% as reported by the Netherlands Cancer Institute.⁹⁴ The presence of cancer within the PLN is associated with a very poor 5-year survival rate that is typically of less than 10%. Based on these prior reports, pelvic lymphadenectomy (resection of external iliac, internal iliac, and obturator lymph nodes) is recommended in patients with 2 or more positive ILNs and in the clinical context of high-grade cancer within the ILN pathologic specimen. Pelvic lymph node dissection (PLND) can be conducted during the same operative session as the ILND if the intraoperative frozen section is positive in 2 or more of the inguinal nodes (raising the importance of obtaining a lymph node count intraoperatively) or in a delayed staged fashion based on the pathologic features of the ILND specimen.^{95,96}

One area of controversy is whether the PLND should be performed ipsilaterally or bilaterally in patients with unilateral positive ILNs. Crossover (right to left or left to right) of inguinal to pelvic nodes has not been well studied; hence, both approaches are feasible and left at the discretion of the surgeon based on case-specific characteristics.

Chemotherapy

A patient who presents with resectable bulky disease will rarely be cured with a single treatment modality. Consideration should be given to neoadjuvant chemotherapy if ILNs are greater than or equal to 4 cm. Patients who may benefit from surgical consolidation would be those who had stable, partial, or complete response following systemic



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chemotherapy, thus increasing their potential for disease-free survival.^{88,89} Pagliaro et al⁹⁷ performed a phase II clinical trial in 30 patients, with stage N2 or N3 (stage III or stage IV) penile cancer without distant metastases, receiving neoadjuvant chemotherapy with paclitaxel, ifosfamide, and cisplatin. In this series, 50% of patients were noted to have a clinically meaningful response and 22 patients (73.3%) subsequently underwent surgery. There was an improved time to progression and overall survival associated with chemotherapy responsiveness ($P < .001$ and $P = .001$, respectively), absence of bilateral residual tumor ($P = .002$ and $P = .017$, respectively), and absence of extranodal extension ($P = .001$ and $P = .004$, respectively) or skin involvement ($P = .009$ and $P = .012$, respectively).

NCCN Recommendations

Non-Palpable Nodes

Most low-risk patients are followed with a surveillance protocol, as the probability of occult micrometastases in ILNs is less than 17%.^{63,91} For patients at high or intermediate risk, a modified or radical inguinal lymphadenectomy is strongly recommended as occult metastatic disease ranges between 68% and 73%.^{49,63,91} If positive nodes are present on the frozen section, then a superficial and deep inguinal lymphadenectomy should be performed (with consideration of a PLND).

As DSNB is currently not widely practiced in the United States, it is a category 2B option for examining non-palpable nodes to determine the need for a modified lymphadenectomy in place of predictive factors.^{98,99} This technique should be performed in tertiary care referral centers with substantial experience. DSNB is not recommended for Ta tumors, as observation alone of the ILNs is sufficient for these well-differentiated lesions in the absence of palpable adenopathy.

Unilateral Palpable Nodes <4 cm

Lymph node biopsy is considered standard for these patients if no risk feature is present in the primary lesion. Risk features include T1 tumors; high grade, lymphovascular invasion; and poor differentiation in more than half of the tumor cells. The NCCN Panel recommends omitting the procedure for patients with high-risk primary lesions to avoid delay of lymphadenectomy. A negative lymph node biopsy should be confirmed with an excisional biopsy. Alternatively, careful surveillance may be considered following a negative lymph node biopsy. Positive findings from either procedure warrant an immediate ILND.

Palpable Nodes ≥4 cm (fixed or mobile)

Large, unilateral, mobile nodes should first be confirmed by needle biopsy. A negative needle biopsy should be confirmed by an excisional biopsy. Patients with confirmed nodes are amenable to standard or modified ILND. Neoadjuvant chemotherapy should be considered before surgery. No further treatment is necessary if no viable tumor elements are detected in the surgical specimen. Patients with viable disease in a single node after undergoing systemic chemotherapy can be considered for a PLND, but the evidence supporting this approach is sparse. Postoperative radiotherapy or chemoradiotherapy may be considered in patients after PLND, particularly in the setting of a positive surgical margin, viable cancer in multiple inguinal or pelvic lymph nodes, and/or presence of extranodal extension on the final pathologic specimen.

In the case of multiple or bilateral ILNs, patients should undergo a needle biopsy of the lymph nodes regardless of whether these are mobile or fixed. A negative result should be confirmed with excisional biopsy. If results are again negative, the patient should be closely followed. Patients with a positive aspiration or biopsy should receive neoadjuvant systemic chemotherapy followed by ILND and PLND.



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Patients with abnormal PLNs on imaging (CT or MRI) are stratified by resectability. Nonsurgical candidates should be treated with chemoradiation. Patients with resectable disease should receive neoadjuvant systemic chemotherapy with consideration of a confirmatory percutaneous biopsy or PET/CT. Patients who respond to therapy or become stable should undergo bilateral superficial and deep ILND and bilateral PLND if deemed resectable. Patients with disease that progresses may receive additional systemic chemotherapy with consideration of local-field radiation or participation in a clinical trial.

Surveillance

Initial treatment of the primary tumor and lymph nodes dictates the follow-up schedule (see algorithm). A large retrospective review of 700 patients found that penile-sparing therapies carry a significantly higher risk of local recurrence (28%) than partial or total penectomy (5%) and thus require closer surveillance.⁹² Patients without nodal involvement had a regional recurrence rate of 2% compared to 19% for patients with node-positive disease. Of all recurrences, 92% were detected within 5 years of primary treatment.

Follow-up for all patients includes a clinical exam of the penis and inguinal region. Imaging is not routinely indicated for early disease (except for obese patients or patients who have undergone inguinal surgery since a physical exam may be challenging), but may be used upon abnormal findings. For patients with N2 or N3 disease, imaging of the chest, abdomen, and pelvic area is recommended.

Recurrence

Invasion of the corpora cavernosa is an adverse finding after initial organ-sparing treatment that warrants partial or total penectomy.^{100,101}

For primary tumor recurrences without corpora cavernosa infiltration, repeat penile-sparing options can be considered (category 2B).

A recurrence in the inguinal region carries a poor prognosis (median survival, <6 months) and optimal management remains elusive. Possible salvage options include systemic chemotherapy, EBRT, surgery, or a combination thereof.^{53,102} A recent study suggests that salvage ILND may be beneficial in patients with penile cancer with locally recurrent ILN metastases.¹⁰³ While potentially curative, patients must be advised of the high incidence of postoperative complications.¹⁰³

Metastatic Disease

Imaging of the abdomen and pelvis should be obtained when metastasis is suspected to evaluate for pelvic and/or retroperitoneal lymph nodes. PLN metastasis is an ominous finding, with a 5-year survival rate of 0% to 66% for all cases and 17% to 54% for microscopic invasion only, with a mean 5-year survival of approximately 10%.^{5,104-108} In patients with ILN metastases, 20% to 30% will have PLN metastases.⁵ This can be further characterized such that if 2 to 3 ILNs are involved, there is a 23% probability of PLN involvement. With involvement of 3 or more ILNs, this probability increases to 56%.¹⁰⁹

Lughezzani et al⁹⁵ identified three independent predictors of PLN metastases that included the number of inguinal metastases (OR, 1.92; $P < 0.001$), the diameter of the metastases (OR, 1.03; $P = 0.001$), and extranodal extension (OR, 8.01; $P < 0.001$). Similar to previous studies, patients with 3 or more ILN metastases had a 4.77-fold higher risk of PLN metastasis. An ILN metastasis diameter of 30 mm or greater correlated with a 2.53-fold higher risk of PLN metastasis. Patients who showed no risk factors had a 0% risk of metastasis, suggesting that this group may not require PLND.⁹⁵



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Pettaway et al¹¹⁰ evaluated the treatment options for stage IV penile cancer—clinical stage N3 (deep inguinal nodes or pelvic nodes) or M1 disease (distant metastases)—including chemotherapy, radiotherapy, and inguinal lymphadenectomy. Cisplatin-based regimens (paclitaxel, ifosfamide, and cisplatin or alternatively 5-FU plus cisplatin) are the most active first-line systemic chemotherapy regimens.^{30,97,111} The panel did not recommend regimens containing bleomycin because of high toxicity.¹¹² Patients with a proven objective response to systemic chemotherapy are amenable to consolidative ILND with curative potential or palliation. However, surgical consolidation should not be performed on patients with disease that progresses during systemic chemotherapy except for local symptomatic control. Preoperative radiotherapy may also be given to patients who have lymph nodes greater than or equal to 4 cm without skin fixation to improve surgical resectability and decrease local recurrence. For patients with unresectable inguinal or bone metastases, radiotherapy may provide a palliative benefit after chemotherapy. Salvage systemic chemotherapy may also be considered upon disease progression. The NCCN Panel strongly recommends consideration of clinical trial participation as data are limited in the second-line setting. However, in select patients, paclitaxel¹¹³ or cetuximab¹¹⁴ may be considered, especially if previous treatments did not include a similar class of agent. Best supportive care remains an option for advanced cases.

therapeutic efficacy and minimizing treatment-related morbidity.

Prognostic factors help predict if lymph node metastases are suspect in the absence of any palpable inguinal lymphadenopathy. When clinically indicated, an ILND has curative potential, particularly when performed early, with contemporary surgical series demonstrating its reduced morbidity.

Summary

SCC of the penis is a disease that mandates prompt medical/surgical intervention and patient compliance to obtain the most favorable outcomes. A thorough history and physical is the initial step in this process, followed by a biopsy of the primary lesion to establish a pathologic diagnosis. Accurate clinical staging allows for a comprehensive treatment approach to be devised, thus optimizing



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