CARCINOMA OF THE PENIS

Key Words:	Cancer, Penis, Radiotherapy, Chemotherapy, Endocrine

Lead Clinicians: Prof. N. James, Dr E Porfiri, Dr R Stevenson, Dr D Fackrell, Dr D Henderson Dr A El Modir, Dr D Ford, Dr A Zarkar

1. SQUAMOUS CELL CARCINOMA

General management as for skin/head and neck.

1.1 PRIMARY MANAGEMENT

1.1.1 Small primary:

- Surgery - referral to Regional Genito-urinary Plastic Surgery Unit should be strongly considered for resection plus elective reconstruction as single procedure.
- CTV - gross tumour + 15 mm for microscopic spread.
- Radiotherapy - implant/electrons to the equivalent of 55 Gy in 6 days for the implant, and electrons to the equivalent of 60 Gy in 2 Gy daily fractions.
- Electrons - energy as appropriate - OR wax block technique: 60 Gy MPD in 2 Gy daily fractions - 2 lateral fields.

1.2 Cytotoxic chemotherapy:

- Chemotherapy is associated with palliation, and should preferably be used in the context of a clinical trial.
- Recent work suggests synchronous chemo-radiotherapy should be considered in all locally advanced SCC's of urogential region.

2. NODAL MANAGEMENT

Nodal management - N0:

- No prophylactic radiotherapy or surgery.

Nodal management – N1 (operable):

- Bilateral radical block dissection:
- Postoperative radiotherapy only if disease is microscopically invading the soft tissue, ie penetrating the lymph node capsules (as for head and neck).
- The equivalent of 50 Gy in 25 daily fractions over 5 weeks.
- CTV - known extent of pathological spread, first echelon nodes.

Nodal management – inoperable:

- Palliative radiotherapy – 21Gy in 3 daily fractions over 1 week.
- Palliative chemotherapy.

CLINICAL TRIALS

There is a large portfolio of current clinical trials. Details can be obtained from Prof James or Dr Porfiri.