# Treatment

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Management is divided into treatment of the primary tumour and treatment of the inguinal nodes. Patients with small lesions surgery , such as limited excision, Mohs’ surgery or laser ablation. Mohs’ micrographic surgery is based on sequential tissue excision under repeat microscopic control. This helps in accurately identifying the tumour margin and maximally preserves the uninvolved tissues. For most primary tumours surgical excision is the mainstay of treatment, with the tradi tional view that a 2-cm margin of normal tissue be removed being superseded by a more recent, more conservative view , such that penis-preserving surgery with excision of m uch lower margins of normal tissue is now accepted. Tumours a ff ecting the glans penis require glansectomy , with more advanced tumours requiring partial penectomy . In advanced cases, total penectomy is required with the formation of a perineal urethrostomy . These techniques are indicated even in advanced metastatic disease for reasons of local control. Treatment of any associated enlarged inguinal lymph nodes should be delayed until at least 3 weeks after local treat ment of the primary lesion. Enlargement caused by infection will usually show signs of subsiding with antibiotic tr eatment. For palpable nodes, ultrasound-guided fine-needle aspiration will confirm the diagnosis and a block dissection of both groins should be undertaken. The management of patients wher the nodes are not palpable involves the use of sentinel lymph node biopsy (SLNB) followed by inguinal node dissection if the SLNB is positive. Management of the pelvic nodes is controversial. When they are involved on CT scanning, surgery probably has little role; however, when the iliac nodes ar e not enlarged in the presence of N2 disease, the options are observation, pelvic lymphadenectomy or radiotherapy . Chemotherapy is relatively ine ff ective and currently is reserved for palliation in those with metastatic disease. The prognosis for tumours confined to the penis is good with 5-year survival rates in excess of 80%. With nodal involvement the 5-year survival rate falls to around 40%. Summary box 85.10 Carcinoma of the penis /uni25CF /uni25CF /uni25CF

Enlargement of super /f_i cial inguinal lymph nodes may be caused by infection or metastatic spread Surgery is the mainstay of treatment Nodal involvement indicates a poor prognosis

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