**Supplementary Materials for “”RECOMMENDATIONS FOR THE TREATMENT OF VULVAR CANCER IN SETTINGS WITH LIMITED RESOURCES: REPORT FROM THE INTERNATIONAL GYNECOLOGICAL CANCER SOCIETY CONSENSUS MEETING ‘’**

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**Supplementary Table 1: List of 38 countries represented by the panel**

Argentina, Bahamas, Bangladesh, Bolivia, Brazil, China, Colombia, Egypt, Ethiopia, Georgia, Ghana, Guatemala, Haiti, India, Indonesia, Italy, Jamaica, Jordan, Lebanon, Mexico, Mozambique, Nepal, Nigeria, Pakistan, Peru, Philippines, Qatar, Romania, Saudi Arabia, South Africa, Syria, Thailand, Tunisia, Turkey, Uganda, Ukraine, Venezuela, and Zambia

**Supplementary Table 2.** Questions related to staging of vulvar cancer.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Questions | **Responses** (%) | | | | | | |
| Which imaging tools are indicated for staging of vulvar tumors ≤2.0 cm in greatest dimension in an area with limited resources? | Pelvic and abdominal ultrasound, chest X-ray, and bone scan | Thoracic, abdominal and pelvic CT (or pelvic MRI) and bone scan | Thoracic, abdominal and pelvic CT (or pelvic MRI) | Pelvic and abdominal ultrasound and chest X-ray | None | Abstain | - |
| 5.7% | 5.7% | 28.2% | 38.7% | 20.2% | 1.6% | - |
| Which imaging tools are indicated for staging vulvar tumors >2.0 cm and or suspected lymph node involvement in an area with limited resources? | Pelvic and abdominal ultrasound, chest X-ray, and bone scan | Thoracic, abdominal and pelvic CT (or pelvic MRI) and bone scan | Thoracic, abdominal and pelvic CT (or pelvic MRI) | Pelvic and abdominal ultrasound and chest X-ray | Chest X-ray, abdominal and pelvic CT (or pelvic MRI) | None | Abstain |
| 1.6% | 6.6% | 66.4% | 10.7% | 12.3% | 1.6% | 0.8% |
| When not all the imaging tools are available, which method is best indicated for systemic staging patients with suspected metastatic vulvar cancer? | Pelvic and abdominal ultrasound, chest X-ray, and bone scan | Thoracic, abdominal and pelvic CT and bone scan | Thoracic, abdominal and pelvic CT | Pelvic and abdominal ultrasound and chest X-ray | None | Abstain | - |
| 4.7% | 15.8% | 63.8% | 14.2% | 1.6% | 0% | - |

Legend: Answers to not all questions may total 100% due to rounding.CT, computed tomography; MRI, magnetic resonance imaging.

**Supplementary Table 3. Questions related to surveillance of vulvar cancer.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Responses (%)** | | | | | |
| How often do you follow up patients treated with early-stage disease after curative treatment in an area with limited resources? | Every 3 months in the first 2 years, after that, every 6 months until 5 years from the treatment | Every 6 months until 5 years from the treatment | Annually until 5 years from the treatment | Every 6 months in the first 2 years, after that, annually until 5 years from the treatment | None | Abstain |
| 57.6% | 18.9% | 1.5% | 22.0% | 0% | 0% |
| What image tools do you recommend for follow-up in patients treated with early-stage disease after curative treatment in an area with limited resources? | Clinical examination only | Pelvic and abdominal ultrasound and chest X-ray | Pelvic and abdominal CT and chest X-ray | Abstain | - | - |
| 71.2% | 14.4% | 12.9% | 1.5% | - | - |

Legend: Answers to not all questions may total 100% due to rounding.CT, computed tomography.

**Supplementary** **Table 4.** **Questions related to the treatment of early-stage vulvar cancer**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Responses (%)** | | | | | |
| What is the minimal microscopic margin considered adequate at the final pathology of invasive vulvar carcinoma (T1a – T2)? | Any free margin | 1 mm of free margin | 5 mm of free margin | 8 mm of free margin | 10 mm of free margin | Abstain |
| 4.3% | 7.8% | 24.1% | 39.7% | 23.3% | 0.9 |
| For patients with T1b – T2 <4cm vulvar carcinoma, what is the recommended approach regarding the use of sentinel lymph node dissection in an area with limited resources? | Should not be used | Should be used only with technetium, when it is available | Should be used with technetium or blue dye | Should be used with technetium and blue dye | Abstain | - |
| 17.7% | 9.4% | 40.2% | 32.7% | 0% | - |
| For patients with T1b – T2 <4cm vulvar carcinoma close to 2 cm from the midline, if the Lymphoscintigraphic shows technetium only in one side, what is the recommended approach on contra-lateral side? | Observation | Inguinofemoral Lymphadenectomy | Use blue dye and sentinel lymph node dissection | Radiotherapy | Abstain | - |
| 9.9% | 60.4% | 26.7% | 3.0% | 0% | - |
| Considering patients with T1b or T2 vulvar carcinomas more than 2 cm from the midline and positive homolateral inguinal lymph node, what is the recommended treatment for the contra-lateral inguinal lymph nodes in an area with limited resources? | No need for further treatment | Contra-lateral inguinofemoral lymphadenectomy | No further surgery and proceed with radiation alone | No further surgery and proceed with radiation with chemotherapy | Abstain | - |
| 13.7% | 58.7% | 10.1% | 17.4% | 0% | - |
| Considering patients with T1b or T2 vulvar carcinomas more than 2 cm from the midline and positive homolateral inguinal lymph node, what is the recommended treatment for the contra-lateral inguinal lymph nodes, in an area without access to radiotherapy? | No need for further treatment | Contra-lateral inguinofemoral lymphadenectomy | No further surgery and proceed with chemotherapy | Abstain | - | - |
| 5.8% | 85.4% | 4.9% | 3.9% | - | - |
| Considering patients with T1b or T2 vulvar carcinomas more than 2 cm from the midline and positive homolateral inguinal lymph node, what is the recommended treatment for the contra-lateral inguinal lymph nodes, in an area where surgeons do not have a full training in gynecology oncology? | No need for further treatment | Contra-lateral inguinofemoral lymphadenectomy | No further surgery and proceed with radiation alone | No further surgery and proceed with radiation with chemotherapy | Abstain | - |
| 2.3% | 17.2% | 27.6% | 46.0% | 6.9% | - |
| Considering patients with T1b or T2 vulvar carcinomas more than 2 cm from the midline and positive homolateral inguinal lymph node, what is the recommended treatment for the contra-lateral inguinal lymph nodes, in an area without access to radiotherapy and surgeons do not have a full training in gynecology oncology? | No need for further treatment | Contra-lateral inguinofemoral lymphadenectomy | No further surgery and proceed with chemotherapy | Abstain | - | - |
| 8.7% | 24.0% | 40.4% | 26.9% | - | - |
| What is your treatment recommendation for early-stage (I or II) patient with resected vulvar cancer that is node-negative after lymphadenectomy, tumor <4 cm and negative margins in areas with limited resources? | Observation | Adjuvant radiotherapy alone | Adjuvant radiotherapy and chemotherapy | Adjuvant chemotherapy alone | Abstain | - |
| 82.2% | 13.9% | 2.0% | 2.0% | 0.0% | - |
| What is your treatment recommendation for early-stage (I or II) patient with resected vulvar cancer that is node-negative after lymphadenectomy, tumor >4 cm or close margins (≤ 8 mm) in areas with limited resources? | Observation | Re-excision | Adjuvant radiotherapy alone | Adjuvant radiotherapy and chemotherapy | Adjuvant chemotherapy alone | Abstain |
| 17.1% | 24.3% | 38.7% | 17.1% | 1.8% | 0.9% |
| If adjuvant radiotherapy alone was the treatment chosen in situations above (node-negativecytoreductive), which radiation volume do you recommend in areas with limited resources? | Primary tumor site only (vulva) | Vulva and inguinal nodes | Vulva and inguinal and pelvic nodes | Abstain | - | - |
| 50.0% | 27.8% | 16.7% | 5.6% | - | - |
| In institutions where there is only a cobalt machine, can patients with vulvar cancer who need treatment for their pelvic nodes be treated with primary or adjuvant external radiotherapy? | Yes | No | Abstain | Unqualified to answer | - | - |
| 92.2% | 6.5% | 1.3% | 0% | - | - |
| What is your treatment recommendation for patients with resected vulvar cancer and one nodal micrometastasis after lymphadenectomy in areas with limited resources? | Observation | Re-operation with inguinofemoral lymphadenectomy | Adjuvant radiotherapy alone | Adjuvant radiotherapy and chemotherapy | Adjuvant chemotherapy alone | Abstain |
| 33.0% | 12.0% | 33.0% | 20.0% | 2.0% | 0% |
| In this setting, when radiotherapy is not available, what is your recommendation? | Observation | Re-operation with inguinofemoral lymphadenectomy | Adjuvant chemotherapy alone | Abstain | - | - |
| 44.3% | 38.9% | 15.0% | 1.8% | - | - |
| What is your treatment recommendation for patients with resected vulvar cancer and macroscopic nodal disease or with >1 micrometastatic involved nodes after lymphadenectomy in areas with limited resources? | Adjuvant radiotherapy alone | Adjuvant concomitant chemoradiation | Adjuvant chemotherapy alone | Chemotherapy followed by radiotherapy | Radiotherapy followed by chemotherapy | Abstain |
| 33.3% | 57.4% | 0.9% | 4.6% | 2.8% | 0.9% |
| In this setting, when radiotherapy is not available, what is your recommendation? | Observation | Re-operation with inguinofemoral lymphadenectomy | Adjuvant chemotherapy alone | Abstain | - | - |
| 13.5% | 37.1% | 46.1% | 3.4% | - | - |

Legend: Answers to not all questions may total 100% due to rounding.

**Supplementary** **Table 5.** **Questions related to the treatment of locally-advanced vulvar cancer**.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Responses (%)** | | | | | | | |
| In locally resectable advanced disease, involving urethra or anus, what is the best treatment in an area with limited resources when radiation therapy is not available? | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy alone | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy followed by chemotherapy | Chemotherapy followed by radical vulvectomy and removal of gross nodes | Chemotherapy followed by radical vulvectomy and bilateral inguinofemoral lymphadenectomy | Inguinofemoral lymphadenectomy followed by chemotherapy and vulvectomy | None | Abstain | - |
| 10.2% | 20.5% | 11.4% | 37.5% | 5.7% | 8.0% | 6.8% | - |
| In locally advanced disease, what is the best treatment in an area with limited resources when chemotherapy is not available? | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy alone | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy followed by radiation | Radiation followed by radical vulvectomy and removal of gross nodes | Radiation followed by radical vulvectomy and bilateral inguinofemoral lymphadenectomy | Inguinofemoral lymphadenectomy followed by radiation and vulvectomy | Abstain | - | - |
| 8.7% | 50.0% | 6.5% | 17.4% | 8.7% | 8.7% | - | - |
| In locally advanced vulvar cancer and poor geriatric score and/or poor performance status, what is the best treatment in an area with limited resources? | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy alone | Radical vulvectomy as a palliative procedure | Chemoradiation followed by radical vulvectomy and removal of gross nodes | Chemoradiation followed by radical vulvectomy and bilateral inguinofemoral lymphadenectomy | Radiation alone | Chemoradiation | Best supportive care | Abstain |
| 2.2% | 13.2% | 4.4% | 2.2% | 30.8% | 35.2% | 12.1% | 0% |
| In locally advanced vulvar cancer and poor geriatric score and/or poor performance status, what is the best treatment in an area with limited resources when radiation therapy is not available? | Radical vulvectomy | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy alone | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy followed by chemotherapy | Chemotherapy followed by radical vulvectomy and removal of gross nodes | Chemotherapy followed by radical vulvectomy and bilateral inguinofemoral lymphadenectomy | Chemotherapy alone | Best supportive care | Abstain |
| 9.9% | 4.4% | 2.2% | 3.3% | 5.5% | 17.6% | 55% | 2.2% |
| In locally advanced vulvar cancer and poor geriatric score and/or poor performance status, which is the best treatment in an area with limited resources when chemotherapy is not available? | Radical vulvectomy | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy alone | Radical vulvectomy with bilateral inguinofemoral lymphadenectomy followed by radiation | Radiation followed by radical vulvectomy and removal of gross nodes | Radiation followed by radical vulvectomy and bilateral inguinofemoral lymphadenectomy | Inguinofemoral lymphadenectomy followed by radiation and vulvectomy | Best supportive care | Abstain |
| 6.2% | 6.2% | 9.9% | 9.9% | 6.2% | 0.0% | 53.1% | 8.6% |
| Which radiation volume do you recommend for patients with vulvar cancer presenting pathologic node involvement in inguinal or pelvic sites and primary resected tumor with negative margins? | Vulva and inguinal nodes | Vulva and inguinal and pelvic nodes | Inguinal and pelvic nodes | Abstain | Unqualified to answer | - | - | - |
| 7.4% | 67.7% | 25.0% | 0.0% | 0.0% | - | - | - |
| Which external radiotherapy technique is recommended as a minimal option for patients with vulvar cancer who need treatment for pelvic nodes in areas with limited resources? | Conventional (2D) | Conformal | Abstain | Unqualified to answer | - | - | - | - |
| 73.6% | 26.4% | 0% | 0% | - | - | - | - |
| In Institutions where there is only conventional (2D) radiotherapy technique, can patients with vulvar cancer who need treatment for pelvic nodes be treated with primary or adjuvant external radiotherapy? | Yes | No | Abstain | Unqualified to answer | - | - | - | - |
| 95.0% | 3.8% | 1.3% | 0% | - | - | - | - |
| In Institutions where there is only a cobalt machine, can patients with vulvar cancer who need treatment for pelvic nodes be treated with primary or adjuvant external radiotherapy? | Yes | No | Abstain | Unqualified to answer | - | - | - | - |
| 94.4% | 5.6% | 0% | 0% | - | - | - | - |
| In patients with locally advanced vulvar cancer, what is the best radiosensitizing agent in an area with limited resources? | Cisplatin | Cisplatin and fluorouracil | Carboplatin | Fluorouracil | Gemcitabine | Abstain | - | - |
| 83.4% | 10.2% | 3.4% | 0% | 0% | 0% | - | - |
| In patients with locally advanced vulvar cancer and ineligible for cisplatin, which is the best radiosensitizing agent in an area with limited resources? | Carboplatin | Carboplatin and fluorouracil | Fluorouracil | Mitomycin and fluorouracil | Gemcitabine | Taxane | None | Abstain |
| 68.2% | 17.7% | 5.9% | 1.2% | 2.4% | 0% | 3.5% | 1.2% |
| What is your treatment recommendation for patients with unresectable vulvar cancer in areas with limited resources? | Palliative radiation therapy alone with hypofractionation | Palliative radiation therapy alone with conventional fractionation | Concomitant chemoradiation | Chemotherapy alone | Best supportive care | Abstain | - | - |
| 11.8% | 3.2% | 77.4% | 5.4% | 2.2% | 0% | - | - |
| What is your treatment recommendation for patients with unresectable vulvar cancer with poor geriatric score and/or poor performance status in areas with limited resources? | Palliative radiation therapy alone with hypofractionation | Palliative radiation therapy alone with conventional fractionation | Concomitant chemoradiation | Chemotherapy alone | Best supportive care | Abstain | - | - |
| 28.9% | 17.8% | 21.1% | 2.2% | 28.9% | 1.1% | - | - |
| In patients with bulky inguinal lymph node metastasis in an area without formal training in gynecologic oncology, the treatment should include: | Metastatic bulky lymph nodes are indication for chemoradiation, and surgery is not indicated as first approach | If feasible, primary cytorreductive surgery (resection of the macroscopically involved lymph nodes) should be performed before chemoradiation | Systematic inguinofemoral lymphadenectomy should be performed before the treatment with chemoradiation | Radiotherapy alone | Chemotherapy alone | Chemoradiation | Abstain | - |
| 20.5% | 24.1% | 7.2% | 1.2% | 1.2% | 43.4% | 2.4% | - |

Legend: Answers to not all questions may total 100% due to rounding.

**Supplementary Table 6.** **Questions related to first-line treatment of metastatic or loco-regionally recurrent vulvar cancer.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Answers and frequency of responses** | | | | | | | |
| What is the recommended first-line chemotherapy regimen for women with metastatic vulvar cancer or loco-regional recurrence not amenable to salvage loco-regional treatment with no contra-indication to cisplatin in an area with limited resources? | Cisplatin**,** 50 mg/m² IV on day 1 with 5-FU**,** 1000 mg/m² IV on days 1-4 every 3 weeks | Cisplatin, 50 mg/m² IV on day 1 with Paclitaxel**,** 175 mg/m² IV on day 1 every 3 weeks | Cisplatin, 50 mg/m² IV with Gemcitabine**,** 1000 mg/m² IV on days 1, 8 every 3 weeks | Carboplatin AUC 5 and paclitaxel 175 mg/m2 every 3 weeks | Cisplatin, 50 mg/m² IV every 3 weeks | Non-platinum agent alone | Best supportive care | Abstain |
| 35.7% | 28.6% | 0% | 35.7% | 0% | 0% | 0% | 0% |
| What is the recommended first-line chemotherapy regimen for women with metastatic vulvar cancer or loco-regional recurrence not amenable to salvage loco-regional treatment with contra-indication to cisplatin in an area with limited resources? | Carboplatin AUC 5 IV on day 1 with 5-FU**,** 1000 mg/m² IV on days 1-4 every 3 weeks | Carboplatin AUC 5 IV on day 1 with Paclitaxel**,** 175 mg/m² IV on day 1 every 3 weeks | Carboplatin AUC 5 IV with Gemcitabine**,** 1000 mg/m² IV on days 1, 8 every 3 weeks | Carboplatin AUC 5 alone IV alone every 3 weeks | Non-platinum agent alone | Best supportive care | Abstain | - |
| 16.7% | 66.7% | 0% | 5.6% | 0% | 0% | 11.1% | - |
| If you recommend a non-platinum regimen as first-line, what agent do you recommend in an area with limited resources? | Paclitaxel | Gemcitabine | 5-FU | Ifosfamide | I do not recommend a non-platinum agent as first-line therapy | Abstain | - | - |
| 58.3% | 8.3% | 4.2% | 4.2% | 20.8% | 4.2% | - | - |
| What is your first-line treatment for patients with metastatic or recurrent vulvar cancer not amenable to salvage loco-regional treatment in countries without access to taxanes or where taxane-related costs are prohibitive? | Cisplatin and 5-fluorouracil | Cisplatin and gemcitabine | Cisplatin | Gemcitabine | None | Abstain | - | - |
| 54.2% | 29.2% | 16.7% | 0% | 0% | 0% | - | - |

Legend: Answers to not all questions may total 100% due to rounding.

**Supplementary Table 7.** **Questions related to loco-regionally recurrent, potentially curable vulvar cancer.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Answers and frequency of responses** | | | | | | | |
| What is the recommended treatment option for a local recurrence potentially resectable without suspicion of lymph node involvement in a patient who was submitted initially only to surgery and without comorbidities in an area with limited resources where radiotherapy is available? | Weekly cisplatin, 40 mg/m² IV in association with radiation therapy | Radiation therapy alone | Salvage surgery alone | Salvage surgery followed by radiation therapy | Salvage surgery followed by weekly cisplatin, 40 mg/m² IV in association with radiation therapy | Cisplatin-based therapy alone | Best supportive care | Abstain |
| 22.6% | 0% | 12.9% | 29.0% | 35.5% | 0% | 0% | 0% |
| What is the recommended treatment option for a local recurrence potentially resectable without suspicion of lymph node involvement in a patient who was submitted initially only to surgery and without comorbidities in an area with limited resources where radiotherapy is not available? | Salvage surgery alone | Platinum-based therapy alone | Platinum-based therapy followed by surgery | Non platinum-based therapy followed by surgery | Best supportive care | Abstain | - | - |
| 80.0% | 2.9% | 17.1% | 0% | 0% | 0% | - | - |
| What is the recommended treatment option for a local recurrence potentially resectable without suspicion of lymph node involvement in a patient who was submitted initially only to surgery and with comorbidities and/or contra-indication to cisplatin in an area with limited resources where radiotherapy is available? | Carboplatin combined with radiation therapy | Non-platinum agent with radiation therapy | Radiation therapy alone | Salvage surgery alone | Salvage surgery followed by radiation or chemoradiation therapy | Chemotherapy alone | Best supportive care | Abstain |
| 13.9% | 0% | 22.2% | 19.4% | 41.7% | 0% | 0% | 2.8% |
| What is the recommended treatment option for a local recurrence potentially resectable without suspicion of lymph node involvement in a patient who was submitted initially only to surgery and with comorbidities and/or contra-indication to cisplatin in an area with limited resources where radiotherapy is not available? | Salvage surgery alone | Carboplatin-based therapy followed by surgery | Non-platinum based therapy followed by surgery | Carboplatin-based therapy alone | Non-platinum agent alone | Best supportive care | Abstain | - |
| 71% | 10.5% | 0% | 2.6% | 2.6% | 10.5% | 2.6% | - |
| What is the recommended treatment option for a local recurrence without suspicion of lymph node involvement in patients with no comorbidities who were submitted to radiation therapy in an area of limited resources? | Weekly cisplatin**,** 40 mg/m² IV with re-radiation therapy | Re-radiation therapy | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by re-radiation therapy | Salvage surgery if resectable, followed by carboplatin and paclitaxel | Cisplatin-based therapy alone | Best supportive care | Abstain |
| 5.3% | 0.% | 55.3% | 7.9% | 29.0% | 2.6% | 0% | 0% |
| What is the recommended treatment option for a local recurrence without suspicion of lymph node involvement in patients with comorbidities and/or contra-indication to cisplatin who were submitted to radiation therapy in an area of limited resources? | Carboplatin with re-radiation therapy | Re-radiation therapy | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by re-radiation therapy | Salvage surgery if resectable, followed by carboplatin and paclitaxel | Carboplatin-based therapy alone | Best supportive care | Abstain |
| 0% | 0% | 67.9% | 3.6% | 17.9% | 0% | 10.7% | 0% |
| If you do not recommend cisplatin as a radiosensitizing agent with radiation due to contra-indication in this scenario, what would be your choice in an area with limited resources? | Carboplatin | Paclitaxel | Gemcitabine | 5-FU | Abstain | - | - | - |
| 75.8% | 3.0% | 3.0% | 15.2% | 3.0% | - | - | - |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient without comorbidities treated initially only with surgery in an area with limited resources where radiotherapy is available? | Weekly cisplatin**,** 40 mg/m² IV with radiation therapy | Radiation therapy alone | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by radiation therapy | Salvage surgery if resectable, followed by weekly cisplatin**,** 40 mg/m² IV with radiation therapy | Cisplatin-based therapy alone | Best supportive care | Abstain |
| 28.6% | 0% | 5.7% | 11.4% | 54.3% | 0% | 0% | 0% |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient without comorbidities treated initially only with surgery in an area with limited resources where radiotherapy is not available? | Salvage surgery alone if resectable | Cisplatin-based therapy alone | Salvage surgery if resectable, followed by cisplatin-based therapy | Best supportive care | Abstain | - | - | - |
| 19.4% | 8.3% | 66.7% | 5.6% | 0% | - | - | - |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient with comorbidities and/or contra-indication to cisplatin treated initially only with surgery in an area with limited resources where radiotherapy is available? | Carboplatin with radiation therapy | Non-platinum agent with radiation therapy | Radiation therapy alone | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by radiation therapy or chemoradiation | Chemotherapy alone | Best supportive care | Abstain |
| 20% | 3.3% | 13.3% | 0% | 60% | 0% | 3.3% | 0% |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient with comorbidities and/or contra-indication to cisplatin treated initially only with surgery in an area with limited resources where radiotherapy is not available? | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by carboplatin-based therapy | Salvage surgery if resectable, followed by non-platinum based therapy | Carboplatin-based therapy followed by surgery if resectable | Carboplatin-based therapy alone | Non-platinum agent alone | Best supportive care | Abstain |
| 28.3% | 45.7% | 6.5% | 6.5% | 6.5% | 0% | 6.5% | 0% |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient without comorbidities treated initially with surgery and adjuvant radiation or chemoradiation in an area with limited resources? | Weekly cisplatinwith radiation therapy | Re-radiation therapy alone | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by re-radiation therapy | Salvage surgery if resectable, followed by carboplatin and paclitaxel | Cisplatin-based therapy alone | Best supportive care | Abstain |
| 2.5% | 0% | 15.0% | 12.5% | 67.5% | 2.5% | 0% | 0% |
| What is the recommended treatment option for a clinical lymph node recurrence in a patient with comorbidities and/or contra-indication to cisplatin treated initially with surgery and adjuvant radiation or chemoradiation in an area with limited resources? | Carboplatin with radiation therapy | Non-platinum agent with radiation therapy | Radiation therapy alone | Salvage surgery alone if resectable | Salvage surgery if resectable, followed by radiation therapy or chemoradiation | Chemotherapy alone | Best supportive care | Abstain |
| 2.7% | 0% | 5.4% | 40.5% | 27.0% | 13.5% | 5.4% | 5.4% |

Legend: Answers to not all questions may total 100% due to rounding.CIN, cervical intraepithelial neoplasia; LEEP, loop electrosurgical excision procedure; LLETZ, large loop excision of the transformation zone.

**Supplementary Table 8.** **Questions related to subsequent lines in vulvar cancer.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Question** | **Answers and frequency of responses** | | | | | | | |
| What is your second-line choice for patients who failed platinum-based therapy in an area with limited resources? | Paclitaxel | Gemcitabine | 5-FU | Methotrexate | Best supportive care | Abstain | - | - |
| 60.0% | 20.0% | 10.0% | 3.3% | 3.3% | 3.3% | - | - |
| What is your third-line treatment choice for patients who failed platinum-based therapy with good performance status in an area with limited resources? | Paclitaxel | Gemcitabine | Vinorelbine | 5-FU | Methotrexate | Best supportive care | Abstain | - |
| 17.2% | 37.9% | 0% | 6.9% | 0% | 24.1% | 13.8% | 0.0% |
| For women with metastatic vulvar cancer previously treated and with no clinical trial available, when do you recommend best supportive care in an area with limited resources? | After first-line treatment | After second-line treatment | After third-line or more treatment | P*erformance status* ≥ *2*, unrelated to line of treatment | Abstain | - | - | - |
| 9.3% | 14.0% | 4.7% | 72.1% | 0% | - | - | - |
| Would you consider metastasectomy, radiation therapy, or either for oligometastatic (< 4 lesions and restricted to one organ) advanced vulvar cancer (excluding bone metastasis) in an area with limited resources? | In the majority of patients, and I prefer surgery | In the majority of patients, and I prefer radiation | In a minority of patients, and I prefer surgery | In a minority of patients, and I prefer radiation | Both are equivalent, and I consider for the majority of patients | Both are equivalent, and I consider in a minority of patients | I do not recommend either surgery or radiation | Abstain |
| 24.6% | 3.5% | 10.5% | 17.5% | 7.0% | 14.0% | 19.3% | 3.5% |

Answers to not all questions may total 100% due to rounding.

**Supplementary Table 9. Questions related to drugs used in vulvar cancer included in the World Health Organization (WHO) essential medicines list that can be purchased at an affordable price from generic manufacturers**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Questions** | **Responses (%)** | | |
| Each of the following drugs is on the WHO essential medicines list. You are able to purchase them at an affordable price from generic manufacturers. Which would you consider as appropriate treatment options for women with metastatic vulvar cancer in the setting of limited healthcare resources? | Yes | No | Abstain |
| Ifosfamide | 23.1% | 74.4% | 2.6% |
| Topotecan | 44.4% | 52.8% | 2.8% |
| Paclitaxel | 95.4% | 4.7% | 0% |
| Gemcitabine | 88.2% | 11.8% | 0% |
| Vinorelbine | 40.7% | 51.9% | 7.4% |
| 5-FU | 91.4% | 8.6% | 0.0% |
| Methotrexate | 29.7% | 64.9% | 5.4% |

Legend: Answers to not all questions may total 100% due to rounding.