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Original Research Paper

Gynaecology

VULVAL CARCINOMA A RARE ENTITY: A CASE REPORT

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ABSTRACT Vulval malignancy is a rare entity and it occur in 2 different types – HPV induced type in younger women,may develop from VIN and non HPV dependent type in older post menopausal women as a result of chronic inflammation [itch – scratch – lichen sclerosis hypothesis]. A 52 year old postmenopausal lady came to OPD with C/O growth on vulvar region since 10 yrs , insidious onset, associated with itching ,later it got ulcerated and she developed burning sensation.on further examination diagnosed as early vulval cancer[T1b]and underwent radical local excision with 1 cm grossly negative margine. Currently , a more individualized and less radical treatment is suggested. The gold standard treatment for even a small invasive carcinoma of vulva was historically radical vulvectomy with removal of the tumor with a wide margin flb an enbloc resection of the inguinal and often pelvic lymph nodes

KEYWORDS : Age,vulval ,pap smear,FNAC,CECT abdomen and pelvis,Biopsy.

INTRODUCTION:

Vulvar malignancy is a rare entity and it occur in 2 different types – HPV induced type in younger women, may develop from VIN and non HPV dependent type in older post menopausal women as a result of chronic inflammation [itch – scratch – lichen sclerosis hypothesis]. Diagnosis based on histology and treatment is surgical resection. There has been a recent trend toward more conservative surgery to decrease psychosexual complications.

Case Report:

A 52 year old postmenopausal lady came to OPD with C/O growth on vulvar region since 10 yrs , insidious onset, associated with itching ,later it got ulcerated and she developed burning sensation.pt was k/c/o type 2 DM on insulin since 9yrs.

Examination:

P/A -Soft , no palpable masses.Both labia majora hypertrophied and pigmented with proliferative growth of 4×4 cm with ulceration present on the lower 1/3rd of left labia majora and another proliferative growth of 3×4 cm with ulceration on the lower 1/3rdof right labia majora [extending on to the perineal skin] present. P/V vagina not indurated, Ut NS/M/AV/FF /NO FT . P/R Rectal mucosa free, O/E no palpable lymphnodes.(figure:1)

Figure:1

Investigations:

Biopsy – well differentiated squamous cell carcinoma. FNAC –Inguinal lymph nodes – Negative for malignancy.CECT ABDOMEN & PELVIS – NO obvious infiltration of urethra; Vagina and anal canal. PAP SMEAR – NILM

Diagnosis: Early Vulval cancer [T1b]

Surgery : Radical local excision with 1 cm grossly negative Margin.(figure 2)

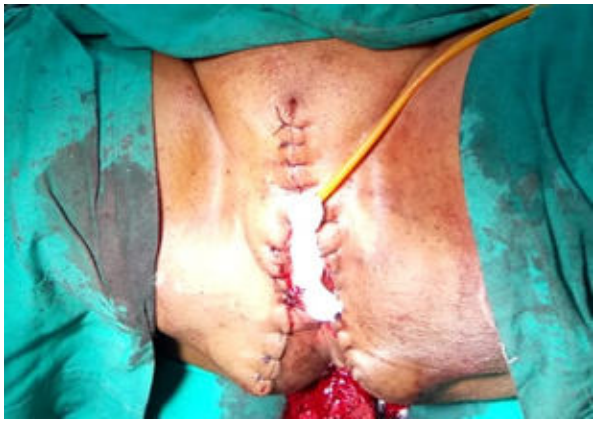

Figure:2

HPE REPORT :

Well differentiated squamous cell carcinoma [all margins are free from growth]

DISCUSSION:

Vulvar cancer accounts for 5% of all malignancies of female genital tract. Pruritus is the most common non specific symptom. The gold standard treatment for even a small invasive carcinoma of vulva was historically radical vulvectomy with removal of the tumor with a wide margin flb an enbloc resection of the inguinal and often pelvic lymph nodes.Radical vulvectomy can be performed by butterfly incision as well as triple incision . The butterfly incision technique involves en-bloc removal of lymphnodes along with vulvectomy, through a single incision. This technique causes increased perioperative blood loss,operative time and severe post op morbidity. This morbidity can be reduced by the triple incision technique.It is performed by 3 separate incisions , 2 for bilateral groin lymphnodes and a separate incision for vulvectomy.In larger primary tumors vulvectomy with B/L inguinofemoral LN dissection is indicated .

CONCLUSION:

Currently , a more individualized and less radical treatment is

suggested; a radical wide local excision is possible in the case of localized lesions[T1]. A Sentinel LN biopsy may be performed to reduce wound complications and lymphedema. (figure:3)

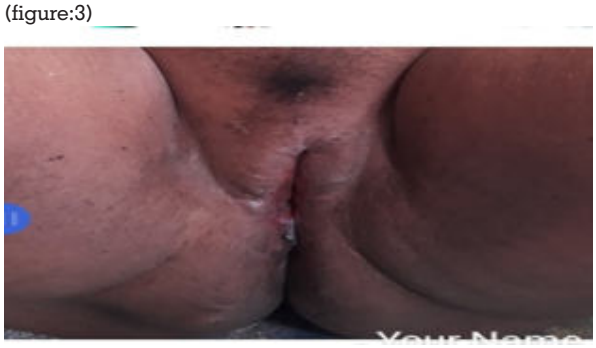

Figure:3

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