

Squamous Cell Carcinoma in a Mutilated Vulva: A Case Report

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Abstract

Vulvar carcinoma is a rare cancer even among the female genital tract cancer. Vulvar squamous cell carcinoma is the most common. We report a case of stage III squamous cell carcinoma of the vulva in a 71-year-old- patient with type III mutilated vulva. Clinical presentation, Histopathological diagnosis, surgical staging, and treatment options with the case challenges will be discussed.

Keywords: Vulva; Squamous cell carcinoma; Female genital mutilation/cutting

Introduction

Vulvar cancer is one of the rarest gynecological cancers. It may arise from the skin, subcutaneous tissue, glandular elements of the vulva or epithelium of the lower third of the vagina [1]. Of all the vulvar carcinomas, 1-2% is basal cell carcinomas, with the majority being squamous cell carcinomas (90%) [2].

Vulvar cancer is primarily a disease of postmenopausal women, with peak incidence in women aged 60-70 years [3]. Up to 15% of vulvar cancers are diagnosed in women less than 40 years old [4].

Case Presentation

A 72-year-old menopause woman was referred to gynecological department for evaluation of chronic vulvar ulceration, which lasted for more than three years. She is a known case of diabetes mellitus and is under good medical control. The rest of her medical and surgical history is of no significance. Physical examination revealed mutilated vulva with excised labia major, labia minor, clitoris and narrowing of vaginal orifice this matches is applicable to World Health Organization (WHO) type III female genital mutilation (Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris -infibulation) The skin shows hypopigmented area extending from anal orifice, perineal body and vulvar region mainly on the left side. The right side shows a fungating tumor, 7 cm × 4 cm, with sloughed area and indurated area that bleeds on touch (Figure 1). The urethral and Paraurethral areas are free. The cervix, vaginal wall, rectum and anus appear normal. There are no enlarged lymph nodes at the inguinal area. The routine laboratory investigations are within the normal ranges. Images of the pelvis prove a local non- spread lesion.

After anesthetic fitness confirmation examination under anesthesia was performed which confirmed the findings the mass was marked with safety margins and excised from the right forchet site and up running on the right side of the vagina to the Paraurethral region and towards the outer aspect of the vulvar region including all the macroscopically identified tumor mass with almost 2 cm safety margin all around the tumor. Homeostasis was secured and the gaps were obliterated followed by wound closure with suitable suture materials. Specimen was send to histopathology (Figure 2).

Histopathology examination revealed well-differentiated keratinizing squamous cell carcinoma F. Clinically, the surgical stage was FIGO stage II (tumor confined vulva/ perineum, >2 cm in largest dimension). However; as involvement of the vaginal wall was

confirmed histologically, the stage changed to FIGO stage III (tumor of any size with adjacent spread to lower urethra or vagina or anus). Furthermore, the resection margins are involved by the tumor.

The case's management faced some challenges being a case of female genital mutilation/cutting Type III, no clear anatomical marks that been identified and the tumor is growing in depth of the FGM/C scar rather than the usually seen in the literature at posterior 2/3 of the labia major. The tumor size is really large for this destructed vulva that makes the defected area difficult for skin grafting. Frozen section evaluation for resection margins is advised in such cases, to be able to achieve complete excision of the tumor. Unfortunately frozen section is not available in our setup so the tumor edge was assessed on the bases of naked eye examination.

Discussion

The cases of carcinoma vulva are infrequently seen in clinical practice and to the best of our knowledge, there is no reported data



Figure 1: Fungated tumor in a background of mutilated vulva.

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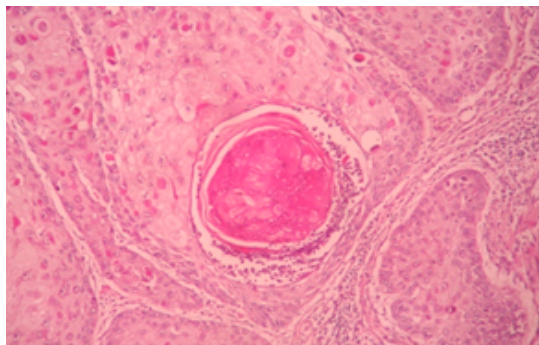


Figure 2: Well-differentiating squamous cell carcinoma, showing keratin pearls formation.

about vulvar carcinoma in Sudan, yet there is a single reported and published case of rhabdomyosarcoma of the vulva [5]. Although worldwide the data are reported.

This case carries the risk of classical vulvar cancer age, as 80% of patients are above 65 years old. In addition, being a case of diabetes mellitus raises the question of considering immunosuppression- as a risk factor- in this patient as well. The other risk factors for vulvar cancer were not proved in this patient includes lichen sclerosis, vulvar intraepithelial neoplasia (VIN), Paget's disease and history of cervical neoplasia.

Characteristically vulvar carcinoma spreads locally to vagina, urethra, clitoris and rectum. It may spread via lymphatic to inguinofemoral groups and very rarely by haematogenous spread.

The surgery in most of the cases remains the first choice especially when the margins are free and there is no lymphadenopathy. Otherwise

radiotherapy and/ or chemotherapy may be need. This was the selected option for this patient, because of advanced stage and involvement of the resection margin.

Female genital mutilation/cutting (FGM/C) is a bad tradition practice as a sequel of this bad practice the vulva are removed totally or partially and this not protective from vulvar carcinoma as we see in our case and should stand against FGM/C as well. Operating for carcinoma vulva after FGM/C type III means operating on old fibrous scar with removal of the real area tissues that limits the options of cosmetic surgery. It is still difficult to study any association between FGM/C and vulvar carcinoma, because of lack of data about vulvar carcinoma in countries with high prevalence of FGM/C.

Conclusion

Squamous cell carcinoma of the vulva is an infrequent entity but represents the vast majority of vulvar malignancy. It has a propensity to remains locally confined. Surgery remains the gold standard in primary carcinoma vulva.

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