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Case Report

A rare case of primary vaginal carcinoma with systemic metastasis with uterovaginal prolapses

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ABSTRACT

Primary vaginal cancer in a prolapsed uterus is a very rare condition. Here we report a rare case of carcinoma of vagina with early systemic metastasis presenting in a middle aged women with uterovaginal prolapse. A 46 year old postmenopausal lady presented with complaints of mass per vagina with foul smelling discharge per vagina. On gynaecological examination, an irreducible uterovaginal prolapse and a 6 × 6 cm ulcer was present on upper 1/3 of lateral vaginal wall. Biopsy of the ulcer suggested squamous cell carcinoma of vagina. She was given palliative chemotherapy.

Keywords: Primary vaginal cancer, Uterovaginal prolapse, Chemotherapy

INTRODUCTION

Primary vaginal cancer accounts for only 1% to 2% of all female genital cancers, and more than 80% are metastases from other sites (most commonly from the cervix and vulva).[1] Squamous cell carcinoma (SCC) accounts for 80% to 90% of cases and most commonly arises in the upper portion of the posterior wall of the vagina. Squamous cell carcinoma is the commonest type; others are adenocarcinoma, melanoma and sarcoma. The cause of vaginal cancer varies depending on the histology. SCC is associated with a history of invasive or in situ cervical cancer, and prior radiation treatment for a prior anogenital cancer. There is a strong association with HPV 16 and prior radiation therapy. The disease seemed to be related to HPV infection.[2]

Primary adenocarcinoma of the vagina is most commonly of the clear cell type and has been primarily seen in women who were exposed to Diethyl stilbestrolin utero.[3] The majority of women diagnosed with primary SCC of the vagina are older than 65 years.[4]

The most frequent clinical symptom is vaginal bleeding, but dysuria and pelvic pain are also common. Unfortunately, the treatment of vaginal cancer is not yet completely defined. Surgical therapy is preferred for early stage of infiltrating cancer, and radiotherapy for progressive lesion.

Overall, the 5-year survival rate for primary vaginal carcinoma is approximately 40%, and the most important prognostic factor is stage at diagnosis.[5] Here we report a case of a patient who presented with a third degree uterine prolapse with vaginal cancer.

CASE REPORT

A 46 year old postmenopausal lady reported to the Gynaecology OPD with the complaints of mass per vagina and foul smelling discharge per vagina since 6 months with weight loss and anorexia. On examination, she was found to be anaemic and emaciated. No other abnormalities were detected during abdominal examination. Local examination revealed foul smelling vaginal discharge. An irreducible third degree

uterovaginal prolapse and 6 x 6 ulcers were seen in the upper 1/3rdof lateral vaginal wall which was indurated and bleeding on touch (Figure 1). Her cervix looked healthy. Bimanual examination showed normal sized uterus with no adnexal mass. Papanicolaousmear was normal. Biopsy of the ulcer was taken. Histopathological examination revealed invasive squamous cell carcinoma of vagina. CT scan of abdomen and pelvis showed descent of bulky cervix (3x2.5 cm) and rectum wall enlargement and perirectal abscess and necrotic nodes, right hydroureteronephrosis from distal ureteric encasement and hypo dense foci in liver suggestive of metastasis. FNAC of liver lesion was positive for malignant cells. Patient was diagnosed with Stage 4 Vaginal carcinoma and Palliative chemotherapy with 2 cycles of Cisplatin and 5-Flouracil was given.

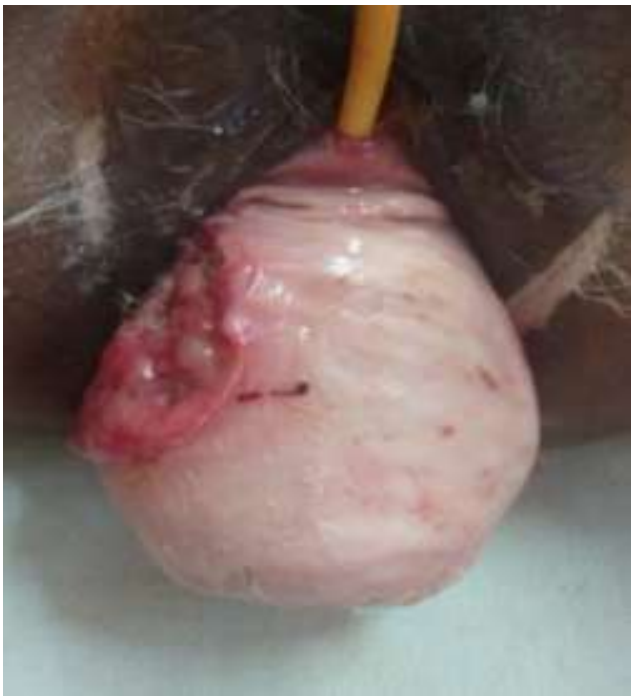

Figure 1: Ulcers seen in the upper 1/3rdof lateral vaginal wall.

DISCUSSION

Vaginal cancer is rare, there is no standard treatment. Radiation therapy is generally the primary and definitive treatment; however, selected stage I to II patients can be treated with surgical resection.[6] This case serves to highlight several important points, including the importance of careful evaluation of vaginal erosions or lesions in patients presenting with pelvic organ prolapse. Though vaginal wall erosions and ulcerations frequently occur in patients with pelvic organ prolapse, any erosion that does not resolve with conservative treatment should be biopsied.[7] Consideration should be given to immediate biopsy for any lesion, active bleeding or foul smelling discharge per vagina. In cases of vaginal cancer presenting with significant prolapse, there are additional considerations during treatment planning. Brachytherapy may not be technically feasible without prior surgery to reduce the prolapse. Performing a palliative vaginal hysterectomy prior to radiation treatment is an additional consideration. Alternatively, a palliative surgery to address the prolapse may be undertaken following radiation treatment. There are no recommendations in the literature to guide this particular treatment decision.

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