Case Report

A large fibroma polyp of labia majora

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ABSTRACT

Fibroepithelial stromal polyps are benign proliferations which are usually polypoid or pedunculated, and less than 5cm in size. They are generally single lesions but can be multiple during pregnancy. They can be polypoid or pedunculated and are usually solitary. Symptoms usually include bleeding, discharge and general discomfort with sensation of a mass. They typically have a central fibrovascular core and contain stellate and multinucleated stromal cells which are best seen beneath the surface epithelium. True myxoid stroma is absent. Although vulvovaginal fibroepithelial stromal polyps are well documented, a giant variant such as the one authors report here is rather rare.

To the knowledge, present case is the largest fibroepithelial stromal polyp compared to others reported in the literature.

Keywords: Fibroma polyp, Giants, Labial, Labia majora, Skin tag

INTRODUCTION

The fibroepithelial polyps (FEPs), which are also referred to as acrochordons or skin tags, are common lesions that typically occur in adults, especially obese women. They show a predilection for the neck, axillae, and groin. FEPs of the lower genital tract often develop in young to middle-aged women and present more commonly in the vagina. They are less common in the vulva and are rarely present in the cervix.¹ These lesions typically do not grow larger than 5-cm in diameter and are found incidentally during routine gynaecologic exams.² They can be polypoid or pedunculated and are usually solitary. Symptoms usually include bleeding, discharge and general discomfort with sensation of a mass. Biopsy is often necessary to make a definitive diagnosis as their clinical features may overlap with those of malignant neoplasms and immunohistochemistry is of limited help.³,⁴ Although the stromal polyp is benign, its differential diagnosis includes some malignant vulva lesions making it critical to ensure that an accurate pathologic diagnosis is made.

These vulvovaginal tumours include fibroepithelial stromal polyps, aggressive (deep) angiomyxoma, superficial angiomyxoma, angiomyo fibroblastoma, cellular angiofibroma and (prepubertal) valval fibroma. Diagnosis often relies on the identification of subtle morphological differences between these different tumours and clinical correlation is paramount. In the diagnosis of gynecological neoplasms, CT and magnetic resonance imaging might be preferred, especially in patients with a history of carcinoma.

However, ultrasound examination may be a more suitable first-line diagnostic approach in terms of cost-effectiveness, wide availability, speed and the capacity for dynamic exploration. It can help in the differential diagnosis of lesions of the inguinal area and vulva such as hernia, lymphadenopathy and neck canal cyst.
CASE REPORT

A 55-year-old female P3L3 all vaginal deliveries presented with a five-year history of a labial mass that was initially slow-growing pedunculated mass which caused difficulty in walking and discomfort. The mass was not associated with pain, fever or trauma.

Figure 1: Fibroma polyp hanging from right labia majora.

On examination, there was a large 22x9cm pedunculated mass arising from right labia majora which showed signs of decubitus ulceration at the distal dependent end. Translucency test was negative, and auscultation failed to reveal any bruit or gurgling sound.

Figure 2: Fibrosis and ulceration on the most dependent part of the polyp.

Bedside ultrasound showed a homogenous mass with fluid pockets, but no bowel segments were found within. However, color doppler showed evidence of vascularity. Her past medical and surgical history was not significant and HIV, HBsAg and VDRL screen was negative. Her family history was not significant. Her vitals were stable on presentation and she was afebrile with no evidence of any lymphadenopathy. Breast examination did not reveal any abnormality. Pelvic examination showed healthy cervix with no vaginal discharge. No cyst was found in the lateral vaginal wall. Uterus was normal size with small bilateral ovaries. There was no history of irradiation, trauma, or topical treatment. The results of routine laboratory tests were normal. Due to the presence of a pedicle, a congenital lesion was in the clinical differential. However, the large size and the extent of the lesion raised the possibility of an aggressive or even malignant lesion.

Figure 3: Preoperative 22cm polyp.

The patient subsequently underwent local excision of the lesion via diathermy at the base of the stalk (Figure 3 and 4).

Figure 4: Intraop-excision from the base.

The lesion was surgically removed without difficulty. The lower genital tract was otherwise normal.

Figure 5: Intraop-after excision of polyp.
The patient was well and discharged during her follow-up visit three weeks post-operatively.

The excised mass weighed about 500gms with fibrosis and ulcerated dependent end.

Excision biopsy revealed solid fibrous tissue with vascular pedicle on gross examination.

**DISCUSSION**

Fibroepithelial stromal polyps are benign proliferations which are usually polypoid or pedunculated, and less than 5cm in size. Vulval fibroma is a rare benign tumour that is predominantly found in women of reproductive age group; though they have been reported in infants, post-menopausal and pregnant women. The tumour may arise from either the deep connective tissue of introitus, labia majora, perineal body or round ligament. They are generally single lesions but can be multiple during pregnancy. They typically have a central fibrovascular core and contain stellate and multinucleated stromal cells which are best seen beneath the surface epithelium. True myxoid stroma is absent. Although vulvovaginal fibroepithelial stromal polyps are well documented, a giant variant such as the one authors report here is rather rare. To the knowledge, present case is the largest fibroepithelial stromal polyp compared to others reported in the literature. Although different psychosocial problems have been reported, but patients in India, try to conceal it. This patient reported to us only because of...
bleeding from the ulcer and difficulty in walking due to the huge size of the tumour. Other reports which had relatively large fibroepithelial stromal polyps include one case of a 10cm lesion in a young girl with a history of congenital lymphoedema, and one case of a 15cm lesion occurring in association with valval psoriasis.9,10 Another case report documented a 15cm giant fibroepithelial stromal polyp and described the sonographic features as an adjunct to the diagnosis of fibroepithelial stromal polyp in large vulvovaginal lesions.11 Other vulvovaginal lesions that can mimic fibroepithelial stromal polyps because of their well-circumscribed margins are angiomyofibroblastomas, superficial angiomyxomas and cellular angiofibromas. Angiomyofibroblastomas are benign tumour which can be distinguished from fibroepithelial stromal polyps histologically because they tend to have alternating cellularity with clusters of epithelioid stromal cells surrounding small capillaries. They are cured by local excision. Vulvovaginal superficial angiomyxomas are also different histologically because they have a multinodular pattern of growth and abundant true myxoid stroma. Although benign, they have a recurrence rate exceeding 30% therefore requiring clear margins.5

Cellular angiofibromas are more cellular spindle cell lesions with hyalinized blood vessels. They are benign and are managed by complete local excision. Another consideration in vulvovaginal lesions presenting in young girls is the more recently described prepubertal valval fibromas. However, these usually have ill-defined margins involving submucosa or subcutis.12 In addition, the spindle cells in these tumour are typically positive for CD34.13

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REFERENCES


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