acrochordon reported an incidence of 40.6% of either overt type 2 diabetes mellitus or impaired glucose tolerance[9]. Histologically acrochordons are characterized by acanthotic, flattened or frondlike epithelium. Cauterization, Cryosurgery, Ligation or Excision, are the treatment options[8,9].

In fact initially the patient came to the gynaecology department. They were confused whether this is a case of inguinal hernia, so they refered the case to our surgery department. Our diagnosis was a neurofibroma. Unlike other fibroepithelial polyp this swelling did not have any definite stalk or peduncle. So we did not think of acrochordon. FNAC report was lipoma but histopathology report came as fibroepithelial polyp. So, presentation is characterized by atypical, big in size and of unusual site.

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Post Hysterectomy Inflammatory Myofibroblastic Tumor: A Rare Presentation

Inflammatory myofibroblastic tumor is a relatively rare neoplasm of unknown etiology. The out look of this disease has changed with time from a benign reactive process to a malignant neoplasm. Histologicaly the tumor composed of spindle cells with ample icytoplasm and an inflammatory background of plasma cell, eosionophills and histocytes [1-3]. There are three main histological patterns: nodular fascitis-like, fibrous histocytoma-like and desmoids or scartissue type. The commonest site of inflammatory myofibroblastic tumor(IMT) is lungs. Second most common site is the genitourinary tract. Optimum management of this disease has not yet been standardized[5]. According to world literature main stay of therapy is surgical resection with excision of recurrent tumor.

A 50 years old women presented with lower abdominal pain and flashy polypoidal mass coming down per vagina with foul smelling discharge for 3 months. She had a history of abdominal hysterectomy for fibroid uterus 6 years back and also a history of exploratory laparotomy due to irregular pelvic mass and severe abdominal pain 2 years after abdomianl hysterectomy. She gave another history of retention of urine and that she was admitted in urology department where cystourethroscopy was done which revealed multiple growths in urethra, bladder neck and trigon. Right sided ureteric stenting was done but no biopsy was taken.

Clinically patient was midly anaemic and there was an ill defined, midly tender mass in hypogastrium and multiple fleshy, polypoidal mass of variable size and shape in vagina. The masses were pale red with superficial ulceration.

Biochemical evaluation of the patient revealed Hb 9 gm/dl, ESR 94 mm in 1st hour. T.C-12000/cumm with nutrophilic leucocytosis, serum creatinine 1.57mg/dl and Tubureulin test was negative. USG of whole abdomen showed a pelvic mass with smaller left kidney. IVU report showed poorly functioning left kidney. CT scan of abdomen showed malignant stump mass with smaller left kidney. Tumor marks CEA, CA-125, with in normal limit.

As an integrated approach a tem of general surgeon and urologist and gynaecologist explored the abdomen. Under G/A pelvic mass was removed and excision of pdypoidal growth of vagina was performed. Histopathololgy of omesstal tissue showed inflammatory lesion. Finally report was inflammatory myofibroblastic tumor.

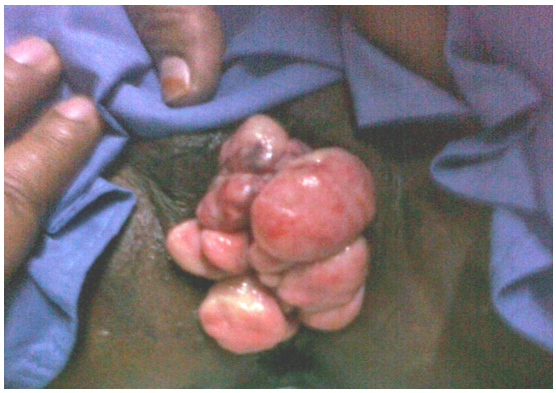

Fig: The Vaginal Mass

Two weeks after operation, the patient developed dysuria and sense of incomplete voiding. Serum creatinine was 2.07mg/dl. USG of KUB region showed soft tissue mass in pelvis with involvement of bladder wall, bilateral small kidney and mild obstructive features in right kidney. Transurethral resection of Bladder Tumor (TURBT) was done by Urologist. Biopsy showed inflammatory myofibrolastic tumor. Our confirmed diagnosis was inflammatory myofibrolastic tumor of the vagina with local invasion to urinary bladder. Her post operative recovery was uneventful and she was advised to come for follow up.

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