

Primary Vaginal Carcinoma, Tales of Tragedy : Case Report

Shahana Begum^{*}
Rowshan Akhter¹
Khadiza Begum

Department of Obstetrics and Gynaecology
Chittagong Medical College
Chittagong, Bangladesh.

Abstract

Primary carcinoma of vagina is a rare entity in gynaecological oncology. Carcinoma of vagina in prolapsed uterus is extremely rare. A tumour should be considered as a primary vaginal carcinoma when cervix is uninvolved. Here two cases of primary vaginal carcinoma are reported. These cases were confirmed by histopathology and exclusion of carcinoma cervix, endometrium and ovary through meticulous physical examination and relevant investigations. These two patients were treated by radiotherapy.

Key words: Vaginal carcinoma; Primary; Radiotherapy; Prolapsed uterus.

INTRODUCTION

Incidence of primary vaginal carcinoma is very rare (about 0.6 per 100,000 women). It constitute about 1% of genital malignancies¹. Secondary vaginal carcinoma is more common than primary carcinoma and this should fulfill the following criteria- primary site of the growth is in the vagina, cervix and vulva must not be involved, there must not be clinical evident of metastatic diseases. Exact etiology is unknown but there are some predisposing factor like HPV infection, vaginal intraepithelial neoplasia, cervical cancer exposure to diethylstilbesterol(DES), exposure of radiation, prolong use of pessary. Commonest site is in the upper two third of posterior vaginal wall². The growth may be ulcerative or fungative. Squamous cell carcinoma are the commonest type, others are adenocarcinoma, melanoma and sarcoma. Treatment option are radiotherapy or surgery or in combinatuion is the accepted modalities for invasive primary vaginal carcinoma. Choice depends on the clinical stage, anatomical location and size of the lesion.

CASE REPORT

Case-1

A 42 years old lady, para: 3+0, ALC 10 years, widow for 5 years, hailing from Cox's Bazar was admitted into CMCH on 6.7.2012 with the complaints of foul smelling vaginal discharge for last one year. She was a regularly menstruating woman. For the last 10 years she was suffering from vulvovaginitis repeatedly and was treated by local doctor and immediately her condition was improved little bit but not cured completely. She also complained that her condition was deteriorating for the last two months associated with weight loss and anorexia. Then she went to a gynaecologist at local hospital where she was diagnosed as a case of carcinoma cervix and reffered to CMCH for further management. At CMCH her examination findings reveals that she was moderately anaemic, her body weight was 40 kg and no other abnormalities was detected during physical and per abdominal examination. Per vaginal examination reveals that foul smelling vaginal discharge coming through introitus, a medium sized excavating lesion was seen in the middle part of the posterior vaginal wall which was friable and bleeds on touch (Figure 1). Tissue was taken from the lesion for biopsy. Her cervix looks healthy, uterus was normal in size and all the fornices were free. Histopathological examination reveals invasive squamous cell catcinoma. Cervix was evaluated by VIA and colposcopy which was normal in findings and her HPV DNA was also negative. Ultrasonography of lower abdomen shows normal size of uterus with normal endometrial thickness, so diagnosis was primary vaginal carcinoma and the patient was referred to radiotherapy department and treated with external beam radiotherapy (EBRT) for 6 consecutive weeks. Now her condition is improved. She is asked for follow up after one year.

*Correspondence to:

Dr. Shahana Begum
Assistant Professor
Department of Obstetrics and Gynaecology
Chittagong Medical College
Chittagong, Bangladesh.
Mobile: +880-1714288794
drshahanashelly@yahoo.com



Figure 1: Ulcerative growth on posterior vaginal wall

Case- 2

Another 75 years old menopausal lady, para: 5+0, hailing from Bashkhali, Chittagong was admitted into CMCH on 11th April 2013 with the complaints of retention of urine for 2 days, pervaginal bleeding with foul smelling blood stained discharge, pelvic pain and irreducible uterovaginal prolapse. On vaginal examination, a large fungating growth (5-6 cm) occupying the middle part of the anterior and right lateral wall of vagina was found. Surface of the ulcer was necrosed and full of slough (Figure 2). Physical examination reveals cervix looks healthy, prolapsed uterus is oedematous and swollen and impossible to reduce within the vagina and impacted within the introitus. digital rectal examination showed no involvement of parametrium and rectum. Inguinal lymphnodes were not palpable. Biopsy was taken from the fungating growth. Histopathological examination reveals squamous cell carcinoma of vagina. Ultrasonography shows bilateral hydroureter and hydronephrosis. Patient was diagnosed as a case of primary vaginal carcinoma with prolapsed uterus. She was referred to radiotherapy department, where after proper assessment of her general condition she was planned for concomitant chemoradiation. Her chemotherapy schedule was with cisplatin and cyclophosphamide for 6 weeks followed by external beam radiation.



Figure 2: Fungating growth on prolapsed uterus

DISCUSSION

Carcinoma of vagina is considered as the rarest gynaecological neoplasm¹. It represents less than 1-2% of gynaecological malignancies. Its incidence peaks during 60s²⁻⁴. Common factors that may increase a women's chance of developing vaginal carcinoma are age factor (over two-thirds of women are 60 years old or older during diagnosis), smoking habit, infection with human papillomavirus (HPV), Human Immunodeficiency Virus (HIV) infection. Other risk factors include: exposure to diethylstilbestrol (DES) as a fetus (mother took DES during pregnancy), vaginal adenosis, vaginal irritation or uterine prolapse, previous cervical dysplasia or invasive lesion. Drinking alcohol may increase the risk of vaginal carcinoma^{3,5}. Malignant diseases of vagina are usually to a primary growth elsewhere⁴. Primary vaginal carcinoma are uncommon. Secondary carcinoma of the vagina is seen more frequent than primary vaginal carcinoma. Secondary or metastatic, tumour may arise from cervical, endometrial, or ovarian cancer, breast cancer, gestational trophoblastic diseases, colorectal cancer or urogenital or vulvar cancer. Among the reported primary vaginal carcinoma, 92% are squamous cell carcinoma⁵. Other tumours are the clear cell adenocarcinoma, malignant melanomas, embryonal rhabdomyosarcoma and endodermal sinus tumour.

Though the primary invasive suamous cell carcinoma is rare but it is found only once for every 30-50 cases of carcinoma of cervix, accounting for the growth is usually high on the posterior vaginal wall opposite to the external os and only 1-2% of genital malignancies⁶. This gives rise to suggestion that it is caused by irritating discharge from the cervix. Long lasting prolapse or prolonged wearing of a pessary could also determine neoplastic changes. As the vagina is thin walled, that's why it is more common in postmenopausal women. The growth quickly involved adjacent organs. Direct invasion to bladder and rectum may occur. Our shortcomings are that we could not perform cystoscopy and proctoscopy to see the involvement of bladder and rectum.

The incidence of lymphnode metastases is directly related to the size of the tumour. Tumours from the lower third of the vagina metastasizes to inguinal lymph nodes and from the upper vagina to common iliac and presacral lymphnodes⁷. In my study, involvement of lymphnode was not assessed by doing CT scan because patient refused to do the investigation for financial constrain.

Few cases of primary vaginal carcinoma and associated with uterine prolapse are reported^{6,8}. In our cases, the first patient had a predisposing factor of repeated pelvic infection for the last 10 years which was similar to the other study and second patient was suffering from uterovaginal prolapse for more than 30 years. It is suggested that, patients with prolapse for long time duration are more likely to develop malignant transformations⁹. This case also similar to another study.

The primary therapeutic consideration encompasses surgery, radiotherapy and chemotherapy. Surgical approach may be curative in stage 1^{2,3,4,5}. Due to early invasion of bladder or rectum and particularly in older patients, primary radiotherapy is common therapeutic modality, although surgery may be implanted in early stage.

The treatment of patient with vaginal carcinoma must be individualized and will vary depending on the stage of the diseases and the site of the vaginal involvement.

Treatment options are surgery and radiotherapy. Treatment of the patient with simple invasive vaginal carcinoma primarily consists of combined external beam and internal beam radiation therapy. In stage I and IIA, also in young woman where coitus is an important factor, surgery should be considered. The 5 year survival rate in stage I is 70%. The size and stage of the disease is the most important prognostic indicators in squamous cell cancers³⁻⁴.

A few published cases of combined uterine prolapse and vaginal carcinoma are reported, but there have been no published reports that assess the management of primary invasive carcinoma of vagina associated with uterovaginal prolapse.

Any fungating or ulcerative lesion in vagina or decubitus ulcer not responding to treatment should be considered as malignant until proved otherwise.

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