

Primary Vaginal Carcinoma in Prolapsed Uterus

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Primary carcinoma of vagina is a rare entity in gynaecological oncology¹. Carcinoma of vagina in prolapsed uterus is extremely rare. A tumour should be considered as a primary vaginal cancer when the cervix is uninvolved.

A 65 years old (para 6) menopausal lady presented with retention of urine, pervaginal bleeding, pelvic pain and irreducible uterovaginal prolapse. On vaginal examination, a large fungating growth (5-6cm) occupying the middle part of anterior and right lateral wall of vagina was found. Physical examination including digital rectal examination showed no involvement of parametrium, urinary bladder or rectum. Inguinal lymphnodes were not palpable. Biopsy was taken from the fungating growth. Histopathology examination diagnosed the case as squamous cell carcinoma of vagina. Paps smear of cervix and X ray chest revealed no abnormalities. IVU showed bilateral hydronephrosis, CT scan of abdomen revealed procidentia with no parametrium or lymph node involvement. The patient was staged as having a FIGO stage I vaginal carcinoma and TNM(T1N0M0)

The treatment performed was radical vaginal hysterectomy and excision of the whole vagina. Histopathology confirmed the squamous cell carcinoma of vagina. All the resection margins of the surgical

specimen were clear. There was not lymphovascular space involvement. Her postoperative period was uneventful. After the operation the patient received external radiotherapy.

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



Fig. : Primary vaginal carcinoma in prolapsed uterus. (Consent for publishing the photograph was taken from patient).

Carcinoma of vagina is considered the rarest gynaecological neoplasms. It represents less than 1-2% of gynaecological malignancies. Its incidence peaks during 60s^{1,2,3}. Among them 85% are squamous cell carcinoma.

Few cases of vaginal carcinoma associated with uterine prolapse are reported⁵⁻⁸. Common factors that may

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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 .

In our case , the patient had a history of prolapse for more than 10 years . It is suggested that , patients with procidentia of 10 years duration are more likely to develop malignant transformations ⁸

Vaginal cancer is often asymptomatic. Postmenopausal vaginal bleeding or vaginal discharge is the most common presenting feature, however urinary tract disturbances and pelvic pain may occur. An ulcerative lesion in vagina may occur following an inflammatory reaction due to prolonged retention of a pessary or other foreign body. Direct invasion to bladder and rectum may occur .The incidence of lymphnode metastases is directly related to the size of tumour. Tumours from the lower third of vagina metastasizes to inguinal lymphnodes .and from the upper vagina to common iliac and presacral lymph nodes.

The treatment of patient with simple invasive vaginal carcinoma primarily consists of combined external beam and internal radiation therapy .In stage 1 and IIA ,also in young woman where coitus is an important factor surgery should be considered .The 5 –year survival rate for stage I is 70% . The size and stage of the disease is the most important prognostic indicators in squamous cell cancers .

As few published cases of combined uterine prolapse and vaginal carcinoma , there have been no published reports that assess the management of primary invasive carcinoma of vagina associated with vaginal 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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