Vulvar fibroma with coexisting uterine fibroma in a postmenopausal patient: A Case Report

Rachna Chaudhary[1,*], Haripriya Bajwa[2]

[1]Associate Professor, [2]Junior Resident, Department of Obstetrics & Gynaecology, LLRM Medical College, Meerut

***Corresponding Author:**
Email: drrachnachaudhary@gmail.com

Abstract

Vulval growths though rare, may be cause of discomfort as well as social withdrawal. The patient usually complains only of swelling or of bleeding and discharges from it. The treatment is excision and removal, recurrence is rare. We present a rare case of a fibroma of the labia majora with coexistent uterine fibroid in a postmenopausal woman.

Keywords: vulvar fibroma, uterine fibroma, postmenopausal.

Access this article online	
Quick Response Code:	Website: www.innovativepublication.com
	DOI: 10.5958/2394-2754.2016.00030.8

Introduction

Tumors of the vulva are rare. Apart from malignant tumors, fibromas are the most common benign tumour of vulva though these occur very rarely. Benign growths may be composed of any of the tissues which make up the vulva. The commonest are the fibroma and lipoma and these can reach large sizes.

Case Report

Mrs. Anarwati aged 65 years was admitted in gynaecology ward with chief complaints of swelling in the genital region since 3-4 months and purulent discharge from the swelling and associated pain since 1 month. Other than that, there was no other complaint. The patient was an old female, well cared by relatives, relatively healthy with good hygiene.

Her detailed history revealed that she was P1 L1 with only one male child delivered vaginally forty years ago. She had not conceived after that childbirth with no history of abortions or still births or early neonatal death. She was postmenopausal since 15 years and had no other significant complaint other than the genital swelling. Patient was nonsmoker and was in good health. There was no history of hypertension, diabetes, tuberculosis or other medical disorders. Detailed history elicited breathlessness on exertion since 1-2 months. There was no history of palpitations, prolonged fever and cough or chest pain.

On General Examination there were no positive findings; patient was 152 cm tall with normal BMI. She was borderline hypertensive (150/80mmHg) with no cardiovascular findings.

Local examination of vulva revealed a mass of about 8×6 cm seen arising from right labia majora. There was an ulcer of 2×2 cm at the centre of the mass which was exuding a purulent discharge. The swelling was of an orange size, firm in consistency, non-fluctuant and was neither inflammed nor tender. The swelling was not communicating with labia minora or vagina. There was no induration at its base. Mons and contralateral labia were apparently normal. Also there was no inguinal lymphadenopathy. The pus discharge was collected and was sent for culture and sensitivity.

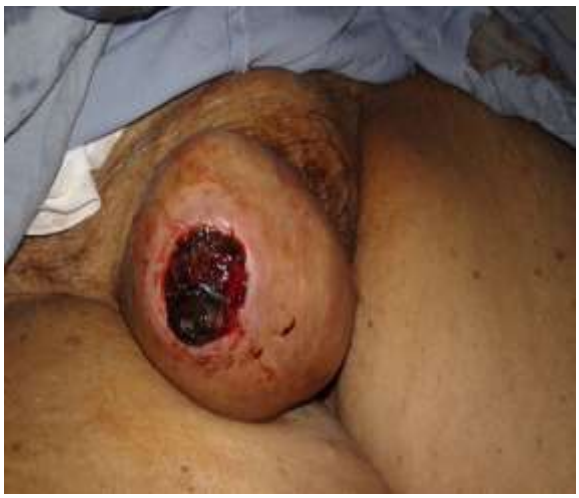

Fig. 1: Picture showing vulvar growth

On Per Speculum examination vagina was apparently healthy, cervix was atrophic, no growth or any abnormality seen, VIA was negative, no cervical descent or vaginal laxity seen. Bimanual examination revealed an enlarged uterus of about 10-12 week size, mobile, firm in consistency, with no uterine or forniceal tenderness. Patient was admitted and all investigations as regards her cardiovascular status and fitness for surgery were sent. All investigations were within

normal range except ECG which was s/o left ventricular hypertrophy. A 2-D ECHO was done which revealed Left ventricular hypertrophy and 50% ejection fraction. A physician opinion was sought and the patient was put on antihypertensives and given medical fitness for surgery.

Ultrasound Findings

A detailed USG was done, USG upper abdomen was normal whereas Pelvic scan revealed a 78×51 mm heterogenous lesion from right vulva. The lesion was solid with central anechoic area s/o necrosis with mild internal vascularity. Lesion was seen involving overlying skin with loss of fat planes; however inner margin was well defined. Uterus was 133×73 mm with large well defined heterogeneously hypoechoic lesion with degeneration and calcification arising from posterior wall of fundus s/o fibroid.

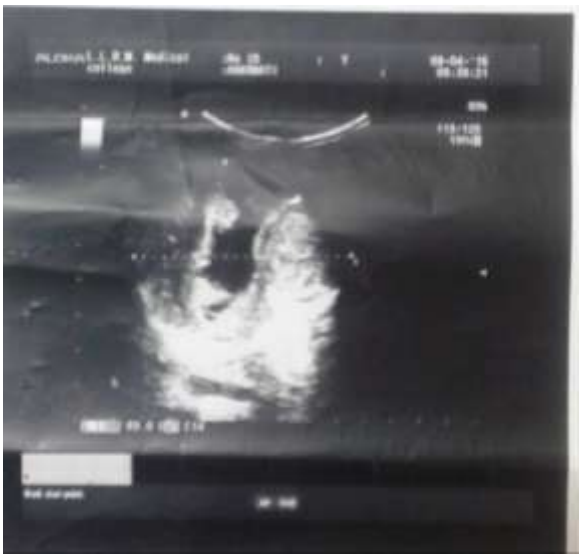

Fig. 2: USG picture showing vulvar fibroid

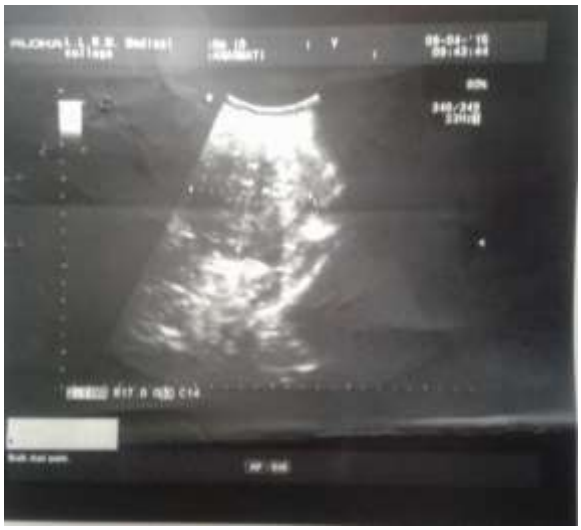

Fig. 3: USG picture showing uterine fibroid

Intraoperative Findings

Patient was prepared for abdominal hysterectomy with B/L salpingo-oopherectomy and vulvar growth excision. Hysterectomy revealed a bulky (10 wks) uterus. On cut section a solitary intramural fibroid was seen with central degeneration. A wide excision was given on vulvar growth base and an encysted mass of 8×7 cm, firm with central softening was removed. Skin was approximated using non absorbable mattress sutures. On cut section, typical capsule with whorled appearance was seen, and no haemorrage was seen. Both the tissue specimens were sent for HPE. Patient recovered well. Abdominal and labial stitches were removed on day 8 and day 10 respectively.

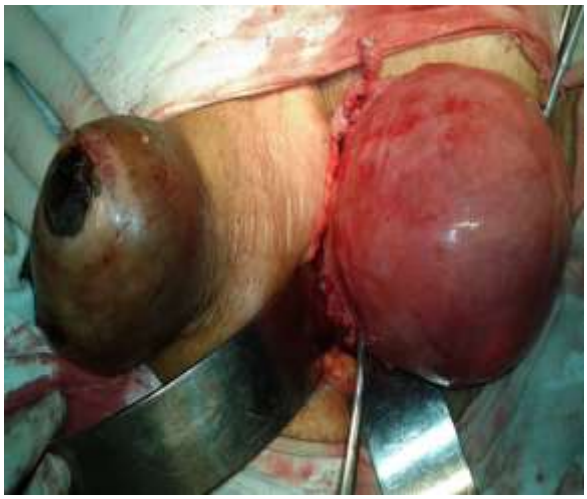

Fig. 4: Intraoperative picture of vulvar fibroma and uterine fibroid

Fig. 5: Specimen of excised vulvar growth and uterus

Histopathological examination revealed:

1. Uterus- endometrium atrophic, myometrium-leiomyoma, cervix –chronic cervicitis
2. Ovary /Fallopian tube –normal
3. Vulval mass –showed focal viable area of hypertrophic squamous epithelium with underlying fibrocollagenous tissue infiltrated with chronic inflammatory infiltrates

Discussion

Vulval fibroma is a rare benign tumour that is predominantly found in women of reproductive age group and is rare in children, breastfeeding and pregnant women, and elderly patients. The tumour may arise from either the deep connective tissue of introitus, labia majora, perineal body or round ligament. The rarity of these tumors prevents a more detailed understanding of their morphological and epidemiological characteristics. To start with, the tumour may be asymptomatic but has the potential to grow to huge sizes. Fibromas are usually asymptomatic in the beginning; however they develop symptoms resulting from their size and from their main complication-the superficial ulceration, which happened in our patient. This patient reported to us only because of pus discharge from the ulcer and difficulty in walking. Apart from causing physical signs due to its size and location, the tumour causes extreme emotional upheaval and social withdrawal, especially in a conservative society like ours. Important differential diagnosis includes lipoma, inguinal hernia, vulvovaginal cysts, vulval elephantiasis, and fibro epitheloid tumours.

The treatment of any vulvar tumour causing symptoms, or whose nature is in doubt, is by excision. Its structure is usually determined only by subsequent microscopic examination; such an examination is important if only to exclude malignant disease.

Details of ethical approval: Not Required

Conflict of interest: None

Source of Support: Nil

References

1. Jeffcoate's principle of gynaecology; Kumar, Malhotra; 442-443; seventh edition;2008. Jaypee publications.
2. Wilkinson EJ, Xie D (2002) benign diseases of the vulva. In: Kuman RJ, pathology of the female genital tract. Fifth edition, New Delhi: Springer-Verlag 37-98.
3. Jeffcoate's principle of gynaecology; Kumar, Malhotra;442-443; seventh edition;2008.
4. Cabrera HN. Nevos del tejido conectivo, In: Cabrera H, Garcia S, editors. Nevos. Buenos Aires: Actualizaciones Medicas SRL; 1998.p.123-6.
5. Hernandes VMV. Fibroma de vulva. Reporte de un caso. Revista de Enfermedades del Tracto Genital Inferior. 2007;1(1):23-6.
6. Leonard VN. Fibroids tumours of the vulva. Johns Hopkins Hosp Bull.1917;28:373.
7. Scully RE, Bonfiglio TA, Kurman RJ, Silverberg SG, Wilkinson EJ. Histological typing of female genital tract tumours. 2nd ed. Berlin: Springer-Verlag;1994.
8. Isoda H, Kuroda M, Asakura T, Akai M, Sawada S, et al. Fibroma of the vulva. Comput Med Imaging Graph.2002; 26(2):139-42.
9. Chen DC, Chen CH, Su HY, Yu CP, Chu TY. Huge pedunculated fibroma of the vulva. Acta Obstet Gynaecol Scand. 2004;83(11):1091-2.