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CASE REPORT

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Primary invasive carcinoma of vagina in association with genital prolapse

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Primary carcinoma of the vagina is rare and association with third degree uterovaginal prolapse is even rarer [1]. Vaginal cancer accounts for approximately 2% of all female genital tract cancers. The incidence peaks during the 6th and 7th decades. More than 90% are squamous carcinomas and postmenopausal vaginal bleeding is the commonest symptom. Although radiation therapy has been the primary treatment for this tumor, there is evidence to suggest that Stages I and II can be successfully treated with radical surgery. Due to its rarity, treatment guidelines are difficult to standardize and there is controversy regarding the optimal treatment [2].

Care report

Mrs. SG, a 49 year old postmenopausal woman who presented with a two year history of a mass coming out per vaginum and difficulty in micturition. There was no history of abnormal vaginal bleeding or discharge. General physical examination was normal. Pelvic examination revealed a third degree uterovaginal prolapse, with a grade 3 cystocele and entero-rectocele. A 3x3 cm ulcerating lesion with indurated and everted margins was present on the middle third of the left lateral vaginal wall. The ulcer was mobile over the underlying cystocele thus excluding the possibility of bladder involvement and on rectal examination, the rectal mucosa was free. The cervix and vulva were normal. On bimanual examination, the uterus was normal in size and freely mobile, and there was no adnexal mass. A cervical smear and other metastatic workup were normal. A punch biopsy of the ulcer confirmed a squamous cell carcinoma of the vagina. She was diagnosed as FIGO stage I primary vaginal cancer and a decision was taken to treat it surgically. On 11th December, 2002 a radical hystero-colpectomy involving removal of parametrium of both sides and bilateral pelvic lymphadenectomy (Figure 1) were performed using an abdomino-vaginal approach under general anesthesia. The abdomen was opened through a Pfannenstiel incision. Bilateral pelvic lymphadenectomy was first completed. All resected nodes were found to be negative on frozen section. A type III radical dissection of the uterosacral – cardinal ligament complex was then done after completely dissecting the pelvic ureters. By vaginal route the entire vagina was dissected from the cystocele anteriorly and the recto-enterocele posteriorly. The paracolpos was clamped and

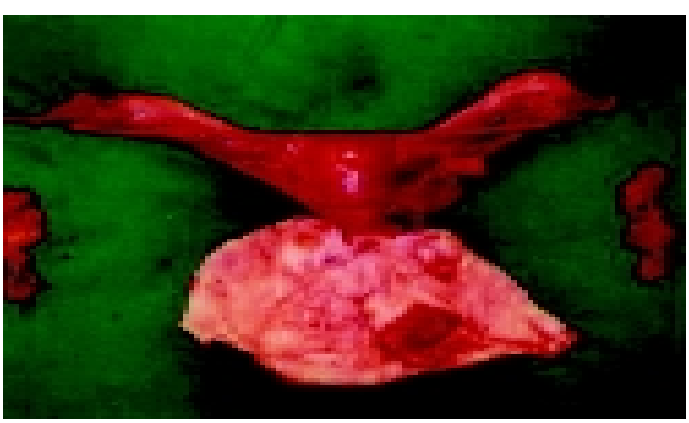

Figure 1. Specimen of radical hystero-colpectomy with bilateral pelvic lymphadenectomy

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cut on both the sides and the entire specimen delivered vaginally. She made an uneventful postoperative recovery and was discharged on day seven. Histopathology confirmed a grade 2 invasive squamous cell carcinoma of the vagina. All surgical margins were free and all pelvic nodes negative. No adjuvant therapy has been advised and she is being followed up clinically as per our protocol.

Post-script - At the follow-up in March 2005 she had no symptons, vaginal cytology showed no malignant cells and imaging study reveated no pelvic or extrapelvic spread.

Although most cancer centers prefer either radical radiotherapy or, more recently, concurrent chemoradiation for primary vaginal cancers, we believe that radical surgery has an important role to play in the management of selected women with primary cancers of the vagina. There is evidence to suggest that the results of radical surgery in selected stage I primary squamous vaginal carcinomas are superior when compared to those acheived with radiation therapy alone [2].

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