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Case Report

Primary squamous cell carcinoma in situ of vagina – A colposcope aided diagnosis

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Introduction

Most common invasive cancers of the vagina are metastatic from the endometrium, cervix or ovary. Primary squamous cell carcinoma is rare, the incidence being 0.6/100,000 women. Vaginal neoplasia will either co-exist or occur at a later date in 1-3% of the patients with cervical neoplasia. A vaginal tumor, occurring after 5 years of disease free interval in a patient with cervical neoplasia should be considered a primary carcinoma of the vagina.

Case report

Mrs S.G. aged 48 years, para 2 with regular menstrual cycles was referred for colposcopic evaluation. She complained of post coital bleeding for the past 12 months. Her pelvic sonography and endometrial biopsy were normal, and pap smear revealed inflammation. She had received in the past many courses of antifungal, antitrichomonal and antichlamydial therapy. Local estrogen cream was prescribed as a last resort, with no relief of symptoms.

The patient was then subjected to systematic colposcopic evaluation[1]. Vulva was normal and cervix showed featureless squamous epithelium, normal columnar epithelium, and squamocolumnar junction. Ecto and endo cervical pap smears were repeated. Vaginal fornices were then examined after applying 5% acetic acid. The cervix was displaced side ways, up and down with long artery forceps to facilitate the view. The anterior and lateral fornices were normal, but the posterior fornix showed a patch of acetowhite epithelium with coarse punctuations and abnormal vasculature. A provisional diagnosis of VAIN 3 (Vaginal Intraepithelial Neoplasia) or invasive vaginal carcinoma was made. In retrospect, the lesion when examined without the use of acetic acid and colposcope, looked like inflamed vagina without any growth and was often hidden behind the speculum blade. Colposcope guided biopsy was taken under general anesthesia. Histopathology revealed squamous cell carcinoma of the vagina in situ (Figure 1). As it was difficult to rule out invasion, after counseling the patient was subjected to radical hysterectomy with partial vaginectomy on 27th March, 2003. The histopathology of the specimen confirmed the results of biopsy with no involvement of the uterus and cervix in disease process. The lymph nodes were negative and margins of excised vagina were clear. She was discharged in good condition on 4th April 2003. She is being regularly flowed up. At

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the last followed up on 16th December 2006, she was in good health and showed no abnormality on clinical examination, colposcopy, pap smears, x-ray chest and sonography of the abdomen.

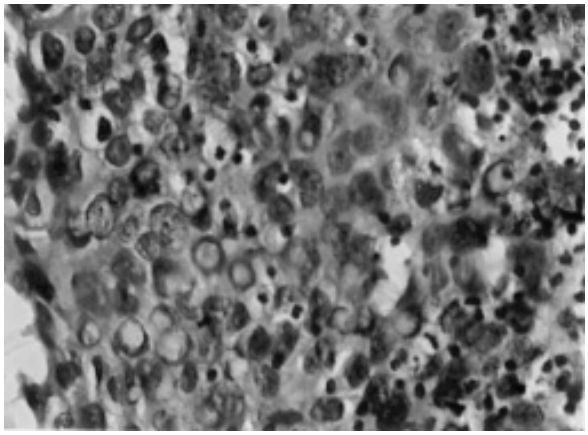

Figure 1. Photomicrograph showing squamous cell carcinoma (H. & E. X 40). The cells possess large pleomorphic nuclei and firm cytoplasm.

Discussion

Primary vaginal carcinoma is a rare disease, squamous cell carcinoma being the commonest followed by adenocarcinoma and melanoma. The cause of squamous cell carcinoma is unknown but it may be associated with human papilloma virus infection. There appears to be a premalignant phase VAIN, but the exact incidence of invasive vaginal cancer developing from VAIN is not known[1]. Most low grade VAIN are asymptomatic and regress spontaneously without treatment, while VAIN 3 is true cancer precursor. However, the progression of VAIN to vaginal carcinoma appears to be far less than the progression of CIN to cervical carcinoma.

Common site for vaginal cancer is posterior upper 1/3rd of vagina and can be easily missed during the initial inspection, being obscured by the speculum blade. Colposcopy and directed biopsy can clinch the diagnosis in a case with abnormal pap result with normal cervix, unexplained vaginal bleeding or ulcerated and erythematous patch of upper vagina[2].

The case is presented because of rarity of the disease and to emphasize the value of colposcopy in picking up the disease in early stage.

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