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RESEARCH ARTICLE

VULVAR SQUAMOUS CELL CARCINOMA REVEALED BY PRURITUS

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Abstract

Squamous cell carcinoma of the vulva accounts for 3 to 5% of all female genital cancers. It occurs in women with a history of HPV infection or lichen sclerosus lesions, and in post-menopausal women is also linked to estrogen deficiency. It is generally manifested by a painful, pruritic ulceration on an erythroplastic background on the inner surface of the labia majora. Diagnosis is confirmed by biopsy with anatomical and histological examination. Diagnosis must be made early, and treatment relies mainly on surgery. We report the case of a post-menopausal woman with no pathological history who consulted us for a single symptom: vaginal pruritus.

Introduction:-

Squamous cell carcinoma (SCC) of the vulva represents 3 to 5% of female genital cancers. It can occur on dysplasia lesions related to HPV infection or on lichen sclerosus lesions [7]. In post-menopausal women it is linked to estrogen deficiency. Clinically, it is a painful and pruritic ulceration on an erythroplastic background located on the inner surface of the labia majora in 40% of cases [5]. Histology confirms the diagnosis by showing atypical keratinocytes crossing the basal membrane, grouped in lobules centered by horny globes. The SCC of the vulva has a bad prognosis with mainly lymph node and locoregional invasion. There is no consensus for the optimal therapeutic management. Surgery remains the cornerstone of treatment [10]. External radiotherapy and interstitial brachytherapy have their place in the therapeutic arsenal [11].

Objective:-

This article shows the value of a clinical examination and dermoscopy, even when faced with symptoms that are not pathognomic of certain tumor pathologies

Patient's Observation:-

We report the case of a 65-year-old postmenopausal women who consulted us for a vulvar pruritus evolving since 1 year. One month ago, the pruritus intensified and became insomniac, with vulvar swelling. The general state was preserved. The clinical examination finds a vulvar erosion of about 0.5cm, painful, indurated, well limited with a regular contour exposing a pinkish surface. Disappearance of the labia minora. Shiny and whitish aspect of the inner side of the labia majora (image 1).

The dermoscopy showed an erythema, dotted and hairpin vessels, white area without structure and ulceration (image 2). The biopsy with anatomical-pathological examination showed a hypertrophic epidermal coating with a well-

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differentiated epidermoid carcinomatous proliferation made of polyhedral tumor cells with eosinophilic cytoplasm and enlarged nuclei. A polymorphic and focally lichenoid inflammatory infiltrate with isolated basal apoptotic bodies. A thoraco-abdomino-pelvic CT scan showed two left external iliac adenopathies. The patient was referred to the gynecology department for surgical management and a total vulvectomy with lymph node curage was performed.

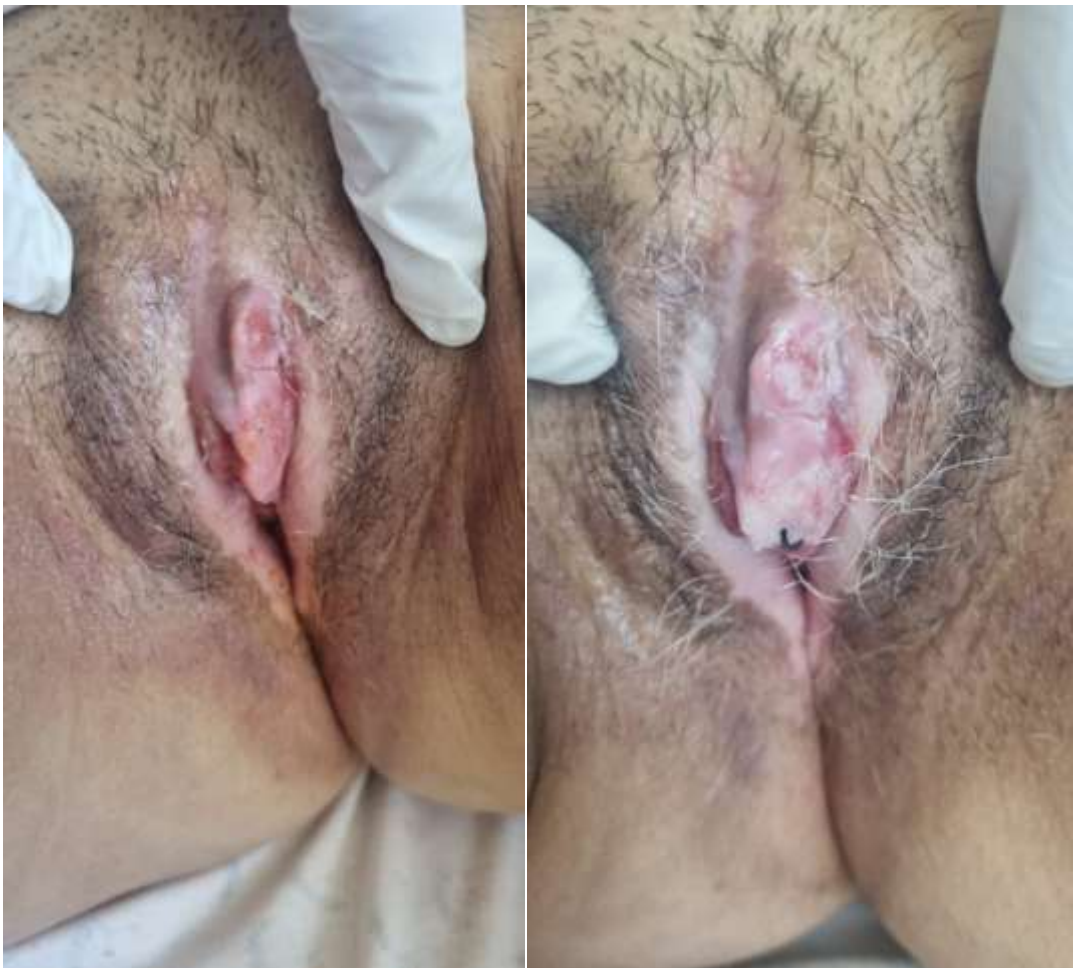

Image 1:- Clinical aspect of the tumor.

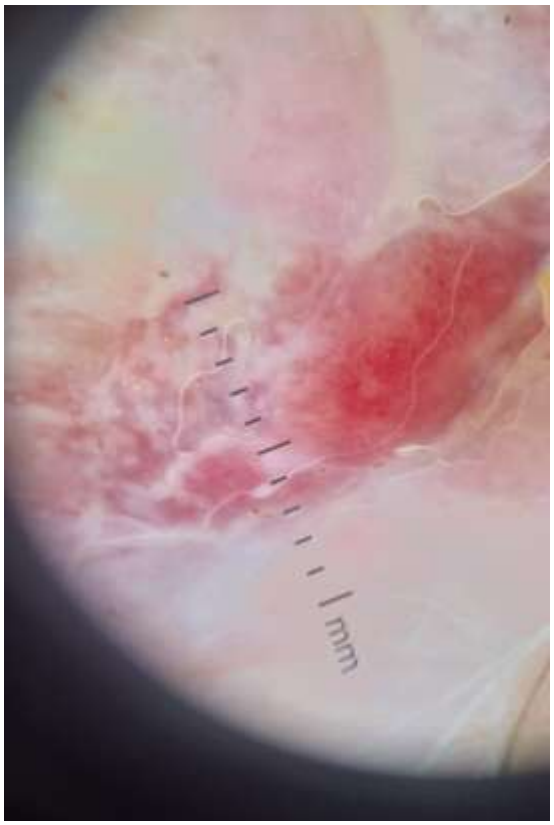

Image 2:- Dermoscopic aspect of the tumor.

Discussion:-

Vulvar cancer is the 4th most common type of gynecological cancer, after cervical, endometrial and ovarian cancers. A rare entity, it accounts for around 6% of all malignant tumors of the female genital tract. An increase in incidence with age has been noted. [1] Vulvar carcinoma mainly affects older women, with a median age of 77 in France [2]. The incidence of vulvar cancer remains low, although it has increased in recent decades, particularly in young women. In this population, persistent genital HPV infection has been reported to be the main cause of the development of vulvar neoplasia. It has also been reported that HIV-induced immunodeficiency favors the onset and persistence of HPV infection, leading more readily to the development of genital cancers, particularly those of the vulva [3].

Clinically, squamous cell carcinoma of the vulva may manifest as chronic vulvar irritation, a burning sensation in the genital labia, pruritus, dyspareunia or discoloration of the labia. A thorough gynecological examination is therefore necessary for women presenting any of these symptoms, and for all HIV-positive women, in order to detect genital cancers at an early stage[4]. Metastases are possible via the lymphatic system to the inguinal or femoral region, but also through pelvic and distant lymph nodes. However, hematogenous spread remains unusual [5].

Histologically, they are essentially squamous cell carcinomas (90%) [5], and rarely melanomas, Bartholin gland adenocarcinomas or skin tumours. Like cervical and vaginal cancers, squamous cell carcinomas are preceded by lesions of the vulvar intraepithelial neoplasia (VIN) type, whose transformation into invasive cancer is in the order of 5 to 10%, whether bowenoid papulosis, genital warts or Bowen's disease [6]. The tumor is most often found on the labia majora (80%), followed by the labia minora (14.3%), and the clitoris (5.7%) [7].

Survival of patients with vulvar cancer is good when appropriate treatment is organized promptly after initial diagnosis. Inguinal and/or femoral lymph node involvement is the most important prognostic factor for survival [5]. Poor prognostic factors include lymph node extension, tumour size and tumour recurrence [8].

Even though therapeutic techniques for cancer management have evolved and are all tending towards organ preservation, radical surgery still has a major place in the treatment of vulvar carcinoma. A radical vulvectomy combined with inguinal lymph node dissection and postoperative radiotherapy is the gold standard [9]. However, the procedural mortality rate associated with this surgery can be as high as 10%, and the complication incidence rate is over 66.6%. There is also a risk of procedure-related morbidity, physical and sexual disfigurement, dysfunction, and a largely unknown influence on overall quality of life. Its 5-year survival rate is less than 50% [10]. Where there are risk factors for local recurrence, such as tumour volume greater than 4 cm, narrow surgical margins (less than 8mm), deep lymphatic vascular invasion and positive lymph node status, post-operative radiotherapy is indicated in the presence of these factors [11]. In retrospective series, complete tumor regression has been recorded in 30% to 50% of cases, mainly with cisplatin-, mitomycin- or 5FU-based chemotherapy [11]. Brachytherapy is rarely indicated, but is particularly useful in the treatment of tumor remnants in contact with the urethra or in the lower levels of the vagina, or in the conservative treatment of tumors smaller than 3 cm [1]. Chemo-radiotherapy represents another therapeutic alternative, but is not without side effects. The most frequent is severe cutaneous toxicity of the vulva and perineum [11].

Conclusion:-

Vulvar cancer is the 4th most common gynecological cancer. The high prevalence of HPV infection during the course of HIV/AIDS exposes patients to an increased risk of genital cancers, particularly vulvar cancers. A biopsy with anamo-pathological examination should be carried out for any suspicious lesion of the vulva in HIV-positive patients, in order to make an early diagnosis [12].

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