

# A Case Report of Vaginal Squamous Cell Carcinoma in Uterovaginal Prolapse

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**Abstract:** A case of 72 years postmenopausal women para 1, live 1, previous normal vaginal delivery, came with history of mass descending per vaginum for the past 20 years and had an episode of postmenopausal bleeding 6 months back now have the complaints of severe abdominal pain for 3 days and urinary retention for the past 2 days. On gynaecological examination patient was found to have third degree uterovaginal prolapse which was edematous and there was an ulcer of size 3×3 centimeters on the anterior wall with marked edema. Patient was catheterized immediately and clear urine was drained. Biopsy of the ulcer was done which was suggestive of invasive squamous cell carcinoma.

**Keywords:** uterovaginal prolapse, postmenopausal, squamous cell carcinoma

## 1. Introduction

Pelvic organ prolapse is the protrusion of the pelvic organs into the vagina [1]. It represents weakening of the pelvic floor muscles. Primary SCC of the vagina is a rare malignancy approximately accounting for 2% of all malignant tumors of the female genital tract [2]. It usually occurs in patients over 60 years of age. [1,3] The most frequent clinical symptom is vaginal bleeding, but dysuria and pelvic pain are also common. Conservative treatment is effective for precancerous lesions, surgical therapy for early stage of infiltrating cancer, and radiotherapy for progression lesion. Radiotherapy/surgery/combination of both is the most accepted treatment modalities that depends on the clinical stage, anatomical location and size of the lesion [5].

### Clinical Presentation

72 Years old female Para 1 Live 1 previous normal vaginal delivery postmenopausal 20 years presented to Sree Balaji Medical College OPD with complaints of mass descending per vaginum for the past 20 years with urinary retention for 3 days. Patient also had complaints of foul smelling discharge for 2 days. History of postmenopausal bleeding of 1 episode 6 months back. Her general examination was normal. Vitals were stable. On local examination third degree uterovaginal prolapse with cystocele and rectocele was with an ulcer of size 4×5 centimeters on the left lateral wall. Marked edema was present and it was irreducible. On admission patient was catheterized and was treated with intravascular antibiotics. Daily magnesium sulphate dressing was done to reduce the edema. Metronidazole ointment local application was given to control the local infection. Intraoperatively prolapse was reduced under anaesthesia and biopsy was taken from the ulcer. Histopathological examination of the biopsy was suggestive of squamous cell carcinoma.

## 2. Discussion

There have been reported extremely rare cases of vaginal carcinoma associated with uterine prolapse [12, 13, 14, 15]. Among vaginal malignancies, SCC is the commonest (95%), others being adenocarcinoma, melanoma and sarcoma. [6] The diagnosis is made on exclusion of other gynecologic cancer and no recurrence after at least 5 years to prior gynecologic cancer. Thus, genital tumors which extend to vagina and reach outer ostium of cervix or those with vulva or urethra involvement are generally classified as cervical carcinomas or primary vulva and urethral cancers, respectively [10,11].

Fonseca et al., studying cytologic, colposcopic and histological findings in patients with uterine prolapse revealed chronic cervicitis in 97.9%, cervix decubital ulcer in 13.6% and carcinoma in situ in 1% of the cases. It demonstrates the importance of accurate preoperative evaluation of cervix in cases of uterine prolapse because its possible association with cervical carcinoma [16]. The management of vaginal cancer depends upon its prognostic factors, i.e. size, location and extent of tumor, patient's age, clinical staging and histological classification [10, 11], but radiotherapy is generally the most preferred modality of treatment for invasive vaginal cancers [10]. Primary vaginal squamous cell carcinomas treated with carefully tailored primary radiation therapy as showing excellent pelvic control [7]. Size and location of the lesion must be well established to determine the dose and type of radiation therapy. Lesions located in the lower region of the vagina wall at clinical Stage I are treated with a combination of external beam and intracavitary radiation therapy. [8] Surgical therapy may be effective for treatment purposes at Stage I. It is essentially the same surgical treatment of early Stage II cervical cancer which invaded the upper 1/3 of the vagina. The surgical approach primarily consists of radical hysterectomy and pelvic lymph nodes dissection. Lesions in the lower vagina are treated by a resection of inguofemoral lymph nodes including external genitalia. [8] Therefore, it is

not appropriate to perform a radical operation only based on the size or location of a lesion.[9] Conservative surgical techniques may still be used to treat young women, microinvasive carcinoma and verrucous lesions [11].

A patient with a long history of uterine prolapse must be treated with care due to the risk potential for malignant change. It is essential to pay careful attention to patients with uterine prolapse by performing various tests to discover malignant lesions before surgical treatment.[8]

### 3. Conclusion

The authors conclude that on these unfavorable changes in the condition, including vaginal bleeding, coldness with foul odor and ulcerating lesions, biopsies must be performed before treatment.

It is essential to pay careful attention to patients with uterine prolapse by performing various tests to discover malignant lesions before surgical treatment. Careful preoperative histological evaluation of cervix in cases of uterine prolapse and postoperative cytologic and colposcopic follow-up of the vagina after hysterectomies are important because possible association with cervical carcinoma and occurrence of late vaginal cancer

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