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Case Report

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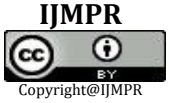

A Case Report of Triple synchronous Primaries of Female Genitaltract - CA Vulva Associated with CA Cervix and CA Endometrium

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ABSTRACT

Introduction: Uncommon tumor, that accounts for 3-5% of all gynecological malignancies. Most commonly seen in postmenopausal women. 90% accounts to SCC. Although external in location, hesitancy results in delayed diagnosis.
Case report: 64 year old P4L3 postmenopausal woman with no known comorbidities, was admitted with multiple episodes of vomiting, irrelevant talk, generalised weakness. Incidentally, a swelling was noted over external genitalia. of size 4x3cm over left labia majora. Vulval biopsy showed Squamous Cell Carcinoma of Vulva. She underwent Total Abdominal Hysterectomy + B/L Salpingo ophorectomy + Appendicectomy + left inguinal lymphnode dissection followed by Modified Radical Vulvectomy. Lymphatics both superficial and deep femoral were dissected. HPE of the specimen showed SCC of vulva-moderately differentiated, SCC insitu of cervix, superficial spreading type extending up to endometrium, following which Adjuvant chemoradiation of dose 54 Gy in 27 fraction along with 5 cycles of weekly Injection Cysplatin was given starting from 1 month post surgery.
Conclusion: Synchronous primary genital cancer is an uncommon occurrence. In this case, additional association with Empty Sella Syndrome makes the management even more complex.

Key Words: *CA Vulva Associated with CA Cervix and CA Endometrium*

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INTRODUCTION

Ca Vulva is an uncommon tumour, that accounts for 3-5 % of all gynecological malignancies. Most commonly seen in postmenopausal women. 90% are SCC.

A synchronous cancer occur when the second primary tumor is diagnosed in less than 6 months of primary cancer. Cases of triple synchronous primaries of female genital tract are extremely rare, and all the cases reported till date are involving cervix, endometrium, and ovary [1, 2].

Hereby reporting a case of 64 year old woman with synchronous Ca vulva, Ca cervix, Caendometrium.

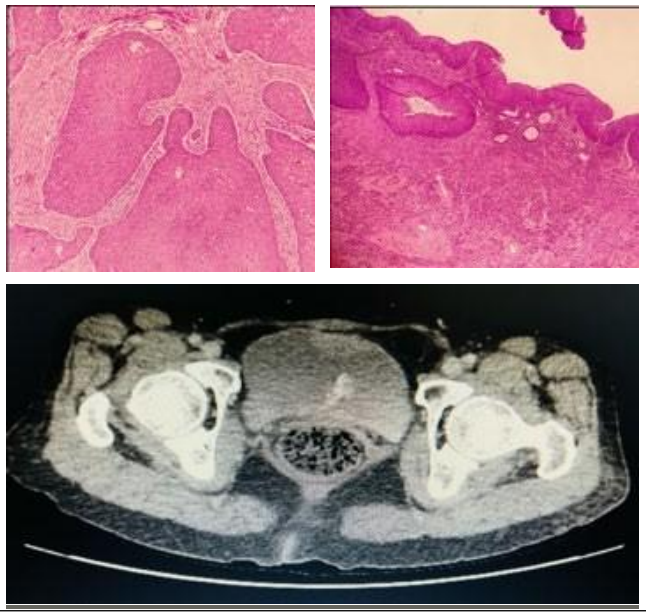
CASE SUMMARY

64 year old P4L3 postmenopausal woman with no known comorbidities, was admitted with multiple episodes of vomiting, irrelevant talk, generalised weakness. Incidentally, a swelling was noted over external genitalia. Patient on enquiry, gave history of swelling since 3 weeks associated with pain and bloody discharge. Patient was diagnosed with Empty Sella Syndrome, Hypopituitarism, and Dyselectrolytemia.

On examination, swelling of size 4x3cm over left labia majora seen, hard in consistency, non tender, associated with brownish discharge. Left inguinal lymph node of size 2x2 cm palpable. CECT abdomen was done showing enhancing lesion in left vulva involving labia minora extending into introitus, peripherally enhancing collection in uterus (likely hematometra or abscess) and enhancing enlarged left inguinal lymph nodes. PAP done showing inflammatory smear, with benign cellular changes. Pipelle done showed atypical squamous cells possibly extension into endometrium. Vulval biopsy showed Squamous Cell Carcinoma of Vulva. After stabilisation, (in view of SCC of vulva she underwent wide tumour excision)which included Total Abdominal Hysterectomy + B/L Salpingo ophorectomy +Appendicectomy + left inguinal lymphnode dissection followed by Modified Radical Vulvectomy. Lymphatics both superficial and deep femoral

were dissected. HPE of the specimen showed SCC of vulva-moderately differentiated, SCC insitu of cervix, superficial spreading type extending up to endometrium. Referred to radiotherapy and was advised for Adjuvant chemo radiation of dose 54 Gyin 27 fraction along with 5 cycles of weekly Injection Cysplatin starting 1month post surgery.

Pre operative and post operative status



1) Vulval growth – SCC keratinising. 2) Cervix full thickness dysplasia 3) CECT abdomen showing collection in uterus.

DISCUSSION

Synchronous primary tumours accounts for 0.7%- 1.8% of all gynecological tumours [3]. The most common (40-50%) synchronous primary tumour of genital tractareovaries and endometrial cancers [3].

Synchronous neoplasms have a common etiological factor. According to "secondary mullerian concept", embyologically similar tissues when simultaneously subjected tocarcinogenic, hormonal, therapeutic or other trigger factors develop synchronousneoplasms in genetically susceptible individuals [4]. Patients are usually postmenopausal with the, median age of presentation being 50-60 years. Most patients present with post menopausal bleeding and vaginal discharge.

It is also important to distinguish synchronous neoplasms from metastatic ones because synchronous neoplasms have a better prognosis and a different treatment regimen. Ulbright T and Roth L proposed that synchronous gynaecological tumour must have a different histopathological origin or they should fulfill all minor criteriasas follows – tumours must be restricted, with no distant metastasis, no connection between the tumour, no lymphovascular tumour emboli and no myometrialinvasion [2]. In this case, all the above mentioned criteria's are fulfilled and hence thediagnosisofsynchronousprimaryneoplasmoffemalegenitaltractwasconfirmed.

Field cancerization is the basis of multiple head and neck SCC. It is a premalignant phenomenon and is frequently

associated with oncogenic HPV infection. The idea of Field cancerization was used by Slaughter to describe the existence of generalisedcarcinogen induced early genetic changes in the epithelium. Multiple independent lesions were found to occur from this. This in turn lead to development of multifocaltumours [2].

Surgical management of vulvar cancer should be individualised and the most conservative operation that will result in cure of the disease should be performed. Over past 25 years, radical procedure of En block excision by Taussig and Waywhich includes radical vulvectomy with bilateral inguinal lymphnodes has given way to a more conservative approach. In this case, primary lesion and groin lymphnodes were considered independently to maximize the chance of cure while reducing treatment related morbidity.

CONCLUSION

90% of all cervical cancers are attributed to high risk HPV infections. 60% of SCC of vulva, vagina, anusare due to infection of HPV [4].

Synchronous primary genital cancer is an uncommon occurrence. In this case, additional association with Empty Sella Syndrome makes the management evenmore complex. The diagnosis of synchronous cancers based on clinical findings and HPE was obvious in this case. HPV infection being the most common cause of synchronous cancers, confirming HPV infection in this case should have been done and would have added value to the diagnosis of field cancerization.

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DECLARATION

Conflict of Interest: We declare that we have no conflicts of interest relevant to this article.
Informed Consent: Informed consent was obtained from the participant of the study before publication.

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