MALIGNANCY IN THE TROPHIC ULCER IN CASES OF PROCIDENTIA

by

ROHIT V. BHATT, M.D., D.C.H.

Resident Medical Officer,

Nowrosjee Wadia Maternity Hospital, Parel, Bombay-12.

Introduction

It is uncommon for trophic ulcers in cases of procidentia to undergo a malignant change. Trophic ulcers are not uncommon findings in cases of long standing procidentia. However, only 100-110 cases have been reported in the English literature where a malignant change has occurred either in the cervix or in the trophic ulcer. There are very few case reports from India. Vartan could not find any reference to such a condition in British Journal of Obstetrics and Gynaecology till 1955. Delvaux (1931) wrote to 14 gynaecologists in England and 9 of them replied they had not seen cases of malignant change in procidentia. Guthrie (1932) wrote to 48 American gynaecologists and 28 out of them replied they had not seen such a case. Smith, Graves et al (1929) studied 683 cases of procidentia in Free Hospital for Women at Massachusetts between 1875 and 1928 and they found only one case of malignancy in a case of procidentia. Smith et al further observed that it was the only case in that clinic seen by any of the staff members in their entire experience. Stones et al (1955) after 25 years reported 10 case of malignancy in procidentia cases from the same hospital.

Growing facilities for histopathological studies in most of the hospitals and recent advances in vaginal cytology for early diagnosis of cancer are responsible for detecting more cases of malignant change in procidentia cases. As against greater facilities for cancer diagnosis, recent advances in anaethesia, blood transfusion and antibiotics have made surgeons bold and so age is no bar for surgical interference. Cases of procidentia are not likely to remain for a long time without surgery and so the surgery is likely to be done before trophic ulcers have time to undergo a malignant change.

We believe that we are likely to detect more cases of malignant change in procidentia if all long standing cases of procidentia are subjected to histopathological examination. It is very necessary to make a diagnosis of malignant change in procidentia because the management will differ in cases of only procidentia and in cases of procidentia with a malignant change. We venture to report two cases of trophic ulcers in procidentia undergoing malignancy. Growing awareness of this entity in

clinical practice is responsible for the change in the old teaching that trophic ulcers usually do not undergo a malignant change.

Case I. A Christian female, aged 50 years, was admitted in the gynaecological ward of the K.E.M. Hospital, Bombay, on 8-10-1956 with the chief complaint of something coming down per vaginam for 10 years and foul smelling vaginal discharge for 2 years. She was a fifth para and she had all normal hospital deliveries. Her last delivery was 22 years ago, menopause for 5 years. She had not used pessaries any time. On examination she had procidentia. She had four trophic ulcers, two on the anterior vaginal wall and two on the antero-lateral vaginal wall. The edges of the ulcers were everted with indurated base. The ulcers used to bleed on touch. The length of the uterine canal was 2½ inches. The procidentia could be reduced. Vaginal examination showed normal sized, anteverted uterus with clear fornices. Her haemoglobin was only 42%. Her blood pressure was 110/70 mm. Hg. Urine examination showed a few pus cells. Cystoscopy revealed nothing abnormal. Biopsy from the ulcer showed changes of epidermoid carcinoma. Patient was treated for anaemia and her general condition improved. Two months after admission she was taken up for operation. Mayo-Ward hysterectomy with excision of vagina with trophic ulcer was done under spinal anaesthesia. The ulcers were found to be superficial and the bladder was not involved. Operative field was a little more vascular. Patient had uneventful post-operative period. She had no wound infection or gaping of the wound. She was discharged 3 weeks after operation. She was given a full course of deep x-rays. She developed a recurrence at the local site after 6 months and had foul discharge and backache. She did not attend the hospital for this recurrence and died two years after the operation.

Case 2. A Christian female, aged 60 years, was admitted in the gynaecological ward of the K.E.M. Hospital on 12-10-1959 for procidentia of 5-6 years' duration. The procidentia could not be reduced. She was menopausal for last 10 years. She had two normal deliveries, the last delivery was 25 years ago. She had not used pessary any time. On examination she had an irreducible procidentia with multiple trophic ulcers. The ulcer on the anterior vaginal wall was about 2 inches in diameter and was very friable with everted edges and indurated base. The length of uterine canal was 2 inches. She also had a complete rectal prolapse. Her haemoglobin was 7 gm. per cent. Urine showed plenty of red blood cells and pus cells. Her urea

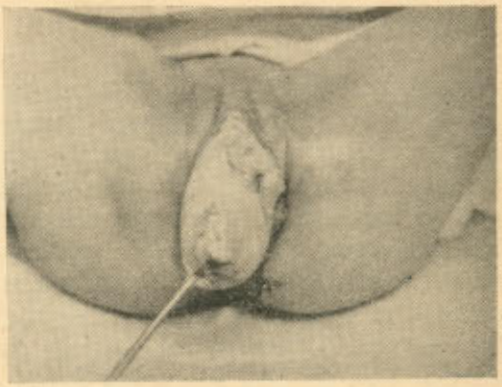

Fig. 1
Procidentia of 10 years standing. The ulcer is seen on the antero-lateral vaginal wall on the left side.

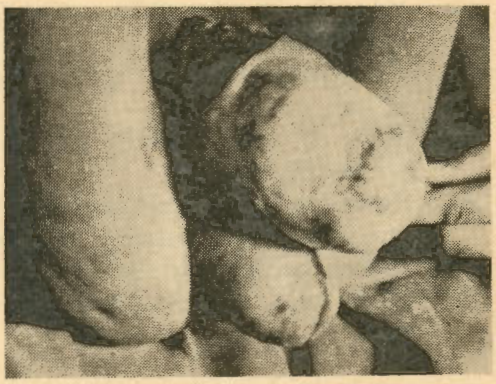

Fig. 2
Procidentia of 6 years duration. The ulcer is seen on the right lateral vaginal wall. There is also complete prolapse of the rectum.

nitrogen was 10.5 mg. %. On intravenous pyelography she had hydronephrosis both sides and no evidence of urinary radio-opaque calculus. Cystoscopy revealed involvement of bladder mucosa with malignant growth. Biopsy from the trophic ulcer showed changes of epidermoid carcinoma. Perineal anterior exenteration, as described by Stanley Way (1958), was contemplated for palliation. In the meantime she developed high fever, neck rigidity and expired within 3 weeks after admission.

Discussion

Rocker (1958) found that majority of the cases of malignant change in procidentia were between 60 and 80 years of age and the procidentia was at least of 10 years' duration in 60% of cases. Fobe (1955) reviewed the world literature on malignant change in procidentia and explained the rarity of malignant change in procidentia on the following basis.

1. Drainage of secretions is more free in procidentia.
2. Atrophy of vaginal and cervical epithelium.
3. Vascular change with constant hyperaemia.
4. Keratinization of prolapsed organ.
5. Age of the patient usually above 60 years.
6. Some patients may have been operated for cancer cervix before prolapse develops.
7. Unknown constitutional factor.

To the above list I may add that the patient may have been operated for procidentia before the trophic ulcers have time to develop malignant change. Following points may be cited in favour of malignant change in a procidentia.

(1) Constant friction of the procidentia with the thighs and clothes acts as a constant irritant stimulating the tissues to undergo a malignant change.

(2) The use of pessary without proper care such as regular douches and frequent removal of the pessary to inspect the vaginal walls.

(3) Decubitus ulcers; once they develop, infection is likely to take place if they are exposed to the outside surrounding. Thus constant friction, chronic infection or irritation from pessary may act as a trigger in stimulating the tissues to undergo a malignant change.

Summary

(1) Two cases of malignant change in a procidentia are reported.

(2) Routine biopsy of trophic ulcers of long standing procidentia is suggested.

(3) Relevant literature on the subject is reviewed.

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