

ELEPHANTIASIS OF VULVA WITH PREGNANCY

(A Case Report)

by

PUSHPA GUPTA,* M.B., B.S., D.G.O., M.S.

and

PUSHP LATA GUPTA,** M.B., B.S., M.S.

Elephantiasis of vulva is much less common than elephantiasis of the scrotum. It includes varieties of cases with different etiology such as venereal diseases, tuberculosis, filariasis and some times no definite cause is known. Sheaffer (1956), quoted an incidence of 2% of tuberculosis of vulva.

An interesting case of elephantiasis of the vulva forming huge masses, associated with pregnancy, is reported.

Case Report

Mrs. D. P. aged 30 years, Hindu female belonging to lower class was admitted in J.L.N. Zenana Hospital, Ajmer, on 15-3-72 with complaints of amenorrhoea 6 months, marked enlargement of vulva and difficulty in walking for 3 months. The patient was primigravida. She noticed small bilateral swellings of the vulva 4 years back which gradually increased in size but for the last 2 months when she was about 4 months pregnant the swellings grew rapidly resulting into huge enlargement of the vulva. These swellings ulcerated at places and were painful. She had no difficulty in micturation and defaecation, but had difficulty in walking.

Menstrual History: Menarche at the age of 14 years, cycles 3-4/30 days, flow moderate, painless. Last menstrual period was 6 months back.

*Professor of Obstetric & Gynaecology, J.L.N. Medical College, Ajmer.

**Lecturer in Obstetric & Gynaecology, J.L.N. Medical College, Ajmer.

Received for publication on 2-5-1973.

Past History: The patient gave a history of masses on either side of the neck and inguinal region in childhood. The masses gradually enlarged and discharged pus and healed without any treatment. Patient does not remember to have suffered from prolonged fever at that time.

Condition on Admission: An average built, fairly nourished woman. No anaemia, jaundice or oedema. Cardiovascular and respiratory systems were normal. Multiple healed scars were present on both sides of the neck and groin, no sinuses or discharge of pus. B.P. 110/80 m.m. of Hg., pulse rate 80 per minute, temperature 37°C., respiratory rate 20 per minute and regular.

Per Abdomen: Uterus enlarged to 26 weeks size, vertex, floating, foetal heart sounds were good.

Vulva: Huge swelling of vulva, involving both labia minora and majora and mons veneris vagina was also involved. Perineum was markedly thickened & ulcerated. Right labium was enlarged to the size of 6" x 7" x 7". Left labium was enlarged to the size of 7" x 6" x 6". Masses were irregularly ovoid in shape and sessile. The skin over the masses was thickened and looked like elephant skin with areas of ulceration. There was offensive discharge. Biopsy of vulva was taken on 16-3-72. Patient absconded after 3 days.

Patient was readmitted in the hospital on 16-6-72 with history of amenorrhoea 9 months with mild labour pains for the last 3 days. On examination the uterus was enlarged to 40 weeks size, vertex presentation, head floating, foetal heart sounds were 140 per minute, good in volume. Uterus was not contracting. The vulva was markedly enlarged, involving

both labia minora and majora and mons veneris with marked thickening and ulceration of perineum. Both labia were enlarged to the size of 8" x 7" x 7" with areas of ulceration and offensive discharge (Fig. 1).

Pelvic Examination: Vaginal introitus was tight, os was closed, and vertex was high up. Proper assessment of pelvis was not allowed by the patient.

Investigations: Blood Hb-11.2 gm/100 ml, total R.B.C. Count 2.75 million/cumm, total W.B.C. 7800/cumm, poly 76%, lympho 20%, eosino 3% E.S.R.—52 mm 1st hour (wintrobe).

Blood—K. T. negative. Blood for Microfilaria—negative, X-ray chest-normal, Montoux test—negative.

Biopsy of skin: Skin tissue shows non-specific chronic inflammatory changes with slight increase in collagen tissue. No specific pathology seen.

Diagnosis: Elephantiasis of the vulva with pregnancy.

Management: The parts were cleaned with dettol solution, and gention violet solution applied locally. Injection procaine penicilline was started.

Abdominal delivery was decided because patient was primigravida in labour with floating head and inability to assess pelvis due to huge growth of vulva involving the perineum. Lower segment caesarean section was done under general anaesthesia on 25-6-72. A live female baby with two loops of cord around the neck was delivered weighing 6 lbs 7 ozs. The postoperative period was uneventful. Abdominal wound healed by primary intention.

After 8 weeks, a simple vulvectomy was performed. The swellings were very vascular and a considerable amount of blood was lost during the operation. The raw edges of the skin and vaginal mucosa were approximated with chromic catgut No. 1. A self retaining catheter was kept for 10 days. The postoperative period was uneventful. The wound in the upper part as well as in lower part healed by first intention. The patient was discharged fully cured 4 weeks after operation.

Histopathological Report of Speciman: Squamous epithelium keratanized sub-epithelial hypertrophy of collagenous tissue with marked stromal oedema and focal mononuclear inflammatory cell collection

suggestive of elephantiasis of vulva. No evidence of tuberculosis was found. (Fig. 2)

Discussion

This condition has been rightly termed by Taussig (1933), as chronic hypertrophic vulvitis. These cases have lymphangitis and chronic lymph stasis leading to oedema and hypertrophy of the connective tissue consisting mainly of fibrous tissue with myxomatous degeneration. Superficial ulcerations exist in some areas. The subcuticular tissue is infiltrated some times with round cells, plasma cells and giant cells.

Shaefer (1956) quoted an incidence of 10 to 16% of tuberculosis of cervix, vagina and vulva. In the present case though there is suggestive history of tuberculosis in childhood but Mantoux test is negative. It is possible that involvement of glands in childhood and growth of vulva are two separate entities.

In some cases elephantiasis of vulva is due to filariasis but microfilariae are very rarely found in the blood. Blood film for Microfilaria was negative in this case also. The condition has to be differentiated from other elephantoid conditions of the vulva i.e. lymphogranuloma inguinale, granuloma inguinale, granuloma venerum, syphilis, cancer and sarcoma. Taussig (1933) found syphilis in 80-90 per cent of cases of elephantiasis of the vulva. Other reports do not show so high a percentage of syphilis. In the present case serological tests were negative for syphilis.

Clinically the condition may form small warty growths or huge masses as in the present case or just brownish induration with thickening of the skin. Ulceration is present usually over the affected skin which can spread to the vulva and may extend to the groin and upper part of thighs and buttocks also.

Usually in many cases no definite cause is known (Calise, 1957; D'Elia, 1955; Jeaning, 1954; Mackenzie, 1948 and Te Linde, 1962). It is much more common among the coloured races with unclean habits. The present case was also of unclean habit and no definite cause was detected.

Pregnancy with elephantiasis of vulva is rare because of formation huge masses. The method of delivery in these cases not only depends on the position, presentation of the foetus and condition of pelvis but also on area of involvement of vaginal introitus and perineum. Chowdhary (1964) reported a successful vaginal delivery in a case because there was no involvement of vaginal introitus but in the present case caesarean section was done because of the marked involvement of vaginal introitus and perineum along with floating head.

Vulvectomy or local excision of the growth is usually the line of treatment. The surgical removal is also necessary for cosmetic reasons and for successful coitus. If some associated cause is found then specific treatment is given even after the excision of the growth. In the present case vulvectomy was done after 8 weeks of delivery with good results.

Summary

A case of elephantiasis of vulva with pregnancy is described and the subject has been discussed.

Acknowledgements

The authors are thankful to the Principal and Controller, J.L.N. Medical and Associated Group of Hospitals to use the records of the hospital and permission to report the case.

References

1. Calise, M.: Arch. Obst. & Gynec. 62: 15, 1957.
2. Chowdhury, S. K.: J. Obst. & Gynec. India, 14: 618, 1964.
3. D'Elia, O.: Riv. Obst. Milano, 37: 42, 1955.
4. Jeanings, A. F.: J. Am. Med. Women's Assoc. 9: 254, 1954.
5. Mackenzie, A.: J. Obst. & Gynec. Brit. Emp. 55: 651, 1948.
6. Schaefer, G.: Tuberculosis in Obst. & Gynec. Boston, 1956, Little Brown & Co.
7. Taussig, F. J.: Quoted by Curtis A. H. Obst. & Gynec. Philadelphia, 1933, Saunders. p. 615.
8. Te Linde, R. W.: Operative gynaecology ed. 3, London, 1962, Pitman Medical Publishing Co. Ltd., p. 744.

See Figs. on Art Paper IX