MALIGNANT LYMPHOMA OF THE VULVA

(A Case Report)

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Introduction

Lymphoma of vulva is quite uncommon. Invasion of vulva by malignant lymphoma is due to metastasis from other organs in most of the cases. But primary malignant lymphoma affecting the vulva though quite rare is not unknown. It includes a group of malignant conditions like lymphosarcoma, reticulum cell sarcoma, plasmacytoma and Hodgkin's disease.

Case Report

Mrs. S. D., 60 years old woman presented with the complaints of lump over the vulva for 6 months, whitish vaginal discharge and pruritus vulvae for the last 8 to 10 months. Her previous menstrual cycles had been regular and she had attained menopause 4 years back. She had 6 normal deliveries at home and age of the last child was 20 years. She belonged to low socio-economic group and was a housewife.

On examination her general health was below par. She was very anaemic, emaciated and extremely malnourised. Skin all over the body was dry and cracked. There was glossitis and angular chealosis. The pulse was 96 per minute, blood pressure was 140/90 mm of mercury. Respiratory and cardio-vascular systems were normal. The liver and spleen were not enlarged and there was no generalized lymphadenopathy. The inguinal lymph glands of both sides were enlarged, more so of the left side. One of the left inguinal lymph glands was very much enlarged, size being 2.5 cms x 3 cms, fungating in appearance, with foul smelling purulant discharge. It was fixed to the deeper structures.

Pelvic examination revealed a big cauliflower like fungating growth involving the mons veneris, labia majora and labia minora of left side. The growth was localized to left side only and the clitoris was spared. It measured 8 cms x 5 cms and the base was covered with slough and friable tissue. The margins were hard to feel. Vagina was smooth, uterus and cervix felt healthy though quite atrophic as after menopause. The adnexae were normal.

It was diagnosed clinically as carcinoma of vulva and a piece of tissue from the main vulval mass was sent for histological confirmation. The biopsy report was—malignant lymphoma of lymphoblastic and diffuse type. The microsection revealed the tumour cells of lymphoproliferative type, the cells involved were lymphoblasts. At places the cells appeared more mature. There were capsular invasions, plenty of mitotic figures and increased vascularity. The spread was of diffused type (vide figure).

Total W.B.C. was 12,000/cumm of blood poly 86%, lympho 8%, eosino 1% and large monocytes 5%. The haemoglobin was 8.5 gm%. Urinalysis did not show any abnormality except for plenty of pus cells. Urine culture was

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sterile and the post prandial blood sugar was 136 mg%.

Since she refused to get hospitalized at that time she was asked to get the ulcers dressed daily. Besides this terramycin 250 mg 6 hourly, vitamins, protein and haematinics were prescribed. She was advised to return for further treatment as early as possible but she came back after 2 weeks in a much worse condition. The general condition had deteriorated a lot inspite of the treatment. Surprisingly the 2 ulcerative masses had increased tremendously in size, so much so that only a very thin bridge of tissue with intact skin was left between the two. The ulcers were full of maggots and slough. She had pyrexia too. Since her condition was not fit for any surgical interference she was hospitalized and local dressing of the ulcers was done twice daily with terpentine oil. She was given repeated blood transfusions at an interval of 4-5 days, a total of 3 pints were transfused. Apart from this Reverine 500 mg. I.V. was given twice daily for 6 days followed by crystalline penicillin 10 lacs 6 hourly, liver extract injections, anabolic steroids by intramuscular route and Cyclophosphamide (Endoxan) 200 mg. I.V. daily were being instituted.

Unfortunately inspite of the treatment she died on the 19th day of hospitalization. The attendants were not agreeable for postmortem examination, hence other viscera could not be studied to see for any involvement.

Discussion

Gall and Mallory (1942) coined malignant lymphoma for the first time and described it as a progressive disease with eventual fatality. Lymphoma of the vulva represents a group of tumours derived from the lymphocytes or from the reticulum cells. According to Janovski and Douglas (1972) it includes lymphosarcomas (lymphoblastic, lymphocytic or reticulum cell type), Hodgkins disease and extramedullary plasmacytoma. In the present case there was lymphoblastic preponderance. The tumour was localized without any features of systemic dissemination.

As regards treatment de Gruchy (1976) has rightly said that there is no curative treatment for malignant lymphoma. Though our patient could not be saved inspite of all attempts we were tempted to report it for several reasons. It is not a common disease of vulva and is many a times wrongly diagnosed as carcinoma of vulva. Thorough search must be made for systemic involvement because as said by Novak and Woodruff (1974) vulval lymphoma is a local manifestation of a systemic disease. Chemotherapy and excision are the treatment of choice. Our case had chemotherapy only as she was not fit for local excision and before improving her general condition she expired.

Summary

A case of primary malignant lymphoma of vulva has been reported.

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See Fig. on Art Paper X