PRIMARY VAGINAL CARCINOMA

(A Case Report)

by

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Introduction

Primary Carcinoma of Vagina is only 1-2% of all gynaecological malignancies.

CASE REPORT

R.D. 38 Yrs, was admitted on 25-6-79 for profuse watery mucoid vaginal discharge which was occasionally blood stained. It was not foul smelling and there was no history of post coital bleeding as her husband was mostly away.

She was 7th para with 3 living children. Last aged 7 yrs. Her menstrual cycle were normal and her last normal period was one month.

O.E. Average body build; Med. Severe pallor. B.P. 124/80 Chest clear: A.P. NAD. Pelvic examination revealed hard irregular growth about 2 cm in diameter not very friable on posterior vaginal wall at juncture of middle and lower third of posterior vaginal wall. The growth was fairly free, bled on touch and there was no surrounding induration Cervix was parous, healthy uterus was of normal size, firm; fornices nil.

On rectal examination rectal was free:

A provisional diagnosis of primary carcinoma of vagina was made as there was no other site of malignancy in genital tract.

Investigation: Hb—8.6 gm%. Fasting blood sugar, 66 mgm. Blood urea—40 mgm. X'ray Chest—Clear.

G.I. tract investigation were not performed as she had no G.I. symptoms.

Examination under anaesthesia revealed uterus, cervix and adnexa normal. Rectal wall was free. Tissue from growth and curettage were sent for histopathological study. The histopathological report came as squamous cell carcinoma of vagina and secretory endometrium. The patient was transfused with 3 units of blood transfusion and was put up for hystero vaginectomy. Preliminary dissection of 1½" of lower vagina was done by making circular incision around the introitus the lower end of vagina was closed by putting interrupted sutures. Ribbon gauze was packed all around the vagina. The patient was then positioned for laparotomy. Abdomen was opened. Uterus was normal in size with normal adnexa; liver, kidneys and stomach were all normal. Bladder and rectum were separated right up to the pelvic floor. Total abdominal hysterectomy with bilateral salpingo-oophorectomy and vaginecomy were performed. Uterus vagina was delivered through the introitus. Stumps were peritonised and abdomen was closed. Again, the patient was put in lithotomy position, bleeding points ligated, raw area was packed with ribbon gauze. Indwelling catheter was put for 8 days. Post-operative period was uneventful and stitches were removed on 7th day. Vaginal examination on 10th day revealed complete obliteration of vagina and the patient had twenty five exposures of Cobalt from 15th post operative day for irradiation of pelvic glands. The patient in follow-up after 6 months was healthy. Rectal examination showed pelvis free. She was again admitted for Mcindoe's operation and reconstruction of vagina was done by vaginal mould and skin graft.

Discussion

The mean age for vaginal carcinoma is 60 years but this patient was only 38 years. Vaginal discharge and bleeding are the main presenting features. 20% of Posterior vaginal wall carcinoma are

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missed because of speculum obscuring the lesions.

85-90% of the vaginal carcinoma are squamous cell carcinoma. Speculum visualisation and direct biopsy and vaginal cytology are frequently positive. The diagnosis of primary carcinoma lesion must be localised in the vagina and no other tumour of similar type should be in genital tract. Our patient was a case of cancer vagina Stage I. The node involvement has not been studied in vaginal carcinoma, but it is felt that Stage I 2-3 cm diameter and smaller growths have less incidence of lymph node metastatis. As the vagina is thin walled and is in close proximity of bladder and rectum, involvement of these structures are early. A primary surgical approach of radical hysterectomy with vaginectomy and pelvic lymphodenectomy results in a 30-40% year cure rate. Lymph node dissection was not done in this case as the growth was at the junction of lower and middle third and it would have involved removal of pelvic glands including the femoral and inguinal glands. She had Cobalt 60 irradiation for irradiation of lymph node: Radiation is preferred in Carcinoma vagina and results are much better, about 83% in Stage I. But as there were no special appliances and complications like vaginal fibrosis, radiation cystitis. Rectal stricture and RVF are more commonly encountered after irradiation therapy. Surgery was preferred in our case.