AN UNUSUAL CASE OF GENITAL MALIGNANCY

(A Case Report with Discussion)

by

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Introduction

Genital malignancies usually encountered follow a definite symptomatology and pose little problem regarding their diagnosis and subsequent management. But in rare occasions, neoplasms at unusual sites make the exact diagnosis difficult even after laparotomy and histopathological examination. These rare events prompted us to report the following case.

Case Report

Mrs. S. K., 28 years P3 + 3 Hindu Female came for dull aching pain in lower abdomen for 2 years, frequency of micturition and dyspareunia for 6 months and watery vaginal discharge for 15 days before admission; the pain in the abdomen had no relation with the menstrual period and she had no bowel disturbances.

Obstetric history

Three normal vaginal deliveries at term and 3 induced abortions—on last occasion hysterotomy with ligation of tubes were done.

Menstrual history

Cycle—29 days regular, Duration—2-3 days.
Flow—average, Dysmenorrhoea—nil.

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Past Medical, Family and Personal History

Nothing significant.

On Examination

Patient was obese with average height with no apparent abnormalities in other systems of body.

On abdominal examination nothing significant.

On speculum examination, cervix appeared normal. A bulging was seen at the upper posterior vaginal wall.

On bimanual vaginal examination, a mass about 12 weeks size, hard in consistency, impacted in Pouch of Douglas, appearing to be separate from uterus, not tender on palpation was felt. Uterus appeared bulky, R/V wittth no mobility. Cervix—high pushed near the symphysis pubis. Other fornices—no mass felt.

On Rectal Examination, Rectal mucous membrane free from the mass.

Sigmoidoscopy—Sigmoidoscope was easily introduced. Rectal mucosa free.

Investigations

Besides routine investigations chest X-ray, straight X-Ray of pelvis, I.V.P. Ba meal, follow through and enema were done all were within normal limits.

Operative findings

On laparotomy, left ovary was found to be enlarged and cystic (about 4 cm x 4 cm). A small T.O. mass was present on right side also. Uterus was fixed and retroverted. A firm lump

was seen in between the rectum and posterior vaginal wall grossly adherent to both of them and utero-sacral ligaments. Recto-vaginal space was opened by dissection. Hysterectomy with removal of adnexae was necessray and most of the mass was removed. During this procedure cheesy material came out from the mass. Vaginal vault was closed and peritonisation done keeping a drain in the space.

The drain was removed after 48 hours. Post operative period was uneventful.

Histopathological Examination Reports

Endometrium—in late secretory phase.

Ovary—haemorrhagic corpus luteum.

Mass—Adenocarcinoma patient was referred to the Radium Board where Inj. Thio-tepa 60 mg 1/v bi weekly x 10 was advised. It was given with close haematologic check up.

Discussion

From the salient features of the above case it is obvious that histopathological report of adenocarcinoma in the undiagnosed lump raised several queries as primary site could not be detected inspite of through search. So we can discuss a few probables regarding the mode of origin correlating the clinical features with histopathological report.

First of all we can think of the possibility of malignancy arising in the endometriosis of the recto-vaginal septum involving the uterosacral ligaments.

Secondly, the histological picture has some similarity with the mesonephric tumours arising from the mesonephric remnants. These tumours may arise at any point in the pelvis at which the primitive mesonephric duct was once present, from the lower vagina upto the parovanian region.

See Fig. on Art Paper VI