CARCINOMA OF THE VULVA IN PREGNANCY

(A Case Report)

by

PUSHPA ROY

and

PROF. A. SINHA

Introduction

Carcinoma of the vulva associated with pregnancy is a rare disease, because of the disparity between the peaks of the age distribution curves for these conditions. A search of literature by Rahman and Rahman (1982), with the inclusion of his own case has shown a total of 12 cases of carcinoma valva with pregnancy till 1982. This case of vulval carcinoma during pregnancy is being reported because this patient has lived for 9 years in a fit physical condition and could conceive during this period and delivered at term vaginaly after deep episiotomy 4 years after radical vulvectomy.

CASE REPORT:

S.D., 23 years, gr. 3, para 2 came for 8 months post partum amenorrhea and a gradually increasing ulcer over right labia majora with pain for 4 months. She had previous 2 full term normal deliveries, the last one eight months back. On examination, she had 16 weeks pregnancy. Examination of the vulval area revealed a big (2″ x 1″), tender cauliflower growth arising from middle of the right labia majora (Fig. I). Histopathology of a biopsy revealed squamous cell carcinoma of vulva (Fig. II). The right inguinal lymph nodes were palpable. The patient was admitted in the hospital on 26-10-74 for radical vulvectomy. Results of the laboratory studies were within normal limits. A radical vulvectomy with resection of bilateral superficial and deep inguinal lymph nodes and external iliac lymphonodes were performed on 31-10-84. The bilateral resection of the above mentioned nodes were followed by radical vulvectomy. The nodes were sent for histopathology which showed no evidence of metastasis. No unusual complication except some wound infection with fever was encountered in the post operative period. Appropriate antibiotic after pus culture and sensitivity was instituted for the wound infection. The pregnancy was continuing normal 'and the patient was discharged to go home after forty days of hospital stay when the wound had healed satisfactorily.

Again the patient was admitted at 36 weeks of pregnancy when she had labour pain. The progress of labour was watched carefully and an alive male child was delivered by applying low forceps with deep episiotomy (Suchardt's type incision). The wound was repaired and patient was discharged after two days.

The patient was under regular follow up thereafter. There was no local recurrence and metastasis when after four years of operation, the patient conceived again and delivered vaginally a normal healthy baby at term. Bilateral tubectomy was done in the post partum period and this opportunity was utilized for inspecting the abdominal visceras and lymph nodes which were found to be normal. Even now the patient is in regular contact with us without having any complaint relating to the previous disease and operation.

From: Department of Obstetrics and Gynaecology, Nalanda Medical College, Patna.

Accepted for publication on 17-2-83.

Discussion

During the past twenty years radical vulvectomy and bilateral inguinal lymph adenectomy with or without pelvic lymph node dissection accomplished as an en-bloc one stage procedure, has been the "standard" therapeutic approach for vulval carcinoma.

Management of a malignant lesion of vulva during pregnancy should be planned according to duration of gestation. In the first and second trimester of pregnancy the treatment would be radical vulvectomy with bilateral inguinal lymphadenectomy. If any of these glands are found to be metastatically involved then a more extensive pelvic lymph node dissection depends upon the size of the uterus at that time. If the size of uterus is too large, the extensive transperitoneal pelvic lymph node dissection should be done after the delivery. In the third trimester upto 36th week of pregnancy only extended vulvectomy should be performed. Groin lymphadenectomy and pelvic lymphadenectomy if required should be done at a later date after the pregnancy is over. This plan of the teratment has been agreed by Collin's and Barclay, 1963; Kempers and Symmond, 1965; Gammel and Haires, 1960; and many others.

Our cast presented at sixteen weeks of pregnancy, the size of the uterus did not pose any difficulty during extra peritoneal inguinal and external iliac lymph node resection. As the glands were not metastatically involved so there was no need to perform a detailed pelvic lymphadenectomy after the pregnancy was over.

Regarding the mode of delivery the vulval scarring posses no problem in vaginal delivery as happened in our case and those reported by others too (Collins and Barclay 1963; Kempers and Symmonds 1965; Rahman and Rahman).

Extensive statistical analysis has shown that patients having lesion less than 4 cms and negative inguinal lymph nodes have favourable long term out comes (Podratz, *et al* 1982). The long term survival in the present case is perhaps due to the small size of the lesion (less than 4 cms) and negative inguinal nodes and pregnancy appears to have no deliterious effect on the coarse of disease. Lastly, does preggnancy provides some immunological protection which is responsible for the long survival of these patients of carcinoma vulva with pregnancy, remains a matter of conjecture.

References

1. Collins, C. G. and Barclay, D. L.: Clin. Obstet. Gynec. **6**: 927, 1963.
2. Gammel, A. A. and Haines, M.: Pregnancy following radical vulvectomy for Carcinoma of vulva. J. Obstet. Gynec. Brit. C'wealth. W. 67, 199, 1980.
3. Kempers, R. D. and Symmonds, R. E.: Obstet. Gynec. **26**: 749, 1965.
4. Podratz, C. C., Symmonds, R. E. and Taylor, W. F.: Am. J. Obstet. Gynec. **143**: 340, 1982.
5. Rahman, M. S. and Rahman, J.: Brit. J. Obstet. Gynec. **89**: 244, 1982.

See Figs. on Art Paper II