Primary Bartholin Gland Adenocarcinoma - A Case Report

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Mrs. S, 55 years old, P5L5, 13 years postmenopausal thin built lady was admitted to the gynecology ward of our hospital wih history of a nodular lesion in the vulvur region associated with pain and pruritis for the past two months. There was occasional irregular bleeding from the lesion. The general physical and systemic examinations were normal. Inguinal lymph nodes were bilaterally enlarged, hard and non-tender. Left side node was 4 cm and fixed to the bone and the right side node 1cm. and mobile. Local examination of the vulva revealed a 5 cm. cauliflower like, hard nodular, friable growth from the inner postero-lateral region of the left labium major. The overlying skin was ulcerated and bled on touch. The growth was invading the lower third of the posterior vaginal wall but was not fixed to the bone. The urethera, clitoris, perineum and anal regions were normal. On per speculum examination, the cervix and upper vagina were healthy. On bimanual pelvic examination the uterus was found to be small and mobile. The fornices were free. The rectal mucosa was also free. The investigations including hemoglobin, urine examination, kidney and liver functions, serum electrolytes, chest X-ray and ECG were within normal limits. Vulval biopsy showed moderately differentiated squamous cell carcinoma and FNAC of the inguinal nodes from both sides showed metastatic adenocarcinoma. Pap smear was suggestive of human papilloma viral changes and foreign body giant cell reaction.

In view of the fixed inguinal nodes a decision for simple vulvectomy was taken. Simple vulvectomy with adequate tumor resection including the lower third of the vagina on the left side and vulvar reconstruction were undertaken under general anesthesia. (Fig. 2)

The histopathology examination showed an adenocarcinoma with focal areas of squamous differentiation. The tumor showed a comedo pattern with necrosis in several foci and a few areas of glandular differentiation. In view

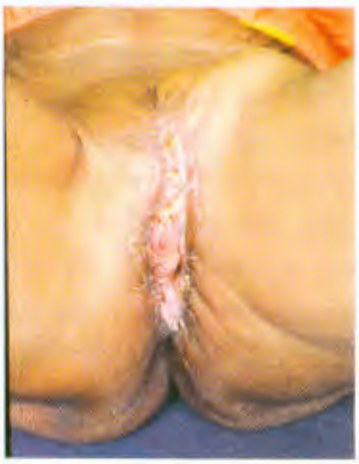

Fig 1. Post-operative photograph (simple vulvectomy) showing bilateral inguinal lymphadenopathy

Fig.2. Photograph of Simple vulvectomy specimen.

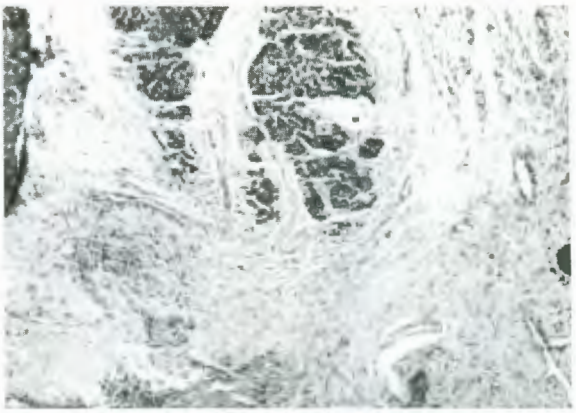

Fig 3. Section from the vulvar tumor showing sheets of tumor cells infiltratingg into the fibromuscular tissue.

of the classical location at the site of the Bartholin gland and a solid deeply infiltrative tumor with a morphology consistent with neoplasm of a Bartholin gland tumour, a diagnosis of Bartholin gland carcinoma was made. (Fig.3). The diagnosis was confirmed on electron microscopy, which showed dark and light secretory granules of large, intermediate and small size respectively. The areas of both adeno and squamous differentiation in the tumor explained the diagnosis of squamous cell carcinoma revealed on biopsy and an adenocarcinoma on fine needle aspiration of the inguinal nodes. The patient had an uneventful postoperative period. (Fig 1) She was referred to a radiotherapy center for adjuvant radiotherapy.

The case is being reported for its rarity and difficulty in the clinical diagnosis. Primarry Bartholin gland carcinoma accounts for only 1 to 5% of vulvar malignancy. About 280 cases have been reported. Since this condition is rare, the recommendation for the management was based on reviews of literature. Several criteria have been described for diagnosing primary Bartholin gland adenocarcinoma like Honan's criteria. The surgical resection should aim less at standard radical vulvectomy and more at adequate resection of tumor. Unless tumor is locally advanced an ipsilateral inguinal lymphadenectomy is reasonable. If nodes are positve, lymphadenectomy or radiotherapy to the opposite groin is warranted. The overall survival is lower than in carcinoma vulva in general.