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Images in Medicine

Obstetrics and Gynaecology Section

A Rare Clinical Presentation of Left Vulval Verrucous Cancer (Figo Stage 3): Image in Medicine

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A 40-year-old perimenopausal female P1L1 with exophytic growth over the vulval region was admitted to the hospital with a history of discharge from the vagina. The patient was apparently healthy six months ago. After which, she started experiencing exophytic growth progressive in nature, with foul-smelling discharge. She complained of decreased appetite and weight loss. Also, she had complained of urinary retention for the last six months.

After physical examination, cauliflower structure growth was noted. High-Resolution Computed Tomography (HRCT) was done, and atelectasis changes were noted in the posterior basal segment of the left lower lobe. Fibrotic changes were noted in the bilateral apical segments. Subcentimetric to centimetric lymph node of size 1.6×0.9 cm was noted in the precarinal region. Visual sections of the abdomen showed renal staghorn calculus on the right-side. Other findings were normal.

Contrast-Enhanced Computed Tomography (CECT) abdomen and pelvis was conducted. There was evidence of irregular heterogeneously enhancing soft-tissue density lesions. There were necrotic areas and air density foci within and the lesions appeared highly vascular. There was a possible liver haemangioma of size 20×18 mm in the segment VI of the liver.

Both the kidneys were normal in shape and axis. Cortical phase, in the nephrographic phase, calculus in the right renal pelvis and lower dilatation of the pelvic-calyceal system were noted on the right-side. The right kidney was small measuring 6.6×3 cm, while the left kidney measured 8.8×3 cm. The visualised skeleton showed degenerative changes. On overall investigations, right staghorn calculus and gross hydronephrosis with severe anaemia (Hb%=5.9%) with left vulval verrucous cancer (Figo stage 3) was detected [Table/Fig-1].

The preferred modalities for the initial assessment of perineal lesions were transtibial and transperineal ultrasound. To ascertain the stage and etiology of the lesions, a histological vulvar biopsy was typically conducted. Malignancies of the vulva and vagina typically presented as big, solid masses that filled the vaginal and perineal areas, whereas verrucous cancer was evident. HRCT and CECT reports showed the above mentioned findings. The line of treatment included management of raised White Blood Cells (WBC), raised Thyroid Stimulating Hormone (TSH), and low potassium. The patient was advised inj. Albumin 100 mL i.v. 20 mL/h for three days, inj. KCL 60 mEq in one Ringer's Lactate (RL) over four hours followed by serum electrolyte. Inj. Piptaz 4.5 gm i.v. TDS was also administered. Blood and urine culture were performed and Two-dimensional Echocardiography (2D ECHO) was conducted. Inj. Lasix 20-20-0 was administered. The urologist was called for further management of renal calculi. The patient was fit to undergo surgery. Follow-up for renal calculi was made in oncology OPD, with the advice of adequate rest, plenty of oral fluids, high iron and fiber-rich diet, and perineal hygiene.

[Table/Fig-1]: Left verrucous cancer (Figo stage 3).

Verrucous carcinoma is a highly rare form of squamous cell carcinoma. There is a less than 1% prevalence rate of verrucous vulvar cancer among women [1]. There is uncertainty on the causes of verrucous cancer and the connection between human papillomavirus infection and verrucous cancer. Although human papillomaviruses testing is usually negative, the role of human papillomaviruses is uncertain because vulvar acanthosis with altered differentiation has been thought to be a precursor of verrucous cancer [2,3].

It shows slow-growing features and usually presents as a locally aggressive malignant tumour with rare regional or distant metastasis. Although the majority of cases were reported in postmenopausal females, young childbearing individuals were also mentioned in this literature [3].

In a similar case previously reported, verrucous carcinoma was treated by vulvectomy without lymph node dissection [4]. Campaner AB et al., mentioned that verrucous carcinoma of the vulva was surgically managed by radical vulvectomy and used the V-Y advancement flap technique. Because of the patient's advanced age, only the palpable lymph node in the left inguinal region was excised [2].

The study conducted by Dryden SM et al., discussed verrucous vulvar carcinoma as an uncommon squamous cell carcinoma, mostly present in older women. Regional lymph node surgery was

reported to markedly improve overall survival in verrucous cancer patients [5].

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