Case Report

A case report on vulval fibroma

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Abstract

A leiomyoma is a benign smooth muscle tumor that can develop anywhere in the body. This is a case report of 40 years old multiparous woman who came to the OPD with complain of a mass coming per vaginum, slowing increasing in size causing her discomfort in walking and sitting. Clinical examination and investigation suggested it as a vulval tumour. It was surgically excised and its histopathology report revealed it to be a benign fibroma
Key Words: Vulva, Leiomyoma, extrauterine, malignancy, benign tumours, mass per vaginum.

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INTRODUCTION

Tumors of the vulva are rare. Apart from malignant tumors, fibromas are the most common benign tumour of vulva though these occur very rarely. Benign growths may be composed of any of the tissues which make up the vulva. Smooth muscle tumors of the vulva are rare and are usually misdiagnosed clinically as Bartholin cysts. These tumors are considered to originate from smooth muscle within erectile tissue, labia majora, blood vessel walls, the round ligament, the dartos muscle, or the erector pili muscle[1]

CASE REPORT

A 40 years old multiparous woman para 6 presented with swelling in the left sided vulva since 3-4 years and the swelling was painless causing discomfort in sitting and walking. There was no history of any vaginal discharge, no history of difficulty in micturition, no history of fever. Her menstrual cycles were regular and bowel habits were also normal. On examination her general condition was fair and vitals were stable. She was afebrile and there was no inguinal lymphadenopathy. On local examination clitoris appeared normal, urethral meatus was deviated to right side. The patient was catheterized with no difficulty, The labia majora labial minora of both sides could be easily aparted. A mass /swelling of approximately 8cmX5cm x5cm was seen on left sided with keratinization on anterior surface, firm in consistency, fixed, non reducible, painless upper limit of the mass to be high up (figure 1) Per Speculum and per vaginal examination were in normal.

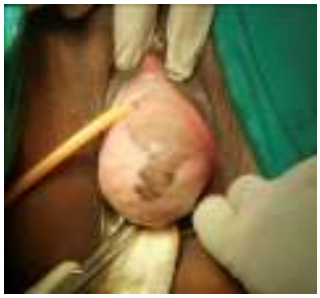

Figure 1: A mass of approximately 8cmX5cm x5 cmwas seen on left sided with keratinization on anterior surface, firm in consistency, fixed, non reducible, painless upper limit of the mass to be high up

Routine investigation of the patient were normal, ultrasonography of pelvis revealed uterus normal size anteverted with normal endometrial lining, both the ovaries were normal. MRI pelvis showed a space occupying lesion in the perineal region measuring 9cmX5cmX3cm in the vagina arising from left labia minora with no bladder and bowel involvement. The patient was planned for surgical excision of the mass through vaginal approach the procedure was performed under spinal anaesthesia the incision was given on the anterior surface of the tumour and enucleation done (figure 2).

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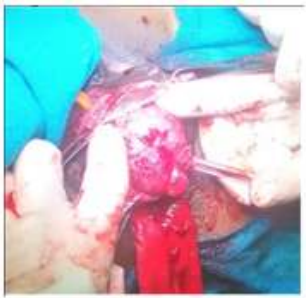

Figure 2

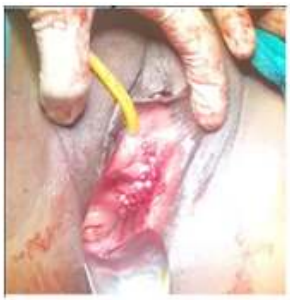

Figure 3

Legend

Figure 2: Intraoperative enucleation of vulval fibroid the free margine of the mucosa were then approximated with interrupted sutures (figure 3); **Figure 3:** Post operative hemostasis

The cut section of the mass had a whorl like appearance and an intraoperative diagnosis of vulval liomyomoma was made. The postoperative stay of the patient was uneventful. Histopathology report of the mass revealed it to be a benign leiomyoma with no evidence of malignancy.

DISCUSSION

Leiomyoma is a benign smooth muscle tumour commonly seen in the uterus, arising from smooth muscle and account for approximately 3.8% of all benign soft tissue tumours[1]. They can develop anywhere in the body where smooth muscle is present, the most common site being the uterine myometrium. Uterine leiomyomas, more commonly referred to as fibroids, are the most common pelvic tumour in women[1]. Vulval fibroma/leiomyoma is a rare tumour that is predominantly found in women of reproductive age group and is rare in children, breastfeeding and pregnant women, and elderly patients. Rarity of these tumors prevents a more detailed understanding of their morphological and epidemiological characteristics. The tumour may arise from either the deep connective tissue of introitus, labia majora, perineal body or round ligament and from stem cells localized in bartholin gland[2,3]. Unusual sites of leiomyoma include ovaries, bladder, urethra, sinonasal cavities, orbits and kidney[3]. Fibromas are usually asymptomatic in the beginning; however they develop symptoms resulting from their size and from their complications like superficial ulceration. Tumour may be asymptomatic but has the potential to grow to huge sizes. They follow unusual growth pattern or may appear at unusual location that may make their identification more challenging.[4] Presence of concurrent uterine leiomyoma or a history of hysterectomy done for the same may be suggestive of the diagnosis. Differential diagnosis includes Bartholin cyst, fibroma, lymphangioma, soft tissue sarcoma and neurogenic tumor. Ultrasound is the most reliable and widely used diagnostic tool for uterine and extra uterine leiomyoma. Magnetic resonance imaging is sparingly used in diagnostically difficult cases because regardless of their anatomic location, classic leiomyoma have signal intensity similar to the images obtained with any MR pulse sequence. Most tumors are solitary and well circumscribed masses. Symptoms include pain and difficulty in walking, discomfort while sitting or difficulty in micturition[5]. Owing to the size and appearance of the tumour, the patient may suffer from stress, anxiety and cosmetic issues.[5] Treatment options include surgical excision and removal of the entire tumour, when symptomatic.[6] Complete enucleation of the myoma along with the capsule is required so as to prevent the chances of recurrence. In cases of large tumors, abdomino-perineal approach is preferred.[6] There is a great challenge to obtain a good cosmetic result particularly in giant tumors Identification of leiomyoma or leiomyosarcoma is necessary because of risk of recurrence, need of radiation and or chemotherapy in addition to surgical excision. Follow-up care with regular check-up is required as the chances of recurrence are not uncommon. After the surgery, a long-term follow-up is advised since some recurrence after 10 years have been reported. Its structure is usually determined only by subsequent microscopic examintion and confirms the diagnosis. It usually present as spindle shaped cells but other histological types such as epitheloid tumors are also reported. Myxoid changes and hyalinization are common over vulval leiomyoma The lesions frequently test positive for estrogen and progesterone receptors that is why they may increase during pregnancy and regress after menopause. Bartholin duct cyst near the orifice is common. Obstruction of the duct can result from gonococcal infection; other infections and trauma more commonly explain the occlusion. During mediolateral episiotomy and postetior colporrhaphy suture can easily injure or even ligate the duct. Asymptomatic bartholin cysts do not need any treatment. Symptomatic cyst requires marsupialisation as treatment of choice. As

chances of malignancy is higher in older patient excision of the cyst needed.

CONCLUSION

When there is vulval swelling which is firm in consistency leiomyoma should be kept as one of the differential diagnosis and biopsy must be done so as not to miss any leiomyosarcoma since it is mostly misinterpreted as bartholin cyst.

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