ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 8, Issue, 11, pp.41319-41320, November, 2016

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

CASE STUDY

RARE CASE OF PREGNANCY AFTER RADICAL VULVECTOMY AND VAGINOPLASTY

***Jayashree Natarajan**

Kidwai Memorial Institute of Oncology, India

ARTICLE INFO

Article History:
Received 10th August, 2016
Received in revised form
22nd September, 2016
Accepted 15th October, 2016
Published online 30th November, 2016

Key words:

Vulval cancer, Vulvectomy,
Vaginoplasty.

ABSTRACT

Cases of vulval cancers are in a increasing trend in young population. This may be attributed to the increasing trend in HPV infections. The vulval surgeries pose risk to conception in these patients. Hence fertility is a matter of concern. Though the surgeries for carcinoma vulva are less radical now, the conception in these patients is still less due to various factors. Here we present a case of radical vulvectomy who had post operative labial adhesion with partial colpocleisis, necesscitating vulvovaginoplasty with urethroplasty, who conceived naturally and delivered after these surgeries.

Citation: Jayashree Natarajan, 2016. "Rare case of pregnancy after radical vulvectomy and vaginoplasty", *International Journal of Current Research*, 8, (11), 41319-41320.

INTRODUCTION

Vulvar cancer is a disease of elderly females, though rare in young few cases of vulvar cancer has been reported in young females in reproductive age group. This tumor incidence has been shown to increase with the incidence of HPV infections. The tumor in vulva is treated primarily by surgery. Surgery has lot of post operative morbidity especially in those who has undergone surgery for groin node dissection. Dyspareunia due to vulval scarring with narrowing of introitus and lymphedema is common. Only few cases of vulval cancer patients operated has conceived after surgery and has been reported in literature.
We are presenting this case of carcinoma vulva with postoperative plastic surgeries for vulval reconstruction, which conceived naturally and delivered.

Case report

24years old lady, married for 4 years with one child presented with complaints of itching in external genitalia for 2years duration and growth over external genitalia of 2months duration in the year 2000. She attained menarche at 14 years and delivered her first child by normal vaginal delivery 2years before reporting for her vulval growth. On examination she had a 4x5cm growth arising from the external genitalia which indents in to the anterior vaginal wall.

****Corresponding author: Jayashree Natarajan,***
Kidwai Memorial Institute of Oncology, India.

Bilateral inguinal nodes were palpable and mobile. Patient was counseled about her condition and nature of treatment. The effect of surgery on future child bearing was explained. Patient underwent radical vulvectomy with Bilateral groin node dissection in March 2000. Her final HPR confirmed squamous cell carcinoma of vulva, both groin nodes were negative. Patient had post operative gaping of groin wounds with discharge. Wound healed with daily dressings. Patient was discharged on 21st post operative day. Patient defaulted for one year and 3 months for follow up. She reported after 15months with complaints of retension of urine .On examination patient had obliteration of vaginal orifice with dense adhesion between labia. Urine was leaking from a pin hole orifice. speculum could not be inserted in to vagina. Though patient had these symptoms for longer duration due to fear of another surgery she did not report to hospital. To relieve retension of urine suprapubic catheterization was done. Patient was counselled about the need for another surgery. She underwent vulvovaginoplasty with urethroplasty in August 2001 in our centre. With meticulous postoperative care, wound healed well. Patient was discharged on 18th post operative day. Patient reported one year after vaginoplasty. Patient offered history of 4months amenorrhoea. Ultrsonography confirmed intrauterine gestation corresponding to period of amenorrhoea. Patient was keen to continue pregnancy. She reported regularly for antenatal visits. With regular antenatal follow up she delivered a live baby at term in 2002 by caesarean section. Again after her second delivery patient defaulted for follow up for 3years. Patient had lymphedema of left lowerlimb, which was managed conservatively.

She is on regular follow up since 2005.She has no recurrence and is leading a healthy and happy family life.

DISCUSSION

Vulval cancer represents about 5% of malignancies of the female genital tract and 0.6% of female cancers. Vulvar cancer occurs mostly in older age group and rare during reproductive age group .The mean age of incidence is. The incidence of VIN is showing a significant increase over decades, this has been attributed to changing sexual behavior, HPV infection and cigarette smoking (1). 15% of vulvar cancer occurs in women aged 50 years or less (2). There are very few cases of pregnancy following surgery for vulvar cancer. Dyspareunia, significant disturbance of body image, less sexual arousal, vaginal and introital stenosis are some of the few reasons for not conceiving after vulvar surgeries. The treatment for vulvar cancer has to be tailored for every patients individualizing based on the extent of disease, age and need to preserve reproductive functions. The management of vulval cancer has improved over decades and the surgery has become less radical now. The radical vulvectomy has the risk of post operative morbidities, wound gaping, wound infection, lymph edema, vulval stenosis etc. These complications prolong the hospital stay with morbidities; prolong the duration in need of medical attention.

Various studies compared radical vulvectomy with less radical procedures and showed that with surgical margin of 1cm the risk of recurrence is low. Hence wide excision of vulvar lesion replaces radical vulvectomy with appropriate patient selection. Still the location of tumor in vulva may cause problem in tension free closure of wound.Plastic surgical procedures are useful in providing good scar allowing the sexual functions. Z-plasty, Rhomboid flap, Transposition flap Vulvovaginoplasty, Labial pedicle flap (Martius flap), Omental pedicle flap, Gracilis, rectus abdominis flaps, Tensor fascia latae flap, Gluteal, perineal, and thigh myocutaneous flaps are few techniques used (2). Cases of pregnancy following surgery for vulval cancer are only few in literatures (3). Few cases of surgery during pregnancy for vulval cancer are reported. These pregnancies did not show any adverse outcome due to previous surgeries. In the reported cases the mode of termination of pregnancy at term or earlier was by caesarean section. The vaginal delivery has the risk of perineal injury and problems in healing of the perineal wound due to previous surgeries. There are no studies reporting congenitalanamolies in pregnancies following vulvar surgeries. The young patients with vulvar cancer unlike the elderly age group have a long lifetime after initial management. Hence the follow up for prolonged period is required.

The risk of recurrence at primary site or a second malignancy should be kept in mind. In patients with HPV related vulvalcancers the risk of recurrence in cervix or vagina has to be considered and same has to be explained to patients. Since there are only limited number of cases of pregnancy after radical vulvectomy and vulvectomy during pregnancy has been reported over a longer duration of period the outcomes of pregnancy and neonate are not clear. Centarlised global cancer registry for such rare cancers can bring insight into these rare tumors.

Conclusion

Vulval cancer in young patients is rare entity with special concerns regarding sexual, reproductive and child bearing functions. The patients need to be counselled regarding all the issues related to the disease and management. The management planning should include plastic surgical approaches for reconstruction of vulva and vagina. The pregnancies following vulval surgeries also have shown good obstetric outcomes. The mode of delivery is by caecarean section to avoid unhealing perineal wounds due to scarring of previous surgeries in the perineum. Patient should be followed up regularly to diagnose recurrence or second malignancies .

REFERENCES

Alice R Rumbold, Sarah E. Tan, John R. Condon, Debbie Taylor- Thomson, Maria Nickels, Sepehr N Tabrizi, Margaret L.J. Davy, Margaret M. O'Brien, Christine M Connors, Ibrahim Zardawi, Jim Stankovichand Suzanne M Garland, Investigating a cluster of vulvar cancer in young women: a cross-sectional study of genital human papillomavirus prevalence: *BMC Infectious Diseases* 2012: 243

Ibrahim Alkatout, Melanie Schubert, Nele Garbrecht, Marion Tina Weigel, Walter Jonat, Christoph Mundhenke, and Veronika Günther. Vulvar cancer: epidemiology, clinical presentation, and management options, *Int J Womens Health,* 2015; 7: 305–313.

Outcome of vulvar reconstruction in patients with advanced and recurrent vulvar malignancies. Zhang, W., Zeng, A., Yang, J., Cao, D., He, X., Wang, X., You, Y., Chen, J., Lang, J. and Shen, K. BMC Cancer. 2015 Nov 5; 15:851.

Woelber, L., Trillsch, F., Kock, L., Grimm, D., Petersen, C., Choschzick, M., Jaenicke, F. and Mahner, S. Management of patients with vulvar cancer: a perspective review according to tumour stage. *Ther Adv Med Oncol.* 2013 May; 5(3):183-92.

****