WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 7.523
Volume 6, Issue 7, 1432-1437. Case Report ISSN 2277–7105

PRIMARY VAGINAL CARCINOMA AS A SILENT KILLER -A RARE CASE REPORT WITH REVIEW

[1]Amera Anjum and [2*]Arshiya Sultana

[1]Lecturer, Dept of Gynecology and Obstetrics (Ilmul Qabalat wa Amraze Niswan) Govt. Unani Medical College, Chennai.

[2]Lecturer, Dept of Ilmul Qabalat wa Amraze Niswan, National Institute of Unani Medicine, Bengaluru.

Article Received on
06 May 2017,

Revised on 26 May 2017,
Accepted on 17 June 2017

DOI: 10.20959/wjpr20177-8767

***Corresponding Author**
Dr. Arshiya Sultana
Lecturer, Dept of Ilmul Qabalat wa Amraze Niswan, National Institute of Unani Medicine, Bengaluru.

ABSTRACT

Primary vaginal carcinoma is a rare condition in gynaecological oncology, as it occurs usually secondary to other malignancies. Usually, diagnosis is delayed in this condition because it goes unnoticed. Here we report a case of primary carcinoma of the vagina in 61-year-old post menopausal woman who presented with complaints of abnormal vaginal bleeding associated with low back pain since one and a half year. On gynaecological examination cervix was not visualized, and a friable growth was felt in anterior vaginal wall cervix flushed with vagina bleeding. The biopsy of the lesion confirmed squamous cell carcinoma of grade III. Hence, patient was referred to oncology hospital where she was advised for radiotherapy. However, patient was reluctant and not willing for the treatment. Hence, patient visited this hospital for the alternative treatment. She was counseled and referred to Kidwai cancer hospital. Further, she was instructed to review periodically for Unani treatment. However, the patient did not review back. Life can be saved if medical practitioners make a point of routinely enquiring about abnormal vaginal discharge, bleeding per vaginum and other associated symptoms after menopause in elderly women which are the hallmarks in clinical diagnosis.

KEYWORDS: Genital carcinoma; Primary vaginal carcinoma; Postmenopausal bleeding; Radiotherapy.

INTRODUCTION

Primary vaginal carcinoma is a rare condition occurring for less than 0.2% of all cancers in women. It constitutes about one to two percent of genital malignancies.[1] The incidence peaks at 60s.[1] Unfortunately only about one third of the patients have regional disease at the time of diagnosis.[2] However, the vagina can be a common site of metastatic gynaecological cancer by direct extension of cervical or vulvar tumours or through lymphatic or vascular deposits as seen in endometrial cancer and gestational trophoblastic disease.[1] Vaginal carcinoma occurs in elderly women when sexual activity is generally ceased.[2] The primary vaginal carcinoma should fulfill the following criteria a) The primary site of growth is in the vagina b) The cervix and the vulva must not be involved and c) There must not be clinical evidence of metastatic disease.[3] Squamous cell carcinoma (SCC) and adenocarcinoma are two primary types of vaginal cancer.[3] The most common clinical symptoms are abnormal vaginal bleeding or discharge associated with pain and discomfort during intercourse. The one of the major causes of SSC is HPV[4] infection whereas, Diethyl stilboesterol (DES) is related with clear cell adenocarcinoma of the vagina. Vaginal adenocarcinoma is found in those who had history of intrauterine exposure to diethyl stilbesterol.[3] Prolonged use of pessary is also a risk factor for vaginal squamous cell carcinoma[1] FIGO staging is followed for treatment plan which is summarized in table 1 Treatment option is surgery or radiotherapy which depends on the stage of disease.[5] Further, the treatment option is also decided on the basis of spread, if the growth is limited to the upper third-radical hysterectomy, partial vaginectomy and bilateral lymphadenectomy is the treatment of choice. If the growth is limited to the lower third- radical vulvectomy with removal of bilateral inguinofemoral lymphnodes along with vaginectomy is the recommended treatment.[3]

CASE REPORT

A 61-year-old post menopausal female patient of P2L2A0 hailing from Bengaluru came to Gynaecology OPD of the National Institute of Unani medicine on December 2016. Her chief complaints were foul smell abnormal vaginal bleeding, weight loss, anorexia and low back pain since one year and6 months. She consulted general practitioner for the above mentioned complaints and after her gynaecological examination the doctor referred her to Kidwai cancer hospital, Bangalore for further diagnosis and management for suspicion of carcinoma of cervix/vagina. In Kidwai hospital, she was examined and her local examination showed a friable growth of 3x2 cm on anterior vaginal wall extending to lateral vaginal wall, parametrium and left pelvic wall. Further, for confirmation, vaginal biopsy was carried out.

The biopsy report confirmed that she had grade III vaginal squamous cell carcinoma. Then patient was referred to gynaec-oncologist opinion. Gynec-oncologist advised her for radiotherapy in view of involvement of anterior vaginal wall, lateral vaginal wall and lateral pelvic wall as surgery was not feasible for her. Hence, the patient came to this hospital for alternative therapy. Patient was interrogated. The history revealed that she had postmenopausal abnormal vaginal bleeding and was diagnosed case of primary vaginal squamous cell carcinoma. No significant past medical and surgical history was reported. Her previous menstrual history was normal with ten to twelve episodes of vulvovaginitis. On clinical examination she was thin built, febrile, and pallor was present. Her other vitals were stable. Crepitations were audible on chest examination. The abdomen was soft, liver and spleen was not palpable. No ascites and vein engorgement was noted. However, lower abdominal tenderness was present. Her chest X-ray was normal. Her other investigations were within normal limits. We have given palliative Unani treatment, *Jawarish Amla* (5g BID), *Khamira Goazaban* (7g BID) and *Qurs Kushta Sadaf* (2 tab BID). Furthermore, patient was counseled and advised to consult in Kidwai cancer hospital for radiotherapy. Patient was advised to review back for alternative treatment along with radiotherapy. However, she did not review.

Table 1: FIGO Classification of vaginal cancer

FIGO Stage	Description
I	The carcinoma is limited to the vaginal wall
II	Carcinoma has involved the subvaginal tissue but has not extended to the pelvic wall
III	Carcinoma has extended to the pelvic wall stage
IV	Carcinoma has extended beyond true pelvis or has involved the mucosa of the bladder or rectum, bullous edema as such does not permit a case to be allotted to stage IV.
IV A	Tumour invades bladder and/or rectal mucosa and/or direct extension beyond the true pelvis
IV B	Spread to distant organs

DISCUSSION

Primary vaginal carcinoma is one of the rarest neoplasms in gynaecology. Lack of periodic or regular pap smear, sexual promiscuity, smoking, use of oral contraceptive pills for a long time, immunosuppressive medications, having the first child at the younger age, uterine prolapse with long standing ulceration, previous cervical dysplasia are attributed as risk factors. However, the common factors that can increase the risk include age and HPV infection. HPV 18 is the most common type and it is the second common type for primary

vaginal carcinoma.[2,3] On reviewing the literature only very few case reports are reported regarding primary vaginal carcinoma because of its rarity. A case report of primary vaginal carcinoma published by Begum et al., has reported that primary vaginal carcinoma was associated with chronic long standing pelvic infection. They have also reported a second patient of primary vaginal carcinoma with uterovaginal prolapse for more than 30 years.[1] Damineni and Shetty reported in their case report that uterovaginal prolapsed can be cause for malignancy.[6] To best of our knowledge this is the fourth case report of vaginal carcinoma. This patient had past history of frequent vaginal infections and age was above 65 year. Hence, in this case report the risk factors were age and frequent vaginal infections. Most likely cause for vaginal cancer in this case might be HPV infection. As HPV is having strong association with vaginal carcinoma. This patient reported postmenopausal abnormal vaginal bleeding, which the most common symptom of genital malignancy. Radiotherapy or surgery or combination is the accepted modality of therapy. The choice of treatment depends on the clinical stage, anatomical location, and size of the lesion.[7] Bracytherapy and teletherapy are also indicated as it reduces the tumour wall and sterilize the regional lymph nodes.[8] Surgery is possible in first stage and stage II-IV requires radiotherapy with overall survival rate of five years with 80% for stage I and 10% for stage four. Hence, any lesion in vagina or long standing ulcers should be taken into consideration for early detection and prompt management.[9] As this patient was diagnosed as grade three malignancy, radiotherapy was advised. However, the patient had not taken radiotherapy and came for alternative treatment. Patient was given *Jawarish Amla* as it contains *Emblica officinalis* has high content of Vit. C. A meta-analysis supports the use of Vit. C in post diagnosed cases of breast cancer as it reduces the mortality rate and increases the quality of life.[10] Further, *Santalum album,*[11] *Borage officinalis,*[12] *Coriandrum sativum,*[13] *Ocimum sativum,*[14] and *Nepeta hindostana* are immunomodulators, and antioxidants properties. The study also reported that anticancer properties of *C. sativum* root.[13]

CONCLUSION

Primary vaginal carcinoma is very rare entity. However, identify the risk factor and early detection may prevent and increase the life expectancy of the patient. Hence, medical practitioners should make a point of routinely enquiring about abnormal vaginal discharge, bleeding per vaginum and other associated symptoms after menopause in elderly women which are the hallmarks in clinical diagnosis.

ACKNOWLEDGEMENT: We are thankful to the patient and her relative for cooperating and giving consent for publication.

Conflict of Interest: Nil

Funding: Nil

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