PEDUNCULATED LEIOMYOMA OF THE VULVA AND LEIOMYOSARCOMA OF THE UTERUS

A rare coexistence

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INTRODUCTION

Any labial mass must be considered cautiously. Pure leiomyoma of the vulva are rarely reported. In contrast, leiomyoma of uteri is the commonest mesenchymal tumour of this origin. Leiomyosarcoma of the uterus is rare and highly malignant with poor prognosis. It is the most frequent histological variant of all sarcomatous forms. This case represents the coexistence of both these rare pathologies occurring in two different sites simultaneously.

CASE REPORT

A 62-year-old female, para 3, five years postmenopausal, presented complaining of acute retention of urine, abdominal distension and pain for the last 24 hours. She also complained of a painless lump on her left vulva which she had suffered for six years. There was no history of postmenopausal bleeding. On abdominal examination, there was a mass in the lower abdomen reaching the umbilicus. External genitalia examination revealed a firm pedunculated mass on the left labium majus. Blood investigations showed C-reactive protein of 301 (0.1–8.0) and cancer antigen125 of 163 (2.6–24.0). An ultrasound scan showed a large pelvic abdominal mass of mixed echogenicity and probably ovarian in origin. On exploratory laparotomy, ascitic fluid was noted along with a large friable uterine mass, arising from the fundus. Extensive tumour deposits involving almost the whole serosal surface of the bowel and parietal peritoneum were noted along with omental cake. Total abdominal hysterectomy with bilateral salpingo-oophorectomy, omental biopsy and excision of the left labial mass was performed. Histology showed leiomyosarcoma of the uterus. Deposits on the serosal surface bowel and omentum also represent leiomyosarcoma and the adnexae were normal. Left labial mass showed a benign pure leiomyoma.

DISCUSSION

Benign tumours of the vulva are rare. Still rarer are pure leiomyoma of the vulva. Leiomyomas are the most common soft tissue tumours of the vagina, despite their extremely low incidence. Leiomyoma of the lower part of the vagina may present as leiomyoma of the vulvae, arising from smooth muscle elements, such as those surrounding the crura of the clitoris. Many patients present with perineal pain, vulval mass or inflammation secondary to Bartholin's gland cancer. Our patient presented with a localised firm pedunculated mass on the vulvae and no signs of Bartholin's gland infection. Familial

occurrence of coexisting leiomyoma of the vulva and oesophagus has been reported⁽¹⁾. In our case, the patient did not complain of swallowing difficulties and had no significant family history.

Sarcomas can occur independently but may be found as a complication of leiomyoma. A neoplastic evolution of some endometrial lesions is acknowledged in the progression of adenocarcinoma, and the same has been suggested, but not irrefutably demonstrated, for the transition of leiomyoma into leiomyosarcoma. If leiomyoma of the vulva and leiomyosarcoma of the uterus are completely independent, then this case is interesting simply because of its rarity. The fact that malignant changes had only occurred in the uterus and not the vulva may support their independence.

Alternatively, the age of uterine lesion was unknown and vulval lesion was six years, and with the peak incidence of leiomyosarcoma being ten years later than leiomyoma could, therefore, the vulval lesion also have progressed to leiomyosarcoma, indicating some form of correlation?

CONCLUSION

Rational interpretation of the correlation of these different conditions is difficult, as is the neoplastic association between benign and malignant disease. Although a continuum in the transformation from the benign to malignant form has been suggested⁽²⁾ it remains unproven. If transformation was identified, how likely is this to occur at multiple sites? Equally, these two conditions could be of totally different origin. Existing research is limited and further study is needed in this area.

REFERENCES

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