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Case report

Atrophic vulvar lichen sclerosus evolving to an epidermoid carcinoma: about an uncommon case

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Abstract

Malignant tumors of the vulva are usually budding, ulcerated, or infiltrating. The fear of cancer must always be in mind, in front of any vulvar lesion. Therefore, do not hesitate to make biopsies of any lesion of the vulva to confirm or deny a cancer. We hereby report the uncommon case of a postmenopausal 68-old-patient followed for an atrophic vulvar lichen sclerosus which eventually transformed into an epidermoid carcinoma of the vulva. The indication for right hemivulvectomy with sentinel lymph node procedure was retained. Vulvar cancer takes a variety of aspects. It is therefore necessary to always have it in mind and to make a biopsy before any suspicious lesion. Since the atrophic vulvar lichen sclerosus of the vulva is a pre-cancerous lesion, we believe that its follow-up must be strict and a second biopsy must be performed before any worsening of the lesions. Finally, the procedure of the sentinel lymph node is of great interest when we know the morbidity of the inguinal region dissections but also the slow learning curve of surgical techniques of vulvar cancer.

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Introduction

Malignant tumors of the vulva are usually budding, ulcerated, or infiltrating [1]. The fear of cancer must always be in mind, in front of any vulvar lesion. Therefore, do not hesitate to make biopsies of any lesion of the vulva to confirm or deny a cancer. We hereby report the uncommon case of a postmenopausal patient followed for a sclereroatrophic vulvar lichen which eventually transformed into an epidermoid carcinoma of the vulva.

Patient and observation

Mrs. B, aged 68, gravida 4 para 4 (4 vaginal deliveries without complication), menopausal for 12 years, was followed in our structure for scleroatrophic lichen vulvar for 5 years under local corticotherapy, which showed an aggravation of lesions with budding in area. During the interview, despite her local treatment, the patient reported persistent vulvar pruritus for 3 months with a lesion that became painful each time the patient sat down. The perineal gynecological examination showed a lesion of 18mm in diameter in the form of a budding of the upper region of the right hemivulva, painful to palpation, not reaching the meatal region below nor the clitoris inside nor apparently the anovulvary fork. The clinical examination revealed no inguinal lymphadenopathy or other associated lesion. A vulvar biopsy was performed and showed an infiltrative lesion of squamous cell carcinoma well differentiated; the connective tissue was infiltrated by large cells with marked atypia and dyskeratosis phenomena, with stromal invasion of 2mm. On the thoraco-abdominopelvic CT (Computerized Tomography), no inguinal lymphadenopathy nor suspicious lesion with secondary localization were observed. Also, the squamous cell carcinoma antigen (SCC-Ag) level was normal. The indication for right hemivulvectomy with sentinel lymph node procedure (by methylene blue) was retained for a tumor stage T1b (Figure 1). The extemporaneous examination of the positive income ganglion was followed by a superficial and deep inguinal lymph node dissection. Examination of the hemivulvectomy specimen showed macrospically a large budding zone of 2 cm in diameter with microscopically the presence of invasive epidermal keratinizing carcinoma and stromal invasion of 2mm. Only one ganglion returned positive with a metastasis > 5mm. According to the 2009 FIGO classification, it was therefore a tumor: T1b, N1b, M0. A follow-up session took place 3 weeks later for a post-operative examination and suture removal. Subsequently, the management was supplemented by external radiotherapy to prevent recurrence. Until today and after 2 years of treatment, no recurrence observed.

Discussion

The lichen sclerosus promotes the appearance of precancerous lesions explaining its association with 70% of genital squamous cell carcinoma in women with a risk of carcinomatous transformation of 3 to 5%. It is this differentiated mature keratinizing either of the usual type, or verrucous type, the latter being of better prognosis [2,3]. This is why the precancerous lesions developed on genital lichen sclerosus are to be clinically and histologically sought immediately at the time of the diagnosis and to be detected during the course of the evolution in case of recurrence if the treatment has been suspended. Our patient was biopsied to diagnose scleroatrophic lichen of the vulva and had a strict follow-up, allowing us to diagnose her progression to early-stage cancer. Vulvar cancer is a rare pathology, which represents 4% of gynecological tumors with an incidence of 0.5 to 1.5 per 100 000 women per year in France. Malignant tumors of the vulva are usually budding, ulcerated, or infiltrating [1]. But the fear of cancer must always be in mind;

thus, before any vulvar lesion, it is necessary to make a biopsy to confirm or deny a cancer. In fact, vulvar cancer can cover various aspects, particularly that of vesicular lesions, which can be very aggressive [4]. Lymph node status is the most important prognostic factor for early stage cancers. The sentinel lymph node is defined as the first ganglionic relay draining an organ; the lymph node status is thus based on its histological result. Lymphadenectomy, with high morbidity, is performed only in case of metastatic sentinel lymph node [5]. According to the latest ESGO (European Society of Gynaecological Oncology) recommendations [6], the sentinel lymph node procedure is recommended in patients with unifocal cancers of less than 4 cm, without suspicious groin nodes. Our patient had a unifocal lesion of 18mm in diameter without suspicious groin nodes and therefore she benefited from sentinel lymph node procedure. The sentinel lymph node technique was performed by peri-tumor infiltration of methylene blue before the incision. Other sentinel lymph node procedures can be used such as: isotopic technique and combined technique (colorimetric and isotopic). The extemporaneous result was positive. Then a complete inguinal lymph node dissection was performed. The final histological report revealed a single positive ganglion with a metastasis > 5mm. Management was supplemented by external radiotherapy to prevent recurrence. No recurrence was seen after 2 years after treatment with disappearance of pain and improved quality of life.

Conclusion

Vulvar cancer takes a variety of aspects. It is therefore necessary to always have it in mind and to make a biopsy before any suspicious lesion. Since the lichen of the vulva is a pre-cancerous lesion, we believe that its follow-up must be strict and a second biopsy must be performed before any worsening of the lesions. Finally, the procedure of the sentinel lymph node is of great interest when we know the morbidity of the inguinal region dissections but also the slow learning curve of surgical techniques of vulvar cancer.

Competing interests

The authors declare no competing interests.

Authors' contributions

All the authors have read and agreed to the final manuscript.

Figure

Figure 1: (A) image showing the lesion infiltrated by methylene blue with the incision; (B) representing sentinel lymph node dissection of the right inguinal area

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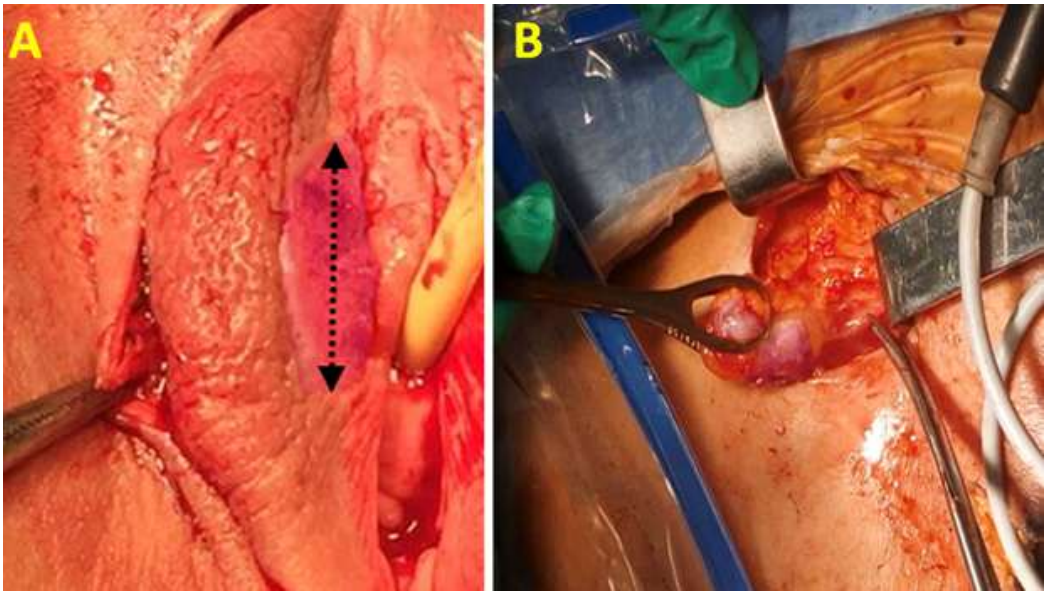

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