

Vaginal Angiomyxoma Mimicking a Large Cystocele

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Objective

Vaginal angiomyxoma is a rare benign mesenchymal tumor of vagina. We present a case which was initially diagnosed as cystocele, was found as a non-reducible soft tissue mass intraoperatively. This was later diagnosed as angiomyxoma at histopathological examination.

Introduction

Angiomyxoma is a rare benign mesenchymal tumor typically arising in pelvis and perineum in the reproductive age group.¹ As it has no typical symptoms, it is commonly mistaken as vaginal cyst, labial cyst, lipoma, cystocele, rectocele, gartner’s duct cyst, bladder mass etc.² It can be superficial or deep (aggressive) depending on its location. It is non-metastasizing but locally infiltrative. As the diagnosis is usually on postoperative histology, it is usually incompletely excised with positive tumor margins hence leading to local recurrence. Mainstay of treatment is surgical excision with clear margins and regular post-operative follow up.

Case report

A 45 years old woman presented with vulvo-vaginal discomfort, stress urinary incontinence, urgency and incomplete bladder emptying. Vaginal examination revealed a prominent cystocele. There was no evidence of uterine descent or rectocele. She was planned for anterior vaginal wall repair. Under anaesthesia, an unusually shaped large mucosal structure was noted below the urethra. Proceeded with repair by separating the bulge from the anterior vaginal wall. Despite all the measures, it was not possible to reduce the mass. On further dissection, the mass appeared to be arising below the urethra, the narrow end reaching up to the pubic bone, measuring 10 cm long. Differential diagnoses were bladder diverticulum or an inclusion cyst. Cystoscopy did not show any diverticulum. Following further discussion with the Urologist, the mass was excised. Patient had uneventful recovery. Histology and Immunohistochemistry confirmed angiomyxoma. Pelvic MRI Scan four months later did not show any residual disease. Patient is under follow up with gynae oncology team.

Discussion

Steeper and Rosai in 1983 first reported aggressive angiomyxoma as distinctive, locally infiltrative and grossly gelatinous soft tissue tumors of pelvis and perineum in females of reproductive age group.¹ Since then more than 500 cases of such tumors have been reported. However, no consensus has been reached regarding the histogenesis of this tumor.³ Aggressive angiomyxoma is mainly seen in the lower genital tract of reproductive women, with the highest incidence in the 30s.⁴ Presentation of aggressive angiomyxoma is non-specific and can mimic cystocele, rectocele, gartner’s duct cyst, bladder mass etc.² There is also a report of it mimicking as a cervical fibroid in a pregnant lady.⁵

Surgical resection with clear margins is the first line of treatment. However, its infiltrating nature and absence of capsule makes microscopically margin negative clearance difficult and local recurrence common which is usually within first 5 years of surgery though it can be as late as after 20 years.⁶ Thus, there is need of long term follow up.

Recurrent tumors are also managed surgically with another resection. However, hormonal treatment with Gonadotropin-releasing hormone agonist, anti-estrogens and aromatase inhibitor, arterial embolization and radiotherapy have also been tried with variable success rate.⁷

Conclusion

Vaginal angiomyxoma can cause diagnostic dilemma. If in doubt, pre-operative assessment with MRI can help in diagnosis and operative planning for complete clearance. Irreducibility of mass during repair should raise the suspicion and effort should be made to excise the tumor completely with clear margins so as to reduce chance of recurrence.

References

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