

Vulval lumps may not always be of gynaecological origin: A Case report

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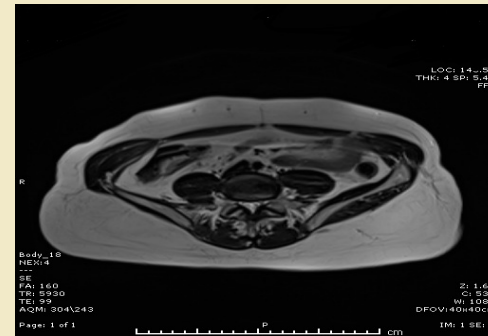
Introduction:

- Anal malignancy is a rare but crucial differential diagnosis to be considered in women with vulval swelling, especially if they are unresponsive to the usual treatment for cysts/abscesses of Bartholin's glands.
- We report a non-gynaecological malignancy, whereby there was a delay in reaching the diagnosis, and the objective is to share our learning.

Case Report:

- A 59-year-old postmenopausal woman was referred to the gynaecology clinic for surgical management of a recurrent Bartholin cyst. She had a 8-month history of a right-sided palpable, tender vulval mass that gradually increased in size with worsening discomfort during sitting.
- She also described intermittent rectal bleeding; the gastroenterology investigations, including endoscopy and colonoscopy were negative.
- She had been seen in primary and secondary care emergency settings over the past few months and received a few courses of antibiotics for suspected Bartholin's cyst/abscess.
- On examination, a deep, firm, immobile mass, 4 cm x 4 cm in diameter, was palpated on the right side of the vulva, adjacent to the posterior fourchette and confirmed on digital rectal examination. Rest of the clinical examination was unremarkable, with no enlargement of regional lymph nodes.

- An urgent MRI scan was arranged based on the consistency of the lump with a differential diagnosis of Bartholin's gland carcinoma, chronic Bartholin abscess, or sinister perianal pathology.
- MRI showed a 3.5 cm x 2.5 cm-sized, heterogeneous soft tissue lesion on the right side of the perineum, which appeared posterior to the vaginal introitus and lateral to the anal canal with suspicion of anal malignancy.
- Staging CT chest, abdomen, and pelvis excluded metastatic disease.
- PET-CT scan showed a focal area of marked apoptosis on the right side of the anal canal measuring 3.5 cm in length and appears to demonstrate some cavitation likely due to necrosis with no evidence of metastatic disease.
- Following multidisciplinary discussion, the Colorectal team's examination under anaesthesia and biopsies demonstrated a 4x4 cm ulcerated lesion involving the anal canal and anal sphincter with extension into the vagina without vaginal mucosal involvement. Histopathological examination confirmed a poorly differentiated anal squamous cell cancer.



Literature Review:

- Bartholin's gland cysts are common and can present with masses involving the vulva. Large or recurrent "BG" lesions may not be what they appear clinically, and malignancy must always be considered, particularly in postmenopausal women but in premenopausal women as well. Other lesions that occur on the vulva may also be mistaken for BG cysts/abscesses, such as the case of anal cancer described.
- The differential diagnosis of a Bartholin's cystic mass should be considered with other vulvar pathologies, such as epidermoid or epidermal inclusion cyst, mucinous or ciliated cysts, canal of Nuck cyst, Skene's paraurethral gland cyst, vaginal wall cysts, lipoma, endometrioma, dermoid cyst, post-traumatic haematoma, inguinal hernia and vulvar malignant tumour.
- Imaging by ultrasound, computed tomography or magnetic resonance may be required to characterise the lesion further. Though magnetic resonance is useful in guiding treatment planning (especially for the detection of extension into deep perineal tissue if the cyst or abscess is large), surgical excision and pathological examination are necessary for diagnosis. In our case, magnetic resonance was performed because the physical exploration raised concerns.

- Anal cancer, although rare, can prove to be a devastating diagnosis. It is commonly misdiagnosed as a benign lesion, resulting in delays in diagnosis and treatment. The foundation for successful therapy includes a timely diagnosis, accurate staging, and routine surveillance.
- Because early diagnosis is the key for some of these potentially aggressive lesions, clinicians should have a high index of suspicion and a low threshold for biopsy when a BG lesion occurs in an older woman or in any woman where the lesion recurs or fails to resolve.

Conclusion:

- This case report highlights the importance of thinking outside the box when considering the differential diagnosis for women with a history of persistent vulval swelling, especially if associated with red flag symptoms like rectal bleeding and/or not responding to usual treatments.
- Thorough history taking and detailed physical examination are crucial. Seeking senior opinion with multidisciplinary involvement leads to early diagnosis and initiating treatment that can improve patient outcomes.

References:

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