University of Basrah
Al-Zahraa Medical College

Ministry of higher Education
and Scientific Research

Academic year 2021-2022

5th year

REPRODUCTIVE BLOCK

Lecture

Duration : 1 hour

Benign and malignant conditions of vulva and vagina

Presented by

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GYNAECOLOGY 20th
EDITION by Ten Teachers

Learning Objectives (LO)

1- Lichen Planus .
2- Lichen sclerosus .
3- Vulval cysts .
4- Vulvodynia .
5- Malignant disease of the vagina .
6- Malignant disease of the vulva .

LO 1

Lichen planus

- **Lichen planus is an autoimmune disorder affecting 1–2% of the population (particularly in people over 40) and affects the skin, genitalia and oral and gastrointestinal mucosa.**

- **There is no known precipitating factor although pressure can increase symptoms (for example restrictive underwear), but symptoms are often pruritis and/or superficial dyspareunia.**

- **Genital lesions can be longitudinal, annular, ulcerative, hyperpigmented or bullous and may cause vaginal stenosis and resulting sexual dysfunction .**
- **Treatment is by high-dose topical steroids**

LO 2
Lichen sclerosus

- **Lichen sclerosus is a destructive inflammatory skin condition that affects mainly the anogenital area of women. the cause is believed to be autoimmune. Many patients have other autoimmune conditions, such as thyroid disease and pernicious anaemia.**
- **The destructive nature of the condition is due to underlying inflammation in the subdermal layers of the skin, which results in hyalinization of the skin. This leads to a fragility and white 'parchment paper' appearance of the skin and loss of vulval anatomy**
- **The main symptoms on the vulva are itching and subsequent soreness of the vulva, usually due to scratching.**
- **A biopsy can confirm the diagnosis and treatment is a combination of good skin care and strong steroid ointments such as those containing clobetasol.**

- **Lichen sclerosus is associated with vulval cancer.it is estimated that there is a low risk of cancer developing in a women with lichen sclerosus (around 3–5%) .**

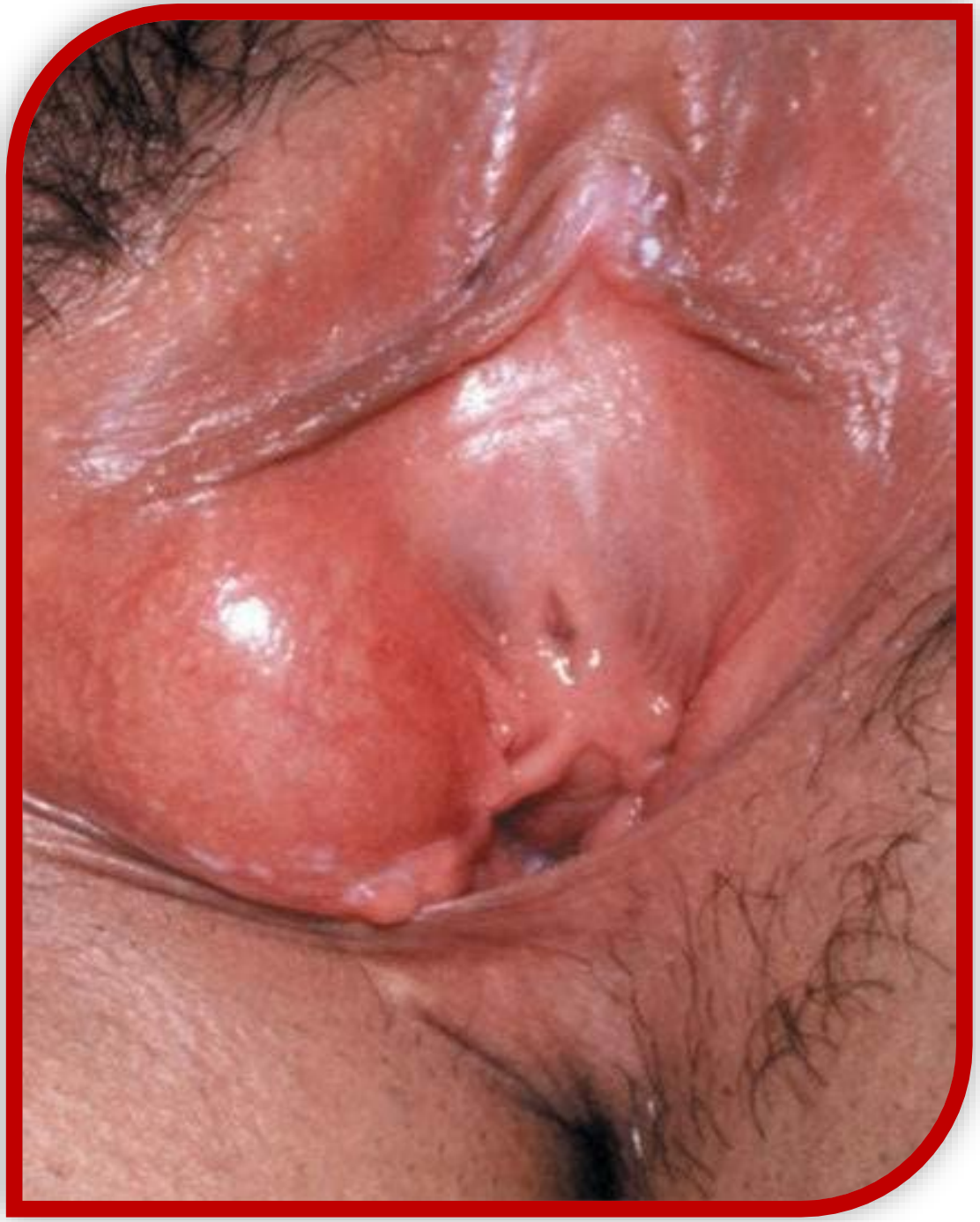
- **If there is not complete resolution of symptoms, biopsy is indicated. Women should be advised to seek advice if the lesions become raised or resistant to treatment.**

Lichen sclerosus

LO 3
Vulval cysts

- **Bartholin's cysts, Skene gland cysts and mucous inclusion cysts can affect the vulval area and cause a lump with or without vulval discomfort. If they do not cause the patient any problem, they can be either monitored or excised.**
- **A Bartholin's cyst is the most common type of cyst and develops in the region of the Bartholin's gland .**
- **The Bartholin's gland has a long duct which, when blocked, causes fluid to build up and eventually forms a cyst. It is not uncommon for these cysts to get infected and cause a Bartholin's abscess that usually presents acutely and may require incision and drainage**
- **Marsupialization of the cyst is the term used when the internal aspect of the cyst is sutured to the outside of the cyst to create a window so that the cyst does not reform.**

Bartholin’s cyst



LO 4
Vulvodynia

- **Vulvodynia is the condition of pain on the vulva most often described as a burning pain, occurring in the absence of skin disease or infection. It is akin to a neuropathic pain syndrome. The pain can be further classified by the anatomical site (e.g. generalized, localized or clitoral) and also by whether pain is provoked or unprovoked**
- **It is essential to exclude physical causes such as dermatitis.**
- **There is recent evidence that neuromodulators are of limited benefit in vulvodynia but some women find them useful (particularly if pain inhibit sleep, when a sedative neuromodulator such as amitriptyline can be used).**
- **Some women can benefit from perineal massage, which may aid vulval desensitization, reduce muscular spasm.**

LO 5
Malignant disease of the vagina

- **Vaginal cancer is rare, accounting for just 1–2% of gynaecological malignancies. The majority of vaginal tumours arise from metastatic spread from the endometrium and cervix. Primary cancers of the vagina are usually squamous cell carcinomas, although clear cell adenocarcinomas and malignant melanomas occur occasionally.**

- **The peak age of incidence is 60–70 years of age More than 60% of primary vaginal tumours are HPV associated and risk factors for the disease include previous malignant and premalignant disease of the cervix, and vaginal intraepithelial neoplasia (VaIN), a premalignant disease with a 10% risk of progression to invasive disease. Vaginal cancer is also sometimes seen in women with a previous history of pelvic radiotherapy.**

Clinical presentation and diagnosis

- **Abnormal bleeding or blood-stained vaginal discharge is the most common presenting complaint Speculum examination reveals a mass or an ulcer, usually at the top of the vagina.**
- **Advanced disease presents with haematuria, constipation, pelvic pain or tenesmus, a feeling of incomplete emptying of the rectum.**

- **Diagnosis is confirmed by biopsy . An examination under anaesthetic, cystoscopy and sigmoidoscopy defines local spread. An MRI scan of the pelvis confirms clinical findings and a computed tomography (CT) scan of the thorax and abdomen establishes whether distant metastases are present**

Staging of vaginal cancer:

Stage	Extent of disease	5 year survival rate
I	Tumour confined to vagina	75%
II	Tumour invades the subvaginal tissue	40%
III	Tumour invades the pelvic side wall	30%
IV	Tumour involves bladder or bowel mucosa or extends beyond the true pelvis	0–20%

(According to the International Federation of Gynecology and Obstetrics [FIGO] staging system.)

Treatment

- **Most vaginal cancer is treated by primary radiotherapy, although early-stage tumours may be managed surgically. Prognosis depends on stage .**

LO 6
Malignant disease of the vulva
Epidemiology and aetiology

- **Vulval cancer is uncommon.**
- **Almost 90% of vulval cancers are squamous cell carcinomas, with malignant melanoma, basal cell carcinoma and adenocarcinoma of the Bartholin gland making up the remainder.**
- **squamous cell carcinoma of the vulva is a disease of two separate etiologies high-risk HPV associated cancers, which arise on a background of multifocal high-grade vulval intraepithelial neoplasia (VIN 3), often in younger women; and non-HPV-associated tumours, affecting older women and associated with the premalignant vulval condition lichen sclerosus .**

Clinical presentation

- **Vulval cancer presents as a lump or ulcer associated with bleeding or discharge that may be painful or painless.**

- **On examination, a well-demarcated raised or ulcerated lesion that is hard and craggy and bleeds on touch is highly suspicious for vulval cancer . the size of the lesion, its position on the vulva and its proximity to important midline structures, particularly the urethra and anus should be assessed .**

Vulval tumours spread:

- **locally and metastasize first via the inguinofemoral lymph nodes, before involving pelvic lymph nodes . It is therefore important to examine the groins for lymph node metastases, which are palpable as hard, craggy and fixed subcutaneous lymph node swellings .**

- **Haematogenous spread to liver and lungs is a late event.**

Investigation:

- **A biopsy is needed to confirm the diagnosis. For large tumours, this should incorporate the edge of the lesion with the transition to normal epithelium, as this aids histological assessment. For smaller tumours, where biopsy would effectively excise the lesion.**

- **A staging CT scan of the thorax, abdomen and pelvis is necessary for large vulval tumours or those with obvious groin node disease, to exclude distant metastases.**

Staging and prognosis of vulval cancer:

Stage	Extent of disease	5-year survival rate
Stage I	Tumour confined to vulva	90%
IA	≤2 cm in size, stromal invasion ≤1 mm, no nodes	
IB	>2 cm in size or stromal invasion >1 mm, no nodes	
Stage II	Tumour extending to lower 1/3 urethra or vagina, or anus	50%
Stage III	Positive inguinofemoral lymph nodes	30%
IIIA1	1 lymph node metastasis ≥5 mm	
IIIA2	1–2 lymph node metastases <5 mm	
IIIB1	≥2 lymph node metastases ≥5 mm	
IIIB2	≥3 lymph node metastases <5 mm	
IIIC	Extracapsular spread	
Stage IV	Tumour invading regional or distant sites	15%
IVA1	Upper urethra/vaginal mucosa, bladder or rectal mucosa, fixed to pelvic bone	
IVA2	Fixed or ulcerated inguinofemoral lymph nodes	
IVB	Distant metastases including pelvic lymph nodes	

(According to the International Federation of Gynecology and Obstetrics [FIGO] staging system.)

Treatment

Vulval excision

- **Radical surgical excision aiming for a clear surgical margin of at least 10 mm is standard of care.**
- **Where lesions impinge on the urethra or anus, achieving good surgical clearance is more challenging. Sometimes it is appropriate to shrink very large or midline tumours with neoadjuvant radiotherapy, often given in combination with chemotherapy, prior to surgery.**

Radiotherapy:

- **Adjuvant radiotherapy, given after surgery with curative intent, is indicated when vulval excision margins are close or involved or in the presence of two or more groin node metastases.**

- **Neoadjuvant radiotherapy, given before surgery to shrink the tumour and render it operable, is used for very large vulval tumors, particularly those that involve the urethra or anus and where adequate surgical effort would have functional urinary or bowel implications.**

- **radical radiotherapy is given instead of surgery in women who are not fit for an anaesthetic due to severe medical comorbidities.**

THANK YOU