involving the anterior and right lateral walls. A biopsy was taken from the growith and at the same time the procedentia was reduced and retained within the introitus by splitting the labia minora laterally and performing a temporary perineorrhaphy. Rectal examination did not reveal any abnormality. Histopathology report confirmed squamous cell carcinoma of the vagina and the patient was referred to J.P.M.C. for radiotherapy.

COMMENT:

Primary carcinoma of the vagina is said to begin on the posterior vaginal wall opposite to the external os, but in the reported caseit involved the anterior wall. This probably rules out the suggestion that it is caused by irritating cervical discharges. A history of "exposure to pessary" said to be present in 25 percent cases vas not obtained in the reported case. It is impossible to relate vaginal a cancer to any known antecedent condition, though prolonged exposure of the vagina to air and trauma could be a predisposing factor in the case described.

Two forms of treatment are available in managing such a case: irradiation and surgery. Squamous cell carcinoma of the vagina is alleged to be less radiosensitive than that of the cervix[4] However, this was considered the treatment of choice as the patient was a poor surgical risk and bladder involvement could not be excluded.

The reults of any sort of treatment are poor and the 5 – year survival rates are not higher than 20–35 percent. Whitehouse and Porteous[5] obtained a 16.6 percent 5 – year salvage rate from radiation, while Whelton and Kottmeier[6] reported (in 1962), a 26.5 percent 5 – year survivours out of 117 treated.

When The Cancer Institute J.P.M.C. was contacted for the follow up, it was known that Mrs. H. J. had left against medical advice after refusing any type of treatment.

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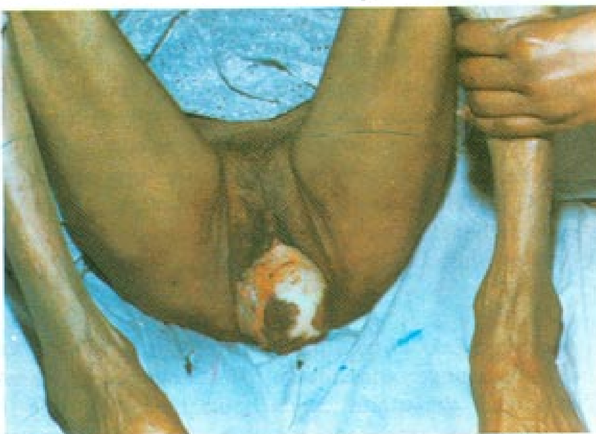

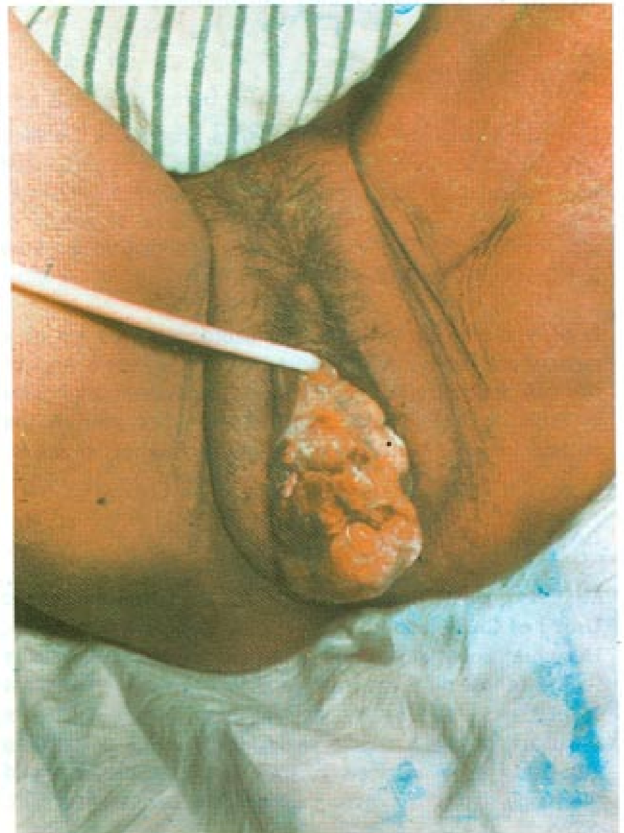

Figure 1–2 Carcinoma of the anterior vaginal wall.

Pakistan Journal of Surgery, 1985, 1, 149–150

CASE REPORT

Primary Carcinoma of the Vagina Complicating procidentia

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ABSTRACT:

Primary carcinoma of the vagina is rare a case of primary vaginal carcinoma associated with vaginal prolapse is reported.

Key Words: Vagina–Primary carcinoma–prolapse.

INTRODUCTION:

Compared with the uterus and vulva, the vagina is a very rare site of malignant growths. Few gynaecologists have seen more than one or two during their entire career. The incidence of vaginal, relative to cervical cancer is 2.2:100 (Way[1]) and vaginal relative to genital growths is 1.3:100. (Palmer and Bibach)[2].

Long standing prolapse or the prolonged wearing of a pessary can bring about neoplastic changes, yet cancer of the vagina or cervix is hardly ever seen in untreated cases of Prolapse[3]. The case reported, is the first seen by the author in her twenty years of gynaecological practice.

CASE REPORT:

Mrs. H. J. aged 76 years, Para 5, was admitted to Gynaec Unit I of Civil Hospital, Karachi, on February 5th, 1985. Her chief complain to was protrusion of a mass from the vagina following a twin delivery 15 years ago. The mass at first reducible by the patient, was lying outside the introitus for the past five years. In the week preceeding admission, she noticed a foul smelling bloodstained discharge from the mass, which had become painful. There was no history of stress incontinence, but she complained of retention of urine on and off for the past six months. The patient had her menopause 20 years ago and her last delivery 40 years ago. She had never worn a pessary at any time. There was no family history of cancer.

On general examination, the patient was an old emaciated lady with normal B.P. and pulse. The systemic examination revealed a large procidentia (figure 1 & 2) with a friable hypertrophic growth involving the anterior and right lateral vaginal walls. The growth was tender and bled on touch. The epithelium of the remaining prolapsed vaginal wall was thickened and white with keratin, due to constant exposure to air. The inguinal glands were enlarged.

Laboratory investigations revealed raised blood urea (80 mg./dL) and serum creatinine (5.3 mg/dL) levles. Her random blood sugar was normal. A swab from the surface of the growth revealed Klebsiella species on culture, sensitive to Amoxil which was prescribed. An E.C.G. tracing was within normal limits. The I.V.P. showed bilateral hydronephrosis. Scan confirmed. The patinet refused to have a cystoscopy.

After a week of antibiotic therapy, the patient was examined under anaesthesia. The prolapsed cervix was atrophic. the uterus which could be felt outside the introitus was small and strophic. No curettings were obtained on endometrial curettage. There was complete eversion of the vagina with a hypertrophic friable growth