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Giant vulvar pendulated lypoma in patients with endometrial adenocarcinoma and inoperated giant ventral hernia

Case Report

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Abstract: A case is presented of a operated giant pedunculated vulvar lipoma weighing 14 kg in a patient with concomitant inoperable giant ventral postoperative hernia, complete diastasis of the anterior abdominal wall musculature and endometrial adenocarcinoma.

Keywords: *Giant tumors • Lypoma • Vulva*

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1. Introduction

Because of their growth, localization and discomfort they cause in genital region, fibroma, lipoma, myoma, myxoma and neurofibroma as the most common benign vulvar neoplasms that are generally detected early, thus preventing further growth to the giant size. Giant benign pedunculated tumors of vulva are extremely rarely reported in gynecologic and (dermato)surgical literature, the more so as they result from long-term and neglected growth [1-5].

A case is presented of a giant pedunculated vulvar lipoma weighing 14 kg in a patient with concomitant inoperable ventral postoperative hernia, complete diastasis of the anterior abdominal wall musculature and endometrial adenocarcinoma.

2. Case report

A 63-year-old extremly adipose (138 kg) woman was admitted for operative removal of a giant vulvar tumor reaching to the floor. History: controlled hypertonia; cholecystectomy by upper median laparotomy, followed by postoperative ventral hernia that extended to lower abdomen, with complete diastasis of m. rectus abdominis, so that the entire anterior abdominal wall consisted exclusively of the skin with visible intestinal curvatures and peristalsis. The patient controlled hernia by abdominal brace and refused to have it operatively removed. A giant vulvar tumor protruded from a wide base on the mons pubis and upper third of labia major, reaching to the floor, with ulcerations on the lowest part of the tumor (Figure 1). In addition to these findings, the patient was depressed, her movement was slow and restricted, and she did not go outside her home. Five months before admission, she experienced uterine bleeding, ten years after the last menstruation. Fractionated curettage was performed and grade 1 endometrial adenocarcinoma was diagnosed. Because of the patient's extreme obesity that prevented radical operative procedure, the oncologic-gynecologic consultation at another institution prescribed 400 mg megestrol acetate daily for three months and follow up curettage, which also revealed grade 1 adenocarcinoma. Abdominal multi-slice computed tomography (MSCT) showed no signs of disease

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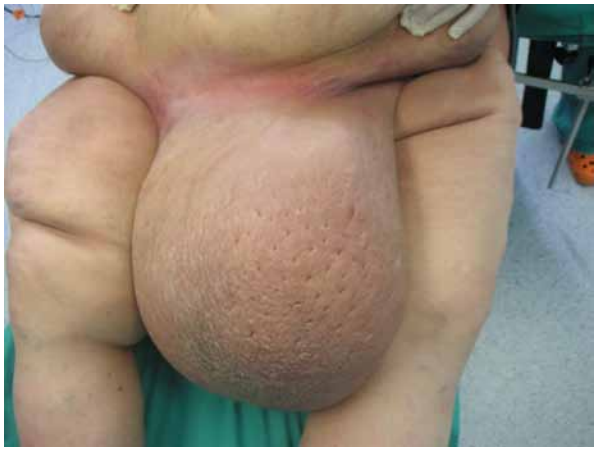

Figure 1. Giant vulvar pendulated lypoma.

progression, while tumor markers were within the reference limits; therefore, radiotherapy was indicated. However, as approach to the uterus and lower abdomen was very difficult due to the giant pedunculated tumor, we decided to perform tumorectomy followed by radiotherapy. Upon preoperative procedure, removal of the tumor weighing 14 kg (45x23x17 cm) (Figure 2) with subcutis drainage and primary reconstruction of the operative wound was carried out under endotracheal anesthesia.

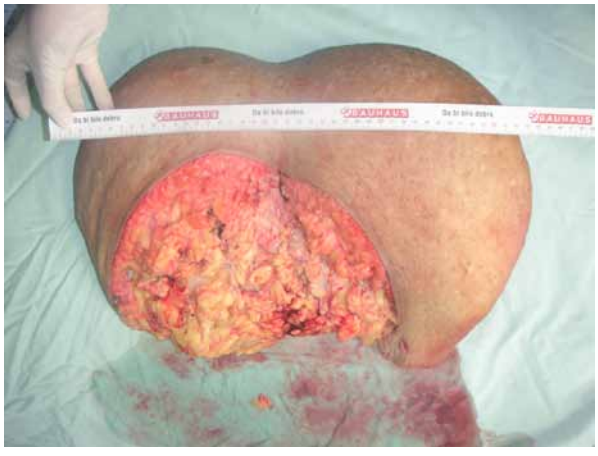

Figure 2. Ectomied giant vulvar tumor weighing 14 kg and 45x23x17 cm.

The postoperative course was normal, with minor wound discharge and partial marginal dehiscence, without elevation of the blood inflammatory parameters and C-reactive protein. Microbiological swabs suggested Staphylococcus aureus infection (MRSA) and vancomycin was prescribed. Regular wound dressing and contact isolation resulted in spontaneous wound granulation and healing. The patient was discharged from the hospital after 3-week inpatient treatment. Histopathology pointed to a lipoma composed of regular adipocytes, with regular and in part centrally ulcerated epidermis; granulation tissue was found at the bed of ulceration, covered by a necrotic layer, while focal mononuclear infiltrates were detected in the dermis.

Four months after the surgery and one week after completion of therapy for local skin infection, the patient underwent irradiation brachytherapy (11x, total dose of 56.50 Gy upon the uterus and cervix) for endometrial adenocarcinoma. Follow up transvaginal color Doppler, radiothoracography and abdominal MSCT showed normal findings without malignant disease progression, while uterobrush revealed endometrial cells without atypia.

3. Discussion

Giant benign tumors of the vulva mostly develop over years, grow slowly and in fact result from the patient's own health neglect. These tumors are generally composed of tissues found in vulvar region (lipoma, fibroma, leiomyoma, myxoma, neurofibroma), frequently are pedunculated and such case reports, although rare, are found in the literature. Giant vulvar neurofibromas have been described by Venter et al. in 1981 [9] and Amita et al. in 2005 [10]. The former authors report on two cases of solitary neurofibroma in patients free from other stigmata of multiple neurofibromatosis, a syndrome where such neoplasms do occur [9]. Amita et al. report on a case of fast-growing painless vulvar tumor, 18x15 cm in size; tumor excision and primary suture were performed, and histopathology demonstrated neurofibroma of labia major without signs of malignant transformation. Other studies also failed to show signs of von Recklinghausen's disease, and the patient's condition was unremarkable 5 years after the surgery [10].

Large perineal leiomyomas after episiotomy have recently been reported by Oliviera Brito et al. [3]; Kurdu-glu et al. report on a giant pendulous vulvar leiomyoma in term pregnancy [5], and Kajiwara et al. on a myxoid leiomyoma, 4x4x4.5 cm in size, in a 29-year-old pregnant woman [11].

Buschke-Löwenstein tumor is a specific form of giant vulvar tumor, primarily acuminate condyloma with fast and progressive growth [8]. Fast tumor growth points to the possible malignant component [6,7]; so Tjalma et al. Reported on a myxoid vulvar leiomyosarcoma [6], and Esparza et al. on a giant mesenchymal vulvar tumor with atypical clinical evolution [7].

The vulvar tumor growth over years in our patient was primarily the result of her postponing the suggested operative therapy; however, when she learned about her suffering from endometrial adenocarcinoma several months before and the oncologic-gynecologic

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consultation decided on treating her with medicamentous therapy for malignancy, then she changed her mind and gave her consent for tumor excision. However, her first gynecologist refused to perform the operation because of her extreme adiposity and inoperable herniation of the entire abdominal wall; therefore the patient presented to another institution, which does not seem to be a rarity [12]. Upon her admission to our department, we decided to perform the tumorectomy in order to enable irradiation brachytherapy and possibly radical vaginal hysterectomy. The operative procedure (tumorectomy) proceeded normally, with only mild and expected postoperative complications. Removal of a giant tumor weighing 14 kg allowed further treatment with radiotherapy and patient's recovery.

Due to the patient's desire and existing comorbidities, extreme adiposity and giant inoperabile abdominal defect (extremelly large herniation with m. rectus diasthasis and visible intestinal curvatures and peristalsis) and possible postoperative complications (pneumonia, mechanic ventilation), simultaneous long-term operative correction with possible synthetic surgical material was not possible.

One year after radiotherapy, the patient's general condition was satisfactory, free from signs of malignant disease progression, confirming that the therapeutic option chosen at our institution was fully appropriate, having allowed a higher quality of life for the patient. She was able to resume the social life that she had been deprived of due to her handicap.

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