

## Clitoral Carcinoma in 30 Yr Lady: A Case Report

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**Abstract:** Vulvar cancer is uncommon, representing about 4% of all malignancies of the female genital tract, and 0.6% of all cancers in women. Squamous cell carcinoma accounts for about 90% of all primary vulvar malignancies. It usually occurs in postmenopausal women, with a median age of 60 years. Vulvar lesions require early biopsy to avoid delay in diagnosis. Postoperative radiation decreases the risk of groin recurrence in patients, with multiple positive inguinofemoral lymph nodes. Here, we present a rare occurrence of clitoral carcinoma in a 30 yr old lady.

### I. Introduction

Squamous Cell Carcinoma (SCC) comprises of 90% of vulvar carcinomas. Mean age 60-74 years, rare in women younger than 30 years. The clinical impression is that localization of SCC on the clitoris may lead to worse prognosis. Risk factors include human papillomavirus (HPV), vulvar intraepithelial neoplasia (VIN), cervical intraepithelial neoplasia, lichen sclerosus, squamous hyperplasia, cigarette smoking, alcohol consumption, immunosuppression, a prior history of cervical cancer, and northern European ancestry.

They are of two types: Basaloid or warty types- occurring mostly in younger women, related to HPV infection, VIN, and cigarette smoking, and keratinizing, differentiated or simplex types, which tend to be unifocal, occurring mostly in older patient, non-HPV related associated with vulvar dystrophies. Commonest site is labia majora, followed by clitoris and labia minora. 20% metastasize to regional nodes; labial tumors to superficial inguinal nodes, clitoral tumors to deep inguinal nodes. Here, we present a rare occurrence of clitoral carcinoma in a 30 yr old lady.

### II. Case Report

A 30 yr old female presented to gynecology O.P.D, with chief complaint of **swelling** and itching in private part since 2 yrs. She has two female children, both delivered by caesarian section. The first child was 4 years, and the second was 2 years. The patient initially had a small swelling in the clitoris, for which she sought no medical advice due to awkwardness, and it gradually increased in size in 2 yrs. It was associated with pain and itching. The pain was relieved by taking analgesics. She had no significant past history.

On examination, the patient was afebrile, with BP-120/80 mmHg, PR-76/min, no pallor, icterus and edema. She had left inguinal lymph node enlargement. Abdomen was soft, bowel sound present, non tender. Per vaginal examination showed, irregular fungating growth in clitoris, approximately 4\*3\*2 cm, firm, did not bleed on touch.

Per rectal, there was no significant finding.

Her Hbg% was 10.9 g% , BT-1min 40 secs,CT-4 mins 30 secs,TRBC-4.42 lacs, MCV-7.3mm<sup>3</sup>,MCHC-31.4 g/dl, MCV-7.3mm<sup>3</sup>, Platelets-2.68 lacs, DLC-N<sub>43</sub> L<sub>43</sub>M<sub>8</sub>E<sub>2</sub>, ESR- 75 mmHg. No abnormality detected in Urine, and her LFT, and KFT were within normal limits. The Histopathology Specimen of Biopsy Clitoris showed Squamous cell carcinoma, well differentiated. Her cervical PAP Smear was negative for intraepithelial lesion of malignancy and showed, reactive cellular changes associated with inflammation. No abnormality was detected on Chest X Ray, and the Ultrasonography lower abdomen showed normal study.

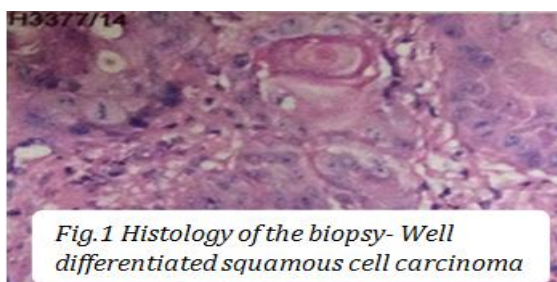
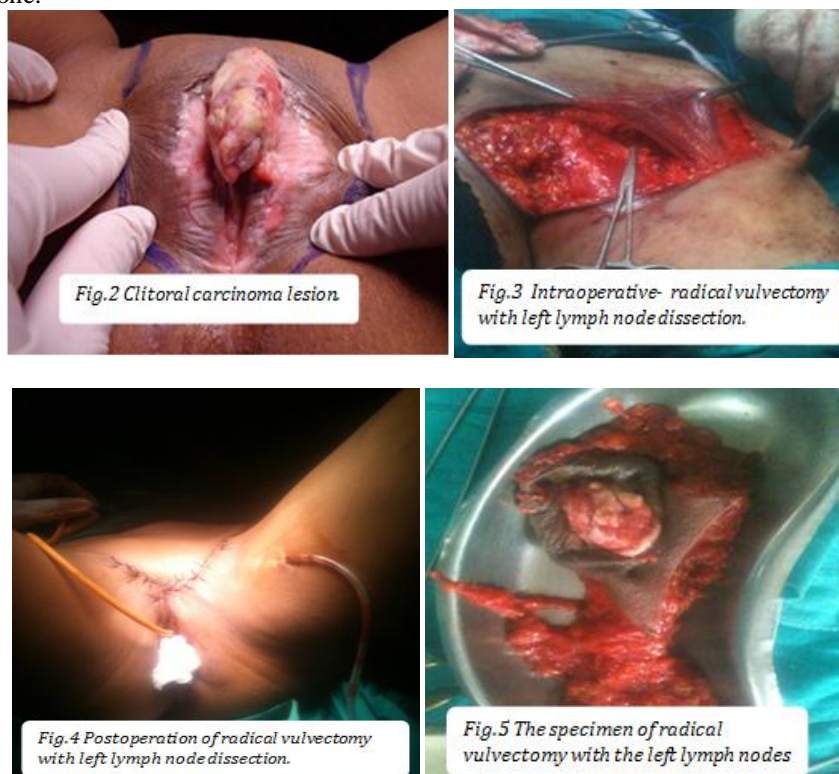


Fig.1 Histology of the biopsy- Well differentiated squamous cell carcinoma

After thorough discussion with the patient and her husband, Radical vulvectomy with left lymph node dissection was done.



Three cycles of chemotherapy, with 5 fluorouracil and cisplatin, at two months interval was administered, with follow up treatment from Gynecology and Radiotherapy department.

The patient responded well systematically and is healthy till date. She is still on follow up treatment 6 monthly, in gynecology and radiotherapy department, with no sign of recurrence.

### **III. Discussion**

The Vulvar cancer is usually diagnosed in later stages, due to ignorance of the symptoms by the patient, and due to embarrassment to divulge the personal details to a health provider. Due to follow up treatment with the basic investigations, and biopsy only as the last resort for diagnosis, valuable time is lost, because the cancer is growing masked by the seemingly normal investigation profiles.

Patients with clitoral SCC have worse prognosis compared to patients without clitoral involvement, which may be explained by the deeper invasiveness of the primary tumors resulting in more groin metastases and its central location, involving bilateral lymph nodes. Any suspicious lesion need to be biopsied early for good prognosis of the patient. In our case, our patient had already lost 2 years time due to reluctance to seek health care, and late biopsy.

Prior to the availability of combination chemotherapy, mortality was very high even for stage 1 disease. Introduction of combination chemotherapy with 5- Fluorouracil and cisplatin, has radically changed the mortality rate, and further increased the survival rate.

However, because of a high local recurrence rate of vulvar SCCs, close long-term follow-up is necessary.

### **IV. Conclusion**

Clitoral carcinoma is a rare tumor encountered in day today practice, even rarer in younger age group of patients. Management of such cases is a challenge for the surgeon due to late diagnosis, and lack of well-accepted protocol for management of such cases.

Religious, ethical and economic factor should be considered along with thorough discussion with the patient and her relatives regarding the risks and hazards of the disease, investigations and the treatment options available.

**Consent:** Well-informed written consent was taken from the patient for publication of her case as a case report.

**References**

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