E-ISSN 2250-0944
ISSN 2250-1150
doi: 10.31838/ijprt/16.01.190

Research Article

Vulvo-Vaginal Cancer Mimicking Prolapse Uterus: An Interesting/Thought-Provoking Case Report

Isha Dash[1], Mayuri Ahuja[2*], Neeharika Tiwari[3], HemKant Verm[4]

[1]PG 1st Yr Department of Obstetrics and Gynaecology Sharda School of Medical Sciences, Greater NOIDA, UP

[2*]Associate Professor Department of Obstetrics and Gynaecology Sharda School of Medical Sciences, Greater NOIDA, UP

[3]Post Graduate Department of Obstetrics and Gynaecology Sharda School of Medical Sciences, Greater NOIDA, UP

[4]Assistant Professor Department of Department of Surgery Sharda School of Medical Sciences, Greater NOIDA, UP

Corresponding Author: Mayuri Ahuja

Received: 11.02.26, Revised: 16.03.26, Accepted: 14.04.26

ABSTRACT:

Background: Differential diagnosis of a mass in the vagina includes genital and rectal prolapses, endocervical polyps, Gardner's cysts, cervical or /vaginal fibroids, and vaginal cancer. We present a rare case of vaginal cancer masquerading as uterine prolapse in an elderly woman and discuss its management based on a literature review.

Conclusion: Uterine prolapse in the elderly, particularly multiparous women, is often ignored as a common occurrence. However, its appearance can be deceptive of a squamous cell carcinoma of the vagina.

Keywords: Vaginal Cancer, Squamous Cell Carcinoma, Uterine Prolapse, Elderly Women, Irreducible Vaginal Mass, Vulvovaginal MalignancyProlapse Uterus, Vulvovaginal cancer, Case Report.

The Case

An 88-year-old multiparous womana (P9, L6, A3, all normal vaginal deliveryNVD)), with a history of Hypertensivehypertension, presented to our OPD with a one-year history of a mass descending through the vagina, associated with pain. She denied any vaginal bleeding or discharge. There was was no prior such history of such, sexually transmitted infections STIs, malignancy, or tuberculosis in the family. She was a vegetarian with no habits or addictions. Her bladder and bowel functions were normal, though she reported disturbed sleep.

Examination

patient was of thin build but with a good performance status for her age. She had mild pallor. The chest was clear with normal breath sounds, and cardiovascular examination showed normal heart sounds. aAbdominal examination revealed no tenderness, lumps, or organomegaly, and. bBowel sounds were normal.

Pelvic examination revealed an a unreducible prolapsing mass that was irreducible. A finger could be inserted between the prolapsed structure and the lateral vaginal wall for about a centimeter. The surface of the mass was irregular and verrucose, extending from 9 o'clock to 3 o'clock (Fig1). The urethral opening was spared, and . There was no inguinal lymphadenopathy was detected. On digital rectal examination, Palpatin per rectum revealed a normalthe rectal mucosa was normal, with no sign of any growth.

Investigations and Management Plan: (Laboratory)

Routine investigations were essentially normal. Urine culture showed growth of Proteus vulgaris. Sensitive to..... and. The chest x-ray showed no abnormalities.liquid-based cytology was inconclusive. could not make a diagnosis. A biopsy from the verrucose area confirmed clinched the diagnosis of Squamous cell carcinoma. Following After adiscussion with the oncologist, a contrast-enhanced MRI (CEMRI) of the abdomen and Pelvis was planned to assess resectability. . If the tumour werewas deemed found to beresectable, the proposed she would be taken up forsurgical plan included radical surgery includingcomprising 'Vvulvectomy with fascio-cutaneous flap reconstruction, with or without skin grafting, with bilateral inguinal lymph

node dissection, and, if necessary, with or without colostomy.'

However, the CEMRI pelvic showed that the growth was locally advanced and had a considerable risk for primary resection. Therefore, in the tumor board meeting it was decided to treat her with radiotherapy, followed by chemotherapy and then reassessment for resectability for surgery.

DISCUSSION

Vulvo vaginal cancers, although rare, can sometimes present with symptoms that mimic symptoms of a prolapsed uterusprolapse, as in the present case. ,Such presentations can leadinglead to potential misdiagnosis or delays in ed diagnosistreatment, particularly in elderly patients, where prolapse is more common. . The key differences from prolapse are the tumour's typical location, irregular or verrucous surface, appearance, and associated symptoms ofsuch as pain, bleeding, or pruritus. itching.Unlike benign prolapse, the mass is often irreducible. Careful palpation may reveal abnormal tissue characteristics.

Verrucous carcinoma of the vulva is a rare type of cancer that accounts for less than 1% of vulvar cancers. It is characterized by its extensive exophytic growth without infiltration of the basement membrane, and its progression is uncertain and unpredictable.

Verrucous carcinoma typically affects postmenopausal women over 60 years old. - Symptoms may include a slow-growing, exophytic lesion on the vulva, often with a cauliflower-like appearance. The lesion may be painful or itchy, and may bleed occasionally. Verrucous carcinoma is a type of squamous cell carcinoma, accounting for a small percentage of vulvar cancers. It is classified as a distinct entity due to its unique histological and clinical features. The International Federation of Gynecology and Obstetrics (FIGO) staging system is used to stage vulvar cancer, including verrucous carcinoma. Wide excision with a centimetric margin is the primary treatment for verrucous carcinoma of the vulva. Lymphadenectomy is not typically recommended due to the low risk of lymph node metastasis. Radiation therapy is not recommended for verrucous carcinoma, as it may not provide any survival benefit and can potentially worsen the disease. Regular followup is essential to monitor for local recurrences, with clinical examination of the vulva, perineum, and lymph node areas every 4-6 months. The prognosis for verrucous carcinoma of the vulva is generally good, with a low risk of metastasis. However, local recurrences can occur, and regular follow-up is necessary to detect and manage these recurrences promptly.

Early detection through clinical suspicion and prompt and biopsy confirmation are is essential for accurate diagnosis. effective surgical treatment.

Imaging modalities, such as contrast MRI, play a critical role in assessing tumour extent and planning surgical intervention. The mainstay of treatment for localized vulvovaginal squamous cell carcinoma is radical surgery, which may include vulvectomy, reconstruction with fascio-cutaneous flaps, and bilateral inguinal lymph node dissection. Multidisciplinary management involving gynaecologic oncologists, radiologists, and reconstructive surgeons optimizes outcomes.

Although vulvovaginal cancers are uncommon, case reports highlight the importance of considering malignancy in elderly women presenting with presumed prolapse, particularly when features such as an irregular, verrucous, or irreducible mass are present. Timely intervention can significantly improve prognosis and quality of life.

Conclusion: Uterine prolapse in elderly, multiparous women is often considered a common, benign condition. However, its presentation can occasionally mask underlying vaginal squamous cell carcinoma. Careful examination and timely biopsy are essential to avoid misdiagnosis and ensure appropriate management.

REFERENCES

1. N., S., & Mallarapu, A. (2025). Unveiling the hidden malignancy: primary vaginal squamous cell carcinoma in longstanding third-degree uterovaginal prolapse rare case report. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*,*14*(8), 2804–2807.
2. Pardal C, Correia C, Serrano P. Carcinoma of the cervix complicating a genital prolapse. BMJ Case Rep. 2015 May 24;2015
3. Wang Y, Li Q, Du H, Lv S, Liu H. Uterine prolapse complicated by vaginal cancer: a case report and literature review. Gynecol Obstet Invest. 2014;77(2):141-4.
4. Kim HG, Song YJ, Na YJ, Choi OH. A case of vaginal cancer with uterine prolapse. J Menopausal Med. 2013 Dec;19(3):139-42.

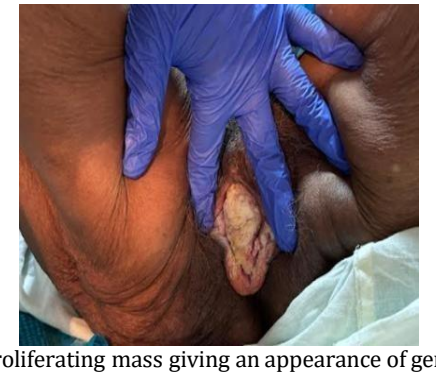

Fig1: Proliferating mass giving an appearance of genital prolapse

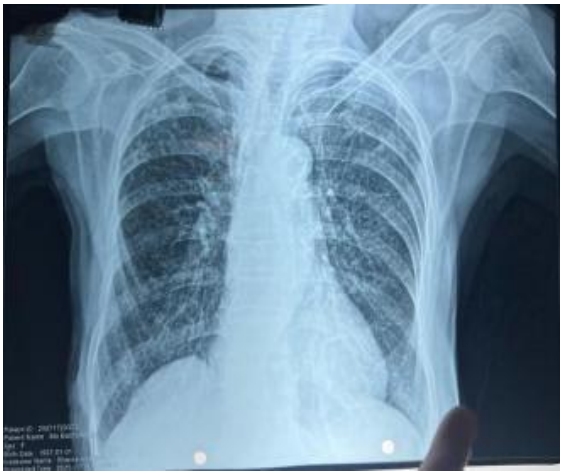

Fig 2: Chest Xray- P/A View Showing Normal Bony Cage, Lung Field and Cardiac Shadow

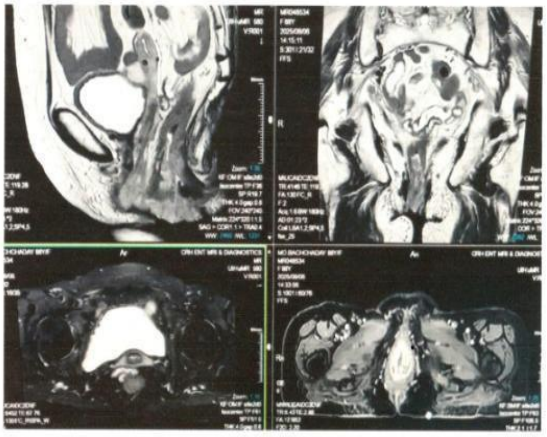

Fig3: CE- MRI of Pelvis: B/L Atrophic Ovaries. Lobulated Solid Mass. Vulva and Introitus 6x2x2 cm, locally advanced: B/L Sub-centric inguinal nodes.