Case report: A rare and uncommon presentation of Anal SCC presenting in gynaecology clinic as vaginal lump

Author(s):Dr Reza Md Zakaria (Presenting Author), Mr Islam Abdelrahman, Dr Roopam Goel, Dr Nandini Halder, Dr Hashim Samir

Department of Obstetrics and Gynaecology, Glangwili General Hospital, Hywel Dda University health Board

CASE REPORT

A 45 year old otherwise fit and healthy lady was referred to the gynaecologists in GGH Hospital by GP with complaints of pain and difficulty during sexual intercourse and a lump inside the vagina which was noticed by her partner. She was reviewed by a Gynaecologist in clinic and a 3x2.5 cm cystic lump was noticed in lower end of vagina. As the Gynaecologist was not sure about the origin and nature of lump a second opinion was asked from another colleague and an MRI was requested. She was reviewed later on by the both gynaecologists and they proceed with an attempt at aspiration of the cystic lump but no fluid was obtained. The MRI also did not comment anything about the lower vaginal lump. In the mean time she attended her GP with complaint of fresh PR bleeding and the GP found hard plaque like lesion in rectum during PR. She was referred to the colorectal surgeon under USC pathway and they found a hard area at the lower rectum around 2-3 cm from the anal verge. An urgent colonoscopy along with tumour markers were requested.

At colonoscopy a lesion at 2cm was discovered and this was approximately 4cm in diameter, the biopsy showed a well differentiated squamous cell carcinoma . She was referred to Anal MDT and after EUA, CT, MRI and PET CT the conclusion was that she has T4N1MO squamous cell carcinoma of anus. As per the MDT plan she had de functioning stoma formation and a full course of chemo radiotherapy (radiotherapy 50.4Gy in 28 fractions concurrent with Mitomycin and Capectabine). She had a CT & MRI six weeks post-treatment and it showed complete regression of tumour. She is now being regularly followed up by the surgical as well as oncology team and will have a reversal of stoma at a later date.

DISCUSSION

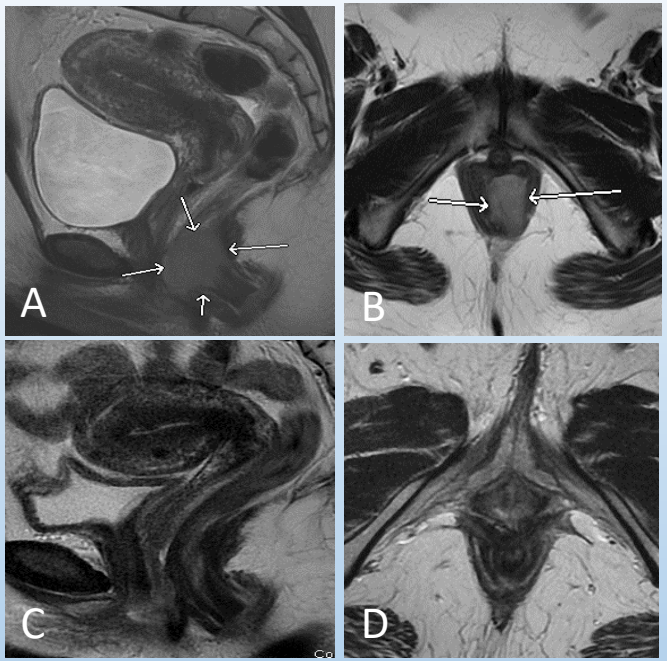
The most common causes for Vaginal lumps are vaginal cysts, Gartner duct cyst, Varicosities, prolapse, Malignancy etc. Very rarely they could be due to metastasis or direct invasion from colorectal or anal malignancies.

80% of vaginal malignancy are due to secondary vaginal cancer rather than the primary one. Most of these Secondary vaginal cancers are either due to local extension from gynaecological malignancies such as cervical or vulvar cancer or due to local invasion or metastasis from anal or colorectal cancer. Other reported sites of origin include the breasts and kidneys. It is important to know for evaluating a vaginal mass is that, most of secondary vaginal carcinoma in the upper-third and anterior wall arise from the upper genital tract. On the other hand the majority of those in the lower-third and posterior vaginal wall usually arise from the gastrointestinal tract. Immunohistochemistry (CK7 and CK20) is a very reliable tool to establish the origin of the vaginal secondary malignancies. The tissues in the lungs, breasts and vagina usually has CK7 but CK7 is usually absent in the colon, whereas CK20 is almost exclusively present in the gastrointestinal tract.

The most common presenting symptoms of patients with anal cancer are usually rectal pain, rectal bleeding , sensation of a rectal mass , complaint of haemorrhoids, weight loss, change in stool calibre , constipation, Pruritus, anal discharge and faecal incontinence. But in advanced stage patients may also present with vaginal or perineal lump, PV bleeding or inguinal lymphadenopathy.
The physical examination usually involves the external examination of the anal margin and perianal skin, PR examination, proctoscopy, palpation of the abdomen for any mass and groin for enlarged inguinal nodes. A pelvic examination is done to assess for vaginal wall involvement. Examination under anaesthesia is usually necessary to obtain a tissue diagnosis. Patients then undergo investigations to determine the stage and are referred for anorectal MDT for further management planning.

LEARNING POINTS

- Anorectal malignancy should be considered as a differential in patients who present with a vaginal lump.
- A history about anorectal symptoms should be taken and an anorectal examination should be performed if appropriate.
- MRI scanning is an effective imaging modality to ascertain the diagnosis.



A & B : The initial MRI shows a small mass bridging the anterior wall of rectum and the posterior wall of vagina (arrows) on the sagittal and axial HR T2W. C & D HR T2W coronal and axial show complete resolution after chemo-radiotherapy .

1. Martin FT, Kavanagh D, Waldron R. Squamous cell carcinoma of the anal canal. Surgeon. 2009;7(4):232–37. [PubMed] [Google Scholar]
2. Creasman WT, Phillips JL, Menck HR. The National Cancer Data Base report on cancer of the vagina. *Cancer* 1998; [PubMed] [CrossRef] [Google Scholar]