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Triple female genital tract cancer—a rare case report of a patient with cervical, vaginal and vulvar cancer

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Background Cervical cancer is responsible for a good proportion of female cancer deaths in the developing world. Cervical cancerrelated deaths in the developed world are declining due to the well-established cervical screening programme. The resource limitation in screening and early detection in developing countries results in advanced cervical cancer cases. Cervical, vaginal and vulvar cancers have high-risk human papillomavirus (HPV) in common. Vaginal and vulvar cancers are rare female genital cancers and peak after 70 years of age. Half of the vaginal or vulvar cancers in young women are linked to high-grade HPV infection. Regular colposcopy and vulvoscopy in high-risk cases would identify early premalignant changes and would minimise the cancer cases. In future, HPV-related genital tract cancer is preventable with HPV vaccination and early screening.

Case We present a case history of a 49-year-old, mother of five, with cervical, vaginal and vulvar carcinoma. At the age of 42, she had irregular vaginal bleeding and was diagnosed to have moderately differentiated squamous cell carcinoma of cervix (FIGO stage II B) and underwent chemo-radiation. She was on regular oncology follow-up. Four years later, she developed pruritus vulvae and was investigated. Computed tomgraphy scan (abdomen–pelvis) revealed thickened vaginal wall. On examination under anaesthesia, stenosed vagina was seen with no obvious vaginal growths. Rectal mucosa was free. Her vulvoscopy showed depigmented erythematous area in both labia minora with diffuse positivity on visual inspection with acetic acid (VIA) with thickened vulvar skin. Biopsy from both vagina and labia minora revealed moderately differentiated squamous cell carcinoma in a background of high-grade vaginal intraepithelial neoplasia with lymphatic invasion. A multidisciplinary meeting was arranged and suggested for vulvectomy and nodal clearance. She underwent vulvectomy and inguinal nodal clearance. As nodes were positive with vaginal involvement, she was offered chemo-radiation and is currently on follow-up.

Conclusion The cervical screening programme (Papanicolaou smear) does not have full coverage in Sri Lanka. There is no recall system and doubtful cases offered VIA/colposcopy assessment. HPV testing is not possible in general. In Sri Lanka, most of the cervical cancers present in advanced stages which need chemoradiation.

Follow-up in oncology clinics is arranged with regular clinical assessment. Doubtful cases are often offered radiological assessment. This case, a patient with triple cancer involvement within 6 years of initial cervical cancer diagnosis, indicates the importance of establishing a well-organised cervical cancer screening programme in SriLanka