Primary adenocarcinoma of Bartholin's gland: A case report

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Summary

Up to now, about 300 primary adenocarcinoma carcinomas of Bartholin's gland have been reported in the literature. A new case of a 57-year-old woman with primary carcinoma of Bartholin's gland is reported. The patient underwent radical vulvectomy and has been healthy for 18 months.

Key words: Bartholin's gland; Adenocarcinoma.

Introduction

Primary carcinoma of Bartholin's gland is very rare. To date, only about 300 cases have been reported [1]. The incidence has been reported as 0.02-0.1 per 100,000 women/year. Primary adenocarcinoma of the Bartholin's gland occurs in 0.1% of all genital malignancies and 2-7% of all vulvar carcinomas [2, 3]. Because of its rarity, individual experience with the tumor is limited, and recommendations for management must be based on a review of the small published series [1, 4]. We report a new case of Bartholin's gland adenocarcinoma with the aim of contributing to the literature.

Case Report

A 57-year-old woman was admitted to our hospital with complaints of a painful mass in the left side of her vulva for approximately six months. On pelvic examination, there was a painful, irregular, partially solid mass in the region of the left Bartholin's gland in the posterior of the left labium majora, measuring 2 x 2 cm in diameter. The skin on the tumoral mass was normal in appearance. The inguinal lymph nodes were not enlarged. Other findings of the genital examination were normal. There was no pathologic finding on the ultrasonographic examination of the abdomen and pelvis. Abdominopelvic computerized tomography (CT) findings were normal. Her chest X-ray findings were also normal as were routine blood examination findings. Of tumor markers, CA-125, CA19-9 and CEA levels were normal. The vulvar mass was excised totally as is done for Bartholin's cysts under local anesthesia.

At gross pathologic examination, corresponding with the site of the Bartholin's gland in the left vulva, an irregular, white colored nodular tumoral mass measuring 2 x 2 x 1.5 cm in diameter was found. Microscopically, abortive adenoid structures and cords of atypic cells in fibroadipous tissue were observed. Non neoplastic glandular structures were entrapped in the tumoral tissue. Tumor cells had hyperchromatic nüclei and pale eosinophilic cytoplasm. There were rare mitotic figures in the tumor areas. Tumor cells stained positively with cytokeratin immunohistochemically. The overlying skin of the tumoral mass was intact. According to these findings, the patient was diagnosed with poorly differentiated adenocarcinoma of the Bartholin's gland (Figure 1). Consequently radical vulvectomy was performed.

Discussion

Classification of a vulvar tumor such as a Bartholin's gland carcinoma has typically required fulfillment of Honan's criteria: 1) The tumor is in the correct anatomic position; 2) The tumor is located deep in the labium majus; 3) The overlying skin is intact; 4) There are some recognizable normal glands [1, 5]. In our case, physical examination findings, anatomic location and histopathologic findings of the tumor were suitable with Bartholin's gland carcinoma.

Adenocarcinomas account for approximately 40% of Bartholin's gland carcinomas; other types include squamous cell carcinoma (40%), adenoid cystic carcinoma (15%), transitional cell carcinoma (less than 5%) and poorly differentiated adenocarcinomas [1, 2]. Adenocarcinomas of Bartholin's gland are usually non-specific in type, but mucinous and papillary forms have been described. The differential diagnosis of adenocarcinoma of Bartholin's gland includes adenocarcinoma of a skin appendage and metastatic adenocarcinoma. These tumors do not typically involve the gland and the tumor type may not be consistent with a primary tumor of the Bartholin's gland [2]. In the case presented, a greater part of the Bartholin's gland contained tumoral properties.

Traditionally, treatment has been radical vulvectomy with bilateral groin and pelvic node dissection. However, there seems to be no indication for dissection of the pelvic nodes in the absence of positive groin nodes, and good results have been reported with hemivulvectomy or radical local excision of the primary tumor [1]. In the case presented, we performed radical vulvectomy and since there was no inguinal or pelvic lymph node enlargement, lymph node dissection was not done.

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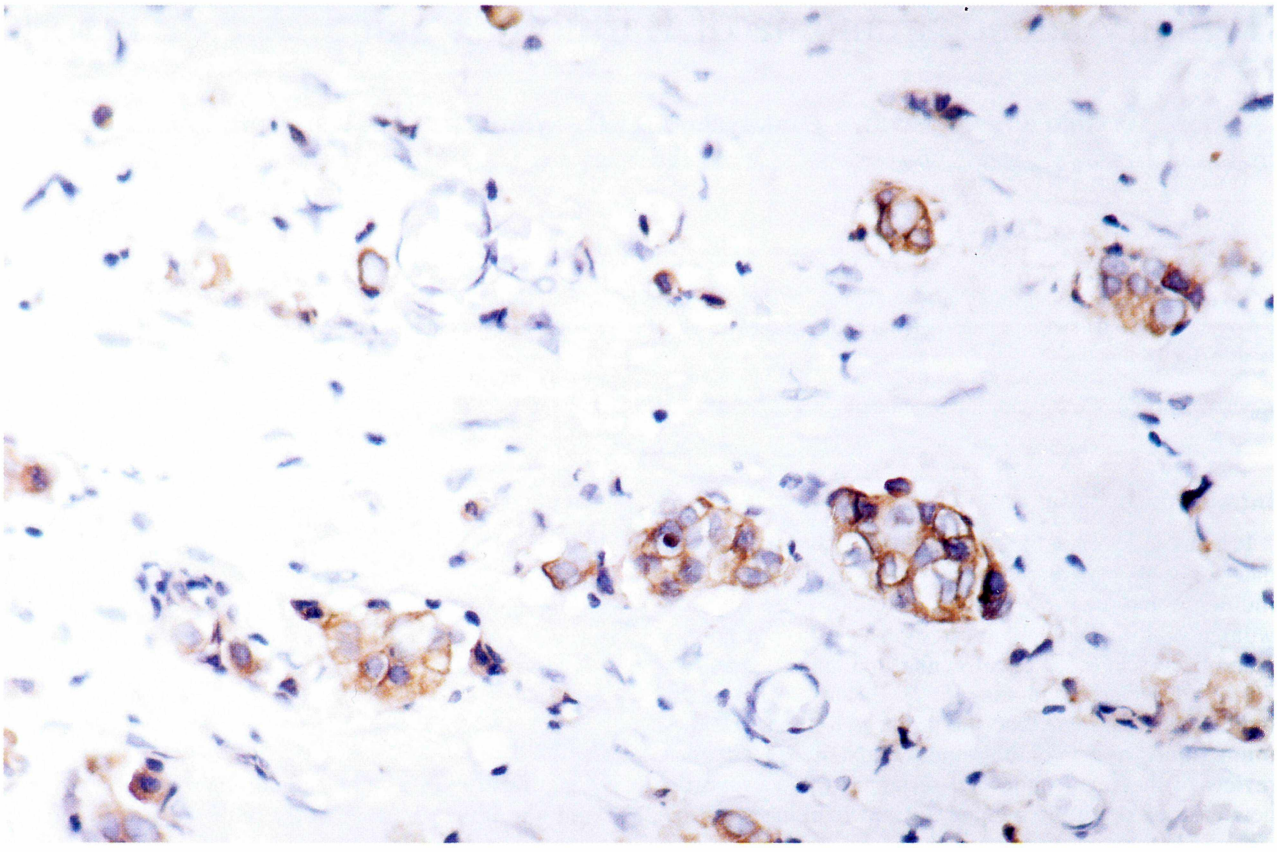

Figure 1. — Microscopic appearance of positive-stained cytokeratin tumor cells arranged in an abortive glandular pattern in hypocellular connective tissue. Immunohistochemical expression of cytokeratin (x 400).

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