Vaginal fibroma. Case Report

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Summary

A case of a vaginal fibroma in a 50-year-old woman is presented. The tumor presented as a solid mass in the upper third of the anterior vaginal wall. Intravenous pyelography (IVP) and cystoscopy excluded any association of the mass with the urinary tract. Surgical excision of the tumor was easily accomplished and histopathological examination established the diagnosis of a fibroid tumor of the vagina.

Key words: Fibroma; Vagina; Tumor; Differential diagnosis.

Introduction

Vaginal fibromas compose a rare entity of solid tumors, as evidenced by the sparse number of cases reported in the literature [1,2]. They originate from the mesenchyma and the majority of them are benign. They were originally described in the pleura [3], but they have been known to occur in other sites, such as the liver, kidney, prostate, urinary bladder, respiratory tract, central nervous system, periosteum and soft tissue [4].

We describe a case of vaginal fibroma and review its management and characteristic components.

Case Report

A 50-year-old woman presented to our hospital complaining of mild pain in the lower abdominal region. Moreover, when she resumed sexual activity she experienced significant dyspareunia. There was no associated stress incontinence, but she experienced some tenderness in the vagina during coughing. A cervical smear test three years before had been negative. She was a non-smoker and was neither hypertensive nor hyperglycaemic. The past medical history was non-contributory. The physical examination was negative apart from pelvic findings. The vulva was normal, but on the anterior wall of the upper third of the vagina a firm non-tender mass was observed. The rest of the pelvic examination disclosed a normal cervix and a slightly enlarged uterine corpus. The adnexa were not palpable. An ultrasound scan revealed an enlarged uterus with a 30-mm leiomyoma in its major diameter and normal ovaries. An intravenous pyelography (IVP) and a cystoscopy excluded a possible relation of the mass to the urinary tract. The full blood count, glucose, urea, electrolytes and urinalysis were normal. Under general anesthesia, the patient underwent excision of the mass through a longitudinal incision into the anterior vaginal wall. The mass was shelled out without difficulty and measured 4 cm in diameter. The vaginal wall was closed with No 2-0 interrupted chromic catgut. A tampon in the vagina and a Foley catheter were left in place. They were both removed 24 hours later. The patient made an uneventful recovery and was discharged on the third postoperative day. Histopathological examination of the mass disclosed a whitish-colored tumor which was composed of fibroblasts and compatible with a vaginal fibroma (Figure 1).

Discussion

Only a few cases of vaginal fibromas have been reported up to now [1, 2]. Because of the variety in size and location of these tumors they may be confused with much more common gynecologic lesions. Thus it is important that these cases be appropriately reported. Usually, they are asymptomatic but under certain circumstances, such as enlarged size and anatomic location, they may cause a sensation of pressure, obstruction of the urethra, vaginal bleeding or dyspareunia. The differential diagnosis must include cystocele, urethrocele, urethral diverticulum, rectocele, inclusion cysts, mesonephric duct remnants (Gartner's duct cyst) and benign or malignant vaginal tumors of different origin. In a previous report the preoperative diagnosis was that of an abscess of Skene's gland [1].

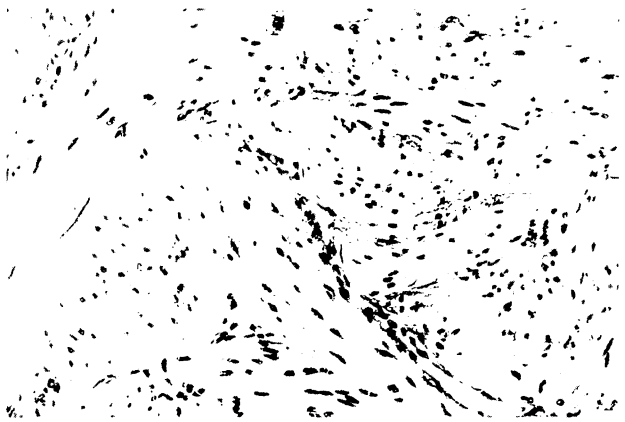

Figure 1. — Microscopic appearance of the fibroma.

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Vaginal fibroma is a well-circumscribed solid tumor. Fibromas are composed of fibroblasts that differ from leiomyomas in that they have more elongated and wavy nuclei with pointed ends. The cells of fibromas are smaller, and the intercellular substance contains abundant collagen fibers. Neurofibromas resemble fibromas but contain serpentine cytoplasmic processes. Moreover, the spindle cells of neurofibromas are S-100 positive. The term "patternless" has been used to describe the most common microscopic picture of fibromas, which means that some of them may be hypocellular or hypercellular or both, and others may show hypocellular-like areas bordering dermatofibrosarcoma protuberant-like zones. The second common microscopic picture is the "hemangiopericytoma-like" where the lesional cells are densest around branching blood vessels. Immunohistochemical studies of fibromas have documented positive reactivity for CD-34, CD-99 and bcl-2 oncoprotein [5,6 , 7].

Almost all fibromas are benign and complete local excision is curative. Atypical and malignant variants are rare and have been reported in thoracic and extrathoracic locations [8]. The histological features that are presented in these variants included high cellularity, increased mitotic activity, nuclear pleomorphism and necrosis.

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