

## Fibroepithelial polyp of vestibule of vulva in periurethral area: A case reported

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### Abstract:

Fibroepithelial stromal polyps are site-specific mesenchymal lesions that typically occur in skin creases, oral cavity, urinary tract and genital areas. Genital presentation in women has a greater predilection for the vulvovaginal region and rarely the cervix. Cases of fibroepithelial polyp in vulvovagina have been rarely reported and usually they do not grow larger than 5cm in diameter. We report a case of 25 year old woman who presented with 7.5x4 cm sized mass overlying the vestibule of vulva near the external urethral meatus without urethral communication. She was successfully treated by wide local excision and reconstruction of urethra

**Key words:** Neoplasm, Fibroepithelial, vulva

### Introduction:

Fibroepithelial polyps of the vagina (FEPV) are mucosal polypoid lesions with a connective tissue core covered by a benign squamous epithelium.<sup>1</sup>

The estimated prevalence of fibroepithelial polyp is 1.2%.<sup>2</sup> The skin and genitourinary tract are common sites for fibroepithelial polyps. FEPs of the lower genital tract often develop in young to middle-aged women and present more commonly in the vagina. They are less common in the vulva and are rarely present in the cervix.<sup>3</sup> Although FEP of the lower female genital tract have been well-recognized since their initial description, they still cause diagnostic difficulties mainly owing to their variable histological appearances rarity.<sup>4</sup> These lesions, apart from being uncommon, have overlapping morphological features with other mesenchymal features specific to the vulvo-vaginal area. These lesions include angiomyofibroblastoma, aggressive angio myxoma, and cellular angiofibroma. Other lesions that can morphologically mimic FEP are leiomyomas, superficial angiofibroma, perineuromas and neurofibromas.<sup>5</sup> The pathogenesis

of FEP is unknown<sup>6,7</sup>. We reported a case involving a FEP of vestibule of vulva.

### Case Report:

A 25 year old, nulliparous, presented through OPD on 21/3/2015 with complained of something coming of vagina since four months. The lump was increasing in size over the course of four month until its current size of presentation. She felt so embarrassed and afraid to report this problem and was forced to present for evaluation because her social and sexual quality of life was suffering with this burdensome size and awful smell. It was irreducible with no relation to posture change and prolong work. There was associated perineal discomfort, heaviness and vaginal discharge. Vaginal discharge was yellow in color, containing pus, copious in amount and with stinging and hurtful smell. The patient also complained of urinary urgency, dysuria and frequency but no history of retention or stress incontinence. She had regular menstrual cycle 4 – 5 / 30 days with moderate flow. There was no significant medical or surgical history. She was Sexually inactive for about 4 month and was a non-smoker and denied alcohol or drug use. Her

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physical examination was remarkable only for a 7.5x4 cm, ovoid, rubbery, non-tender mass with large area of ulceration and superficial necrosis in the overlying mucosa with pussy discharge. It has a broad pedicle anteriorly attached to vestibule of vulva near left periurethral area, displacing the external meatus. The posterior vaginal wall, cervix and uterus was seen healthy. There was no increase in the size of the mass with Valsalva. She reported to address the growth at Civil Hospital Karachi two months back, where examination under anesthesia was done and mass was biopsied, which revealed fibro epithelial polyp with overlying squamous epithelium. She was referred to Sindh Institute of Urology from Civil Hospital for further evaluation and surgical management as mass was close to urethra and distorted the normal anatomy. Patient left against medical advice from there and reported at Jinnah Medical College Hospital. After admission intravenous antibiotic were given and surgical management done on 24/3/2015 in conjunction with urological team. Her examination under anaesthesia showed Urethral orifice was grossly edematous, slit like and shifted to right, urethral catheter was passed with great difficulty. She proceeded and the mass was separated by sharp dissection from vestibule, meatus and urethra. Wound was closed with vicryl suture 0 material. Reconstruction of external urethral meatus done with 3/0 vicryl suture material, homeostasis secured. She was remained in ward for 14 days. Her post-op period was uneventful except some dribbling of urine while straining. She was catheterized for 14 day, catheter was removed and patient discharged with wound healing satisfactory. She came up for follow-up at three weeks with pathology report returned as a fibroepithelial stromal polyp. Her urinary symptoms of incontinence was much improved and vulva was noted to be healing well. At six weeks follow-up, she was quite happy with no urinary complain. After follow-up of four month (to date of operation), the patient has shown no evidence of recurrence. She was advised to follow-up for continued surveillance because of chance of recurrence Fibroepithelial tumour.

#### **Discussion:**

In this case report we present a case of 25 year old female presenting with a mass in genital area. The site and macroscopic appearance were rather not unusual and the case was diagnosed as a benign fibroepithelial stromal polyp. These polypoid exophytic tumor growth arises from proliferation of mesenchymal cells within the hormone sensitive sub epithelial stromal layer of the lower genital tract in females of reproductive age<sup>8,9</sup>. Symptoms include bleeding, discharge and discomfort. Usually the margins are unidentifiable as they merge with the normal tissue.<sup>10</sup> Another recently published report described a similar clinical presentation in a 21 year old female, giant fibroepithelial polyp, size of 18.5cm in largest diameter with vascular supply was thick-walled vessel with central core.<sup>11</sup> FEPs of the female genital tract are benign lesions but they are often misdiagnosed as malignant. The polyps are sessile or pedunculated and have a hypercellular stroma and may exhibit increased mitoses and bizarre cytomorphology.<sup>12</sup> Microscopic evaluation of the lesion in this case revealed connective tissue core covered by benign squamous epithelium. The stroma contained chronic inflammatory cells. Recurrence is extremely uncommon.<sup>13</sup> Although the recurrence after incomplete excision has been reported.<sup>13</sup>

**Consent :** Consent to publish the images in this paper has been obtained from the patient. Gross appearance of mass at three weeks follow up.

#### **Contribution and role of authors:**

Dr Asha Mahesh, Head of the department, Jinnah Medical College Hospital, Karachi. She wrote preliminary case report and she was also 1st assistant performing the surgery and proof reader.

Dr Sheena Memon, Assistant Professor, Jinnah Medical College Hospital, Karachi. she contributed in writing of the case report and collecting the data and references.

Dr Mumtazuddin Haider, Head of Urology and Surgery, Jinnah Medical College Hospital Karachi. He operated the case and did proof reading.



Dr Atifa Afsheen Sharique, Assistant professor Jinnah medical college hospital Karachi. she help in write-up of the case report and help in data collection and writing of the discussion.

**Conflict of Interest:** none

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