Case Report

Lymphangiectasia follows traumatic ulcer of the vulva - A rare coincidence: Case report

Usha Kataria[1*], Dinesh Chhillar[2]

[1]Assistant Professor, Department of Dermatology, BPS Govt. Medical College for Women, Sonepat, Haryana, India
[2]Resident, Department of Forensic Medicine, Pt. BDS. PGIMS, Rohtak, India
[*]Corresponding author email: **ushachillar@gmail.com**

International Archives of Integrated Medicine, Vol. 2, Issue 9, September, 2015.

Available online at http://iaimjournal.com/
ISSN: 2394-0026 (P) **ISSN: 2394-0034 (O)**
Received on: 17-08-2015 **Accepted on:** 25-08-2015
Source of support: Nil **Conflict of interest:** None declared.

Abstract

A 40 years old woman, presented with vulvar itching associated with warty lesions appeared after a trauma to vulvar region few months back. She gave history of fall on a sharp object and developed those lesions while working as a labourer. She was diagnosed as a case of Lymphangiectasia of vulva. It was a rare coincidence, so we are reporting this case.

Key words

Lymphangiectasia, Vulva, Trauma, Ulcer.

Introduction

Lymphangiectasia is a pathological dilatation of lymphatic vessels. Vulvar involvement is uncommon and it may mimic genital warts, molluscum contagiosum or cutaneous tuberculosis verrucosum. They are a consequence of buildup of lymph in the superficial vessels following damage to deep lymphatics. They can be a late sequel of radical mastectomy, radiation therapy, lymphogranuloma venereum or Scrofuloderma [1, 2]. They typically present in adults as numerous fluid filled vesicles in a chronic lymphedematous area accompanied by oozing of a clear or milky fluid from ruptured vesicles [3]. Lesions may have a verrucous surface.

Case report

A 40 years old woman, who was labourer by occupation, presented with vulvar itching, swelling and ulceration over the genitalia. She gave history of fall over the sharp object and got ulceration over the vulvar region. There was no history suggestive of sexually transmitted diseases, filariasis, tuberculosis, crohn's disease or any pelvic radiation or surgery. Clinical

examination revealed a diffuse induration with verrucous appearance of both labia majora and non tender ulceration over the lower side of vulva. (**Figure – 1**) There were papulo-vescicular lesions present over the Mons pubis and labia majora. (**Figure – 2**) There was no inguinal lymphadenopathy. Histological examination revealed presence of multiple dilated lymphatic vessels in the papillary dermis. The diagnosis of vulvar lymphangiectasia was made. The test for tuberculosis and sexually transmitted disease especially lymphogranuloma venereum were negative. Ultrasound of abdomen revealed large polymyomatous uterus with multiple fibroids of various sizes. There was no other obvious cause, so we considered that this benign pelvic tumour was the cause of impaired lymph flow inducing lymphangiectasia. Patient was referred to Gynecology Department for hysterectomy but patient didn't turn up and operation was not done. Other routine laboratory investigations were normal and her family was complete. We report here an original case of vulvar Lymphangiectasia following trauma to the vulva, which was a coincidence. Patient correlated this with the trauma, although the etiology was large polymyomatous uterus.

Figure - 1: Ulceration over the lower side of vulva.

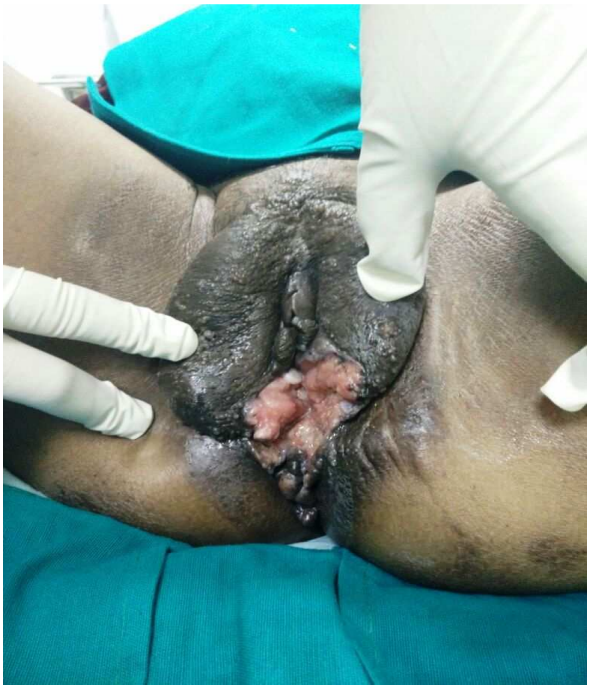
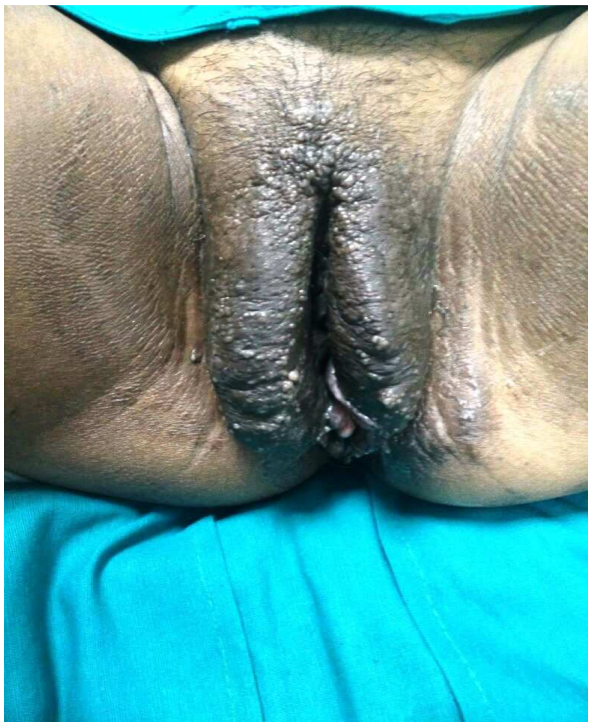


Figure - 2: Papulo-vescicular lesions present over the Mons pubis and labia majora.



Discussion

Lymphangiectasia is also called acquired lymphangioma circumscriptum (LC). Requena, et al. considered that this disorder results from obstruction of previously normal lymphatics, unlike congenital LC in which dilated superficial lymphatics are a consequence of transmitted pressure from a congenital malformation of deep dermal lymphatics [4].

Clinical and histological findings of Lymphangiectasia and congenital LC of the vulva are very similar. However, history of congenital or early onset of the disease and the presence of deeper lymphatics abnormalities in reticular dermis on histopathology are suggestive of congenital LC [5].

For our patient, late onset of the disease and absence of deep lymphatic extension on histopathological examination and on abdominal-pelvic ultrasound were suggestive of Lymphangiectasia of vulva. Previously, such case was reported post-radiation therapy of

carcinoma cervix uteri. Other predisposing conditions reported were crohn's disease, urogenital tuberculosis and radical pelvic surgery [6].

In all these cases, Lymphangiectasia was induced by obstruction of previous normal lymphatics. In our case, the large uterine myomas were the probable cause of impaired lymph flow producing Lymphangiectasia. Malignant transformation of congenital LC has been reported in some cases [7]. These complications have never been reported with Lymphangiectasia. Nevertheless, a close follow up of the patient with vulvar Lymphangiectasia is advisable.

There is no consensus about the treatment of Lymphangiectasia. Treatment must provide a good cosmetic result, prevent recurrence and prevent infection. After surgical removal there is chance of recurrence. Other treatment options include laser therapy, sclerotherapy, cryotherapy and electro-coagulation. CO2 laser ablation is generally well tolerated and it represents the main alternative to surgery [5].

Conclusion

Monitoring of such patients is important to check the malignant transformation and relapse.

References

1. Schwab RA, McCollough ML. Acquired progressive lymphangiomas. A sequel of radiation therapy. Cutis, 2001; 67: 239-40.
2. Mendiratta V, Harjai B, Serdana K. Tubercular lymphadenitis with lymphangiectases of the vulva. J Eur Acad Dermatol Venereol., 2005; 19: 264-5.
3. Moon SE, Youn JI, Lee YS. Acquired Cutaneous lymphangiectasia. Br J Dermatol.,1993; 129: 193-5.
4. Requena L, Sangueza OP. Cutaneous vascular anomalies. Part I. Hamartomas, malformations, and dilatation of preexisting vessels. J Am Acad Dermatol., 1997; 37: 523-49.
5. Huilgol SC, Neill S, Barlow RJ. Laser ablation of vulval lymphangiectasia and lymphangioma. Dermatol Surg., 2002; 28: 575-7.
6. Vlastos AT, Malpica A, Follen M. Lymphangioma circumscriptum of the vulva: A review of the literature. Obstet Gynecol., 2003; 101: 946-54.
7. King DT, Duffy DM, Hirose FM, Gurevitch AW. Lymphangiosarcoma arising from lymphangioma circumscriptum. Arch Dermatol., 1979; 115: 969-72.