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LETTER TO THE EDITOR

A huge acrochordon in labia majora- An unusual presentation

Acrochordons are flesh-colored pedunculated lesions which occur in areas of skin folds[1].These lesions are benign but may be associated with other disease states. Acrochordons were reported to have a probable association with diabetes mellitus[2]. Neck and axilla are the most common sites but any skin fold, including the groin may be affected[3]. Most acrochordons vary in size from 2 to 5 mm in diameter, although larger acrochordons up to 5 cm are sometimes evident[3]. Acrochordon is common in elderly and distinctly uncommon in childhood[4]. In one study 120 female patients were studied with non venereal dermatoses of external genitalia, among them only 2 were acrochordon[5]. Although this is a common tumour it is reported for its unusual size and site.

A 45 years well controlled hypertensive lady attended the surgery department, Shaheed Suhrawardy Medical College & Hospital on 19th March 2009 with a big swelling in her vulva for the last one and half year associated with dragging pain. Local examination revealed a huge lump, about 12x5 cm hanging from the right side of labia majora.fig1 a,b,c.

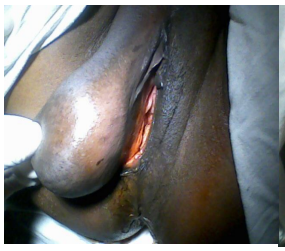

Fig. 1(a)

Fig. 1(b)

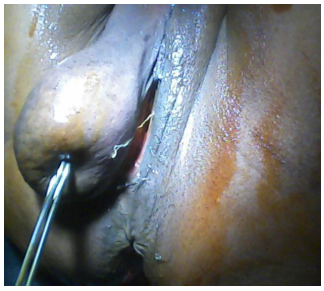

Fig. 1(c)

It was pear shaped, having some engorged superficial vessels over it but no cough impulse or visible pulsation. It was nontender, firm and surface was smooth .There was no palpable regional lymph nodes. Hernial orifices were intact. The patient was otherwise healthy on systemic examination and relevant investigations. Fine neddle aspiration cytology (FNAC) report was lipoma. The lump was excised (fig2a,b) and biopsy done with an elliptical incision under spinal anaesthesia and the specimen was sent for histopathology and the report was a fibroepithelial polyp fig. 3.

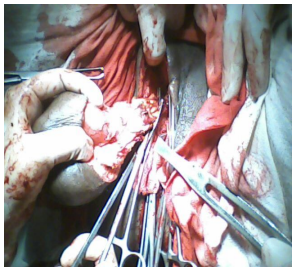

Fig. 2(a)

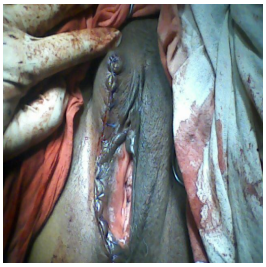

Fig. 2(b)

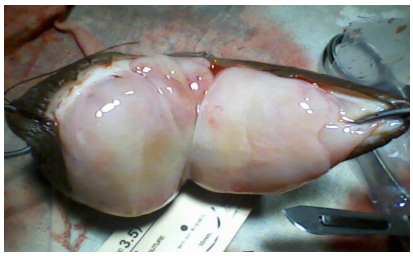

Fig. 3

Acrochordon is a polypoid out growth of both epidermis and dermal fibro vascular tissue. They have an incidence of 46%in the general population[3]. These are benign tumors but on rare occasions, as for e.g. in a recent study, 5 of 1335 clinically diagnosed fibro epithelial polyp (FEP) specimens were malignant, 4 were basal cell carcinoma (BCC) and 1 was squamos cell carcinoma (SCC) in situ[3]. Incidence of acrochordons is equal in males and females[3]. They increase in frequency up through the 5th decade. As many as 59% of persons may have acrochordons by the time they aged 70 years[3]. A family history sometimes exists. These tumours are usually asymptomatic but patient may complain of pruritus or discomfort when it is snagged by jewelry or clothing. These may occur at unusual sites of the body. A huge acrochordon has been described on the penis[1]. A lymphedematous acrochordon of the glans penis unassociated with condom catheter use also has been described[6]. Ureteral fibroepithelial polyps are unusual tumors of uncertain etiology[7]. Frequent irritation is the most important causative factor[3]. Viral infection specially HPV types 6/11 DNA should be considered as a pathogenic cofactor[8]. A study of 118 research subjects with

acrochordon reported an incidence of 40.6% of either overt type 2 diabetes mellitus or impaired glucose tolerance[9]. Histologically acrochordons are characterized by acanthotic, flattened or frondlike epithelium. Cauterization, Cryosurgery, Ligation or Excision, are the treatment options[8,9].

In fact initially the patient came to the gynaecology department. They were confused whether this is a case of inguinal hernia, so they refered the case to our surgery department. Our diagnosis was a neurofibroma. Unlike other fibroepithelial polyp this swelling did not have any definite stalk or peduncle. So we did not think of acrochordon. FNAC report was lipoma but histopathology report came as fibroepithelial polyp. So, presentation is characterized by atypical, big in size and of unusual site.

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Post Hysterectomy Inflammatory Myofibroblastic Tumor: A Rare Presentation

Inflammatory myofibroblastic tumor is a relatively rare neoplasm of unknown etiology. The out look of this disease has changed with time from a benign reactive process to a malignant neoplasm. Histologicaly the tumor composed of spindle cells with ample icytoplasm and an inflammatory background of plasma cell, eosionophills and histocytes [1-3]. There are three main histological patterns: nodular fascitis-like, fibrous histocytoma-like and desmoids or scartissue type. The commonest site of inflammatory myofibroblastic tumor(IMT) is lungs. Second most common site is the genitourinary tract. Optimum management of this disease has not yet been standardized[5]. According to world literature main stay of therapy is surgical resection with excision of recurrent tumor.

A 50 years old women presented with lower abdominal pain and flashy polypoidal mass coming down per vagina with foul smelling discharge for 3 months. She had a history of abdominal hysterectomy for fibroid uterus 6 years back and also a history of exploratory laparotomy due to irregular pelvic mass and severe abdominal pain 2 years after abdomianl hysterectomy. She gave another history of retention of urine and that she was admitted in urology department where cystourethroscopy was done which revealed multiple growths in urethra, bladder neck and trigon. Right sided ureteric stenting was done but no biopsy was taken.

Clinically patient was midly anaemic and there was an ill defined, midly tender mass in hypogastrium and multiple fleshy, polypoidal mass of variable size and shape in vagina. The masses were pale red with superficial ulceration.

Biochemical evaluation of the patient revealed Hb 9 gm/dl, ESR 94 mm in 1st hour. T.C-12000/cumm with nutrophilic leucocytosis, serum creatinine 1.57mg/dl and Tubureulin test was negative. USG of whole abdomen showed a pelvic mass with smaller left kidney. IVU report showed poorly functioning left kidney. CT scan of abdomen showed malignant stump mass with smaller left kidney. Tumor marks CEA, CA-125, with in normal limit.

As an integrated approach a tem of general surgeon and urologist and gynaecologist explored the abdomen. Under G/A pelvic mass was removed and excision of pdypoidal growth of vagina was performed. Histopathololgy of omesstal tissue showed inflammatory lesion. Finally report was inflammatory myofibroblastic tumor.