Bartholin gland adenoid cystic carcinoma: A rare vulva cancer case

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BACKGROUND

Bartholin glands produce mucus for vaginal lubrication. A primary carcinoma of the Bartholin gland is rare and accounts for 0.1 - 5% of all vulva carcinomas.

DISCUSSION

Bartholin gland carcinoma, though rare, should be considered in patients with persistent or enlarging vulvar masses. Management with an MDT approach including surgical resection ensuring appropriate margins are taken, radiation or chemotherapy. Where sufficient margins cannot be taken, other treatments are preferred with surveillance.

CASE

57 year old female, Para 3, presented with a left vulva swelling causing discomfort, 4-month history of lower abdominal pain, and two periods after a 10-month period of amenorrhoea. Cervical screen up to date and normal. Menopause at age 54. Previous history of jaw surgery and GORD. No regular medications or known allergies. On examination, a 2cm hard mass on the left lower vulva, possibly a Bartholin cyst, was noted.

Pelvis ultrasound showed a well circumcised 14 x 12 x 8 mm oval soft tissue lesion in the left labia major with homogenous internal echo and no internal vascularity. Endometrial thickness of 7.5 mm, uterus of 138 cc. She had an Examination under Anaesthetic, Hysteroscopy, Dilatation and curettage and biopsy of the vulval lump.

Hysteroscopy, dilatation and curettage findings: mild cystocoele, mild rectocoele, cervix descended down 2 cm above the hymenal ring, atrophic endometrial cavity, and 2 left 2 cm hard lump at Bartholin's area.

Histology confirmed a FIGO 1B unresectable vulva adenoid cystic carcinoma of Bartholin's gland, present at radial stromal margin, 0.1mm from deep margin; pT1b, no LVI, no PNI, p16 negative.

Pelvic MRI post operatively showed evidence of resection at the left of midline introitus, with no enlarged lymph nodes or metastasis.

PET-CT confirmed no evidence of FDG-avid separate metastatic disease.

Diagnosis is Stage 1B incompletely excised Left Bartholin adenoid cystic carcinoma.

Review of all investigations results showed a diffuse thickening on the left side of vulva to the pelvic floor, which was palpable under the skin with tethering.

Multiple multidisciplinary discussions deemed the case a likely difficult excision with difficulty ensuring complete resection despite extensiveness required to ensure margin hence decision for radiotherapy. She completed 60Gy/30# radiotherapyMRI post radiation therapy showed subtle asymmetrical bulkiness with T2 signal hyperintensity in the left introitus, hence for ongoing MRI Pelvis surveillance.

REFERENCES

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