OBJECTIVE: Clinical outcome after surgical treatment of vulvar intraepithelial neoplasia (VIN).

STUDY DESIGN: 16 women with vulvar intraepithelial neoplasia were reviewed. Histologic diagnosis was based on classification of the International Society for the Study of Vulvovaginal Diseases (ISSVD).

RESULTS: All cases had unifocal lesions in vulvar examination. In 13 cases (81.5%) lesions were white, in 2 cases (12.5%) lesions were papillary in appearance and in a case (6%) there was an ulcerative lesion. In all cases diameter of the vulvar lesions were less than 2 cm. Local excision was performed for VIN 1 lesions. VIN2 and VIN3 lesions underwent simple vulvectomy. Imiquimod therapy was preferred for a case with VIN3 lesion who refused surgery. In a case with VIN3 lesion squamous cell carcinoma in situ diagnosed after vulvectomy operation. Recurrence of disease has not yet been diagnosed during the follow up period.

CONCLUSION: VIN lesions should be surgically treated and careful long term surveillance is mandatory.

Key Words: Lesion, Premalign, Vulva

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tomy. Imiquimod therapy was preferred for a case with VIN3 lesion who refused surgery. In a case with VIN3 lesion squamous cell carcinoma in situ diagnosed after vulvectomy operation. Mean follow up of the group was 4.4±3.5 years (1-9 year) and still going on. Recurrence of disease has not yet been diagnosed during the follow up period.

Discussion

The clinical manifestation of VIN are varied, ranging from warty lesions on vulva to erythematous or ulcerated areas or slightly raised lesions. The range of symptoms in these patients is wide and includes pruritus, soreness and the presence of lump. Many asymptomatic patients are also reported. There is growing evidence that HPV infection is involved in the development of VIN in younger women. In this group multifocal lesions are common. The modern management of VIN is mainly surgical and there has been a trend away from radical surgery. One of the reason this trend is the high recurrence rate of VIN following primary surgical excision. Hrd et al reported 48% recurrence rate in 133 women treated for VIN. Because of the risk of malignant transformation long term follow up for these cases is mandatory. The potential psychological sequel from this chronic condition possibly requiring repeated surgical procedures must not be underestimated. Conservative management of VIN following diagnosis regular colposcopic examination and biopsies of areas suspicions of invasion. Clear 1 cm margin around the lesion is recommended for local excision of the lesions, where the excision margins are not clear the recurrence rate increases.

Malignant transformation from VIN to vulvar cancer is poorly understood. Most authors have estimated the risk to be around 5%. The possibility of transition to malignancy based on involvement of the resection borders or not is doubtful. Inverson at al reported that 8 of their 16 patients who later developed cancer had free resection borders at the time of primary surgery for VIN. They also reported that the median time between intraepithelial neoplasia and invasive cancer diagnosis was 2 years with a range of 1 to 11 years and suggested that age was a strong significant prognostic factor. 28% of their study group were younger than 40 years.

In our study 12.5% of our cases were younger than 40 years. Regression after diagnostic biopsy occurred in 47 women who at diagnosis of VIN ranged in age from 15 to 45 years (mean 24.6 years). They demonstrated a striking association of VIN with sexually transmissible infections and advised sexual health screening, cervicovaginal cytology and colposcopy assessment for continuing case of women with VIN.

Conclusion

We concluded that VIN lesions should be surgically treated and careful long term surveillance is mandatory.

16 Olguda Vulvar İnaaşpetikal Neopla29 Tedavisi Sonuçları

Vulvar intraepithelial neoplasiesi cerrahi tedavi sonrası klinik sonuçları.

Vulvar intraepitelal neoplası saptanan 16 olgu arastırıldı. Histolojik tanıda Uluslararası Vulvavajinal Çalışma Grubu Topluluğu sınıflaması kullanıldı.

Tüm olguların vulvar muayenesinde unifokal lezyon saptandı. Lezyonlar 13 olgu (%81.5) beyaz, 2 olgu (%12,5) papiller, bir olgu (%6) ulseratif olarak gözlendi. Tüm vulvar lezyonların çapı 2 cm'den küçük idi. VIN 1 saptanan lezyonlara lokal ekzisyon, VIN2 ve VIN3 saptanan lezyonlarda basit vulvektomi uygulandı. VIN3 saptanan ve cerrahi tedaviyedi reddeden bir olgu Imiquimod tedavisi uygulandı. VIN 3 saptanan ve cerrahi tedavi uygulanan bir diğer olgu vulvektomi sonrası insitu karsinom saptandı. Tüm olguların takip periyodunda rekkürens gözlemendi.

Vulvar intraepitelal neoplaszler cerrahi tedavi edilebilir. Uzun dönem takiplerinin dikkatli yapılması gerekliktir.

Anahtar Kelimeler: Lezyon, Premalign, Vulva

References


