

VULVAL ELEPHANTIASIS: A SEQUEL TO TUBERCULAR LYMPHADENITIS

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Two cases of vulval elephantiasis arising as a sequel to complete destruction of regional lymph nodes of tubercular aetiology are described for its rarity.

Key Words : Vulval elephantiasis, Tuberculosis

Introduction

Elephantiasis is dramatic end result of a variety of obstructive diseases of lymphatic system commonly affecting arms, legs and genitalia. Genital elephantiasis is a common sequel of filariasis, lymphogranuloma venereum and rarely it follows Donovanosis, carcinomas, lymph node irradiation and tuberculosis.¹ We report two unusual cases in whom vulval elephantiasis was ascertained to be the consequence of extensive lymph node destruction by tubercular infection.

Case Reports

Case 1: A 28-year-old female presented with asymptomatic diffuse swelling of vulva of 5 years duration. It started twenty years back when she developed small multiple asymptomatic swellings in both inguinal regions one after the other followed by ulceration and discharge of cheesy material lasting about 8-10 months. It took about another 6-12 months to heal with indigenous oral medication. She developed similar swellings with similar course of events in both cervical regions over a period of another 4-5 years. Presently the patient had diffuse lymphoedema of both labia majora and

minora attaining double the normal size, with multiple yellowish papular lesions over cutaneous parts of labia majora (Fig.1).



Fig. 1. Lymphoedema of vulva with papular lesions and puckered scars in the inguinal and femoral regions.

Both inguinal and cervical regions on either sides showed linear puckered scars overlying the lymph nodes. A single 1.5 cm big, firm, mobile lymph node was present in left cervical region. No lymph node mass was palpable beneath the scars in cervical and inguinal regions. Axillary lymph nodes were not enlarged. There was no hepatosplenomegaly. General health of the patient was preserved. She had not received any anti-tubercular treatment till now.

Skin biopsy from vulva showed features suggestive of lymphoedema. The lymph node from left cervical region on

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histopathology showed loss of lymph node architecture, replaced by granulomatous tissue consisting of epithelioid cells with occasional Langhans type giant cells and foci of caseation. Stain for acid fast bacilli was negative. X-ray chest did not reveal any active or healed focus suggestive of tuberculosis. Mantoux test was positive.

Case 2 : This 40 years old female had almost similar history and findings except that the elephantiasis was gross, reaching about 10-12 times the size of normal vulva (Fig. 2). No lymph node mass was available

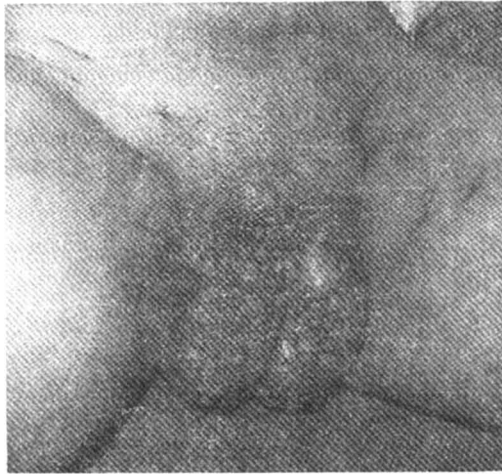


Fig. 2. Elephantiasis of vulva with scars in regions of the inguinal and femoral group of lymph nodes.

for biopsy in both cervical and inguinal regions. Mantoux test was positive. Biopsy from vulva showed changes of lymphoedema with gross fibrosis and no malignant changes. Tissue smears were negative for acid fast bacilli and Donovan bodies. No active focus of tuberculosis was found.

Discussion

Though pseudoelephantiasis of vulva has been reported previously,^{2,3} elephantiasis of vulva due to extensive destruction of lymph nodes in inguinal region by tubercular process is hitherto unreported to the best of our knowledge. In our cases, absence of tubercular histology from vulva rules out direct infiltration i.e., pseudoelephantiasis. Clinical events point towards almost complete destruction of lymph nodes in inguinal region.

In case I, the only remaining cervical lymph node showed typical tuberculous granuloma corroborating well with the clinical diagnosis. However in case II, the diagnosis was presumptive and retrospective based on typical history and clinical features. Although antitubercular treatment has been started in case I it is unlikely to reverse the elephantiasis in this patient. In case II, long standing lymphoedema of vulva has probably contributed to extensive fibrosis.

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