



Fibroepithelial Polyp Presenting as a Large Vulvar Mass

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Clinical Image

A 51-year-old P3043 woman presented to the emergency room with complaint of large mass hanging from her right labia. Patient reported to be homeless and was a poor historian. She reported that the mass was painless, but causing her constant discomfort and that it interfered with sitting and walking. She was not able to recollect the duration of the mass but did note that it had been steadily growing and was now associated with a foul smelling discharge. She also reported subjective fevers, decreased appetite and weight loss. Her past medical history was significant for Hepatitis C and a motor vehicle accident that required hospitalization in remote past. Surgical history was significant for two cesareans sections and right leg abscess incision and drainage. She reported illegal use of drugs.

Her vitals were stable on presentation. On exam a pedunculated mass was noted arising from the right labia majora. The stalk measured 5 cm × 2 cm and a large venous plexus was noted in the stalk. The mass measured 20 cm × 11 cm × 8 cm (Figure 1). The inferior aspect of the mass was ulcerated and foul smelling discharge tinged with blood was noted coming from the ulcerated area. Her white blood cell count was 15.7/mm³ and Hemoglobin 12.3 G/dl. Sexually transmitted infection screening was positive only for Hepatitis C, which she endorsed on admission.

Surgical resection of the vulvar mass was performed under general anesthesia without complication (Figures 2-4). Surgical pathology revealed fibroepithelial stromal polyp (FEP) without a typical features. Resection margins were negative for neoplastic cells. Overall histologic findings were consistent with fibroepithelial polyp with marked edema. However due to unusual size and some histological resemblance to a neoplastic lesion (angiomyxoma), close clinical monitoring was recommended by pathology.

Comments

Here we describe a rare case of FEP arising from the vulva. Moreover the size of this FEP in our case is impressive. Fibroepithelial polyps commonly occur in the vagina. Typically, FEPs are less than five centimeters [1]. To our knowledge, only one other case of a FEP measuring this large has been reported (20 cm) [2]. Others have reported FEPs over 15-18 cm [3,4]. The pathogenesis of FEPs is not clear. The presence of estrogen and progesterone receptor-positive FEP stromal cells and their more common occurrence in reproductive-aged women and in pregnancy-followed by regression after delivery-suggest that these growths are hormonally driven [1].

FEPs arise from mesenchymal tissue and must be distinguished from other vulvovaginal mesenchymal lesions to achieve an accurate diagnosis by clinical presentation and histopathologic features. The lesion described in this report is consistent with the typical presentation of FEPs, polypoid and exophytic with large, thick-walled vessels located at the core of the lesion. On immunohistologic staining, they are typically Desmin positive, as was reported here [5]. Histologically, stellate and multinucleate stromal cells are present with varying degrees of cellularity, nuclear pleomorphism, and mitotic activity. For this reason, it can be difficult to exclude malignancy [1,6]. FEPs bear most resemblance to angiomyxomas, which are also most likely to appear in reproductive-aged women. Aggressive (deep) angiomyxomas tend to be deeper, poorly circumscribed, and have minimal cellularity on histology. Like FEPs, they can grow quite large and are also Desmin positive. However, a distinguishing feature may be HGMA2 positivity on IHC. HGMA2 protein is expressed in aggressive angiomyxomas but not in FEPs [7]. Superficial angiomyxomas may also be on the differential for FEPs. They tend to be polypoid, well-demarcated, with spindle and stellate-shaped stromal cells, but they differ from FEPs in that they stain negative for Desmin on IHC and have smaller, thin-walled vessels. Acute inflammatory cells throughout the tumor can also be identified in these tumors. Unlike deep angiomyxomas, they do not involve deeper tissues and do not stain positive for HGMA2.

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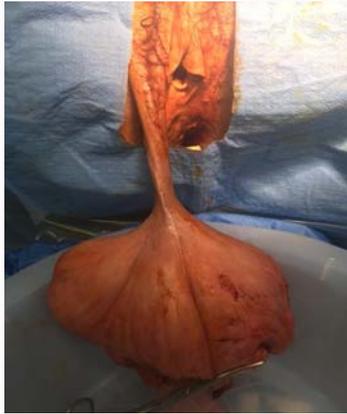


Figure 1: Large right vulvar mass attached by thick stalk.



Figure 2: Mass after surgical excision.



Figure 3: Homogenous, soft tissue core of excised mass.

Given such overlap, achieving the correct diagnosis of these vulvar soft tissue growths can be a challenge. Excision is the recommended treatment for both benign and malignant lesions, with 1-cm margins



Figure 4: Right vulvar demonstrating operative site following excision.

preferred for deep angiomyxomas, but recurrence is possible with incomplete excision or in the setting of continued hormonal stimulation [1,8]. We emphasize the importance of excision followed by histopathological and immunohistochemical evaluation of these lesions in order to achieve the correct diagnosis and appropriate treatment.

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