Pseudo tumour appearance of vulvar varicose veins

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DESCRIPTION

A 26-year-old Moroccan woman consulted the gynaecological emergencies service, for pelvic pain after sex. An interview revealed that the patient had not had a period for 14 weeks; and this was medically supported by her family doctor, who also provided a vulvar biopsy owing to knowledge of a history of cervical cancer in the patient's mother.

Medical examination of the vulva exposed an 8×4 cm lobe-shaped blackish blue mass, with no pain on palpation (figure 1). Vaginal examination showed a long, closed cervix, with no bleeding. The uterus was enlarged on bimanual examination. No varicose veins were found on inspection of the

Figure 1 Pseudo tumour appearance of vulvar varicose veins.

Learning points

- Pregnancy leads to an elevation of pressure in the pelvis, causing difficulty in venous return,¹ the slowing down of blood flow and the resultant stagnation in turn increasing the dilation of the vulvar varicose veins.
- Vulvar varicose veins can lead to vulvar tumour requiring a biopsy, which is dangerous because of the possibility of bleeding; exploration of any lesion of the vulva is mandatory before performing invasive action.^{1 2}
- Treating varicose veins of the vulva is required because the breakdown of varicose veins during childbirth is likely to cause significant bleeding, compromising the patient's life.² The treatment of vulvar varicose veins using sclerotherapy is not always conclusive, making surgery necessary.³

Figure 2 Surgical treatment of vulvar varicose veins.

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thighs and legs. The patient's temperature was normal at 36.9°C, her weight was 61 kg and height 1.60 m; blood pressure was 110/70 mm Hg.

Doppler ultrasound made the diagnosis of varicose package vulva and an incontinent great long saphenous vein arch. Transvaginal ultrasound confirmed pregnancy; the biometrics of the fetus corresponded to 14 weeks of amenorrhoea.

Given the large vulvar varicose veins, the discomfort these caused to walking and the risk of injury with bleeding at the time of delivery indicated performing sclerotherapy, to no effect. We opted for surgical ligation of the arch of the long saphenous vein and surgical resection of the varicose package (figure 2). The result was satisfactory, with disappearance of the

lesion and the ability for the patient to normally give birth without complications.

Competing interests None declared.

Patient consent Obtained.

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