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A Neglected Vulvar Ulcer with Unusual Huge Left Inguinal Lymph Node in a Postmenopausal Woman: A Case Report on Delayed Diagnosis of Carcinoma of the Vulva

Lilungulu Athanase Gervase[1], Catherine Anthony Mnyeti[1,2]

[1]Department of Obstetrics & Gynaecology, University of Dodoma, Dodoma, Tanzania
[2]School of Medicine & Dentistry, University of Dodoma, Dodoma, Tanzania
Email: catherinemnyeti@gmail.com; athanas.lilungulu@udom.ac.tz

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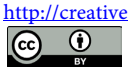

Abstract

Vulvar carcinoma is a relatively uncommon gynecological malignancy, accounting for approximately 5% of all female genital tract cancers and predominantly affects postmenopausal women. Survival rate observed to be approximated up to the 70% of cases, although with the presence of other comorbidities, it may worsen its morbidity and mortality. Magnificent appearance of either non healing ulcerative or inguinal mass ulcerated for those with diabetes cases could be contradicted as a persistent vulvar lesion and this may be associated with the delay in its diagnosis [1]. **Case Presentation:** We report the case of a 57-year-old multiparous (P7L5), postmenopausal woman who presented with a one-year history of progressive left vulvar swelling associated with intermittent pruritus, localized pain, and foul-smelling watery discharge. She also developed a progressively enlarging, painless swelling in the left inguinal region. Despite multiple consultations at peripheral health facilities over approximately six months, she received unspecified oral medications without symptom resolution. Physical examination revealed a large ulcerative lesion involving the left labia majora with extension toward the vaginal introitus and a markedly enlarged left inguinal lymph node. Punch biopsy performed on 14 April 2025 demonstrated Grade II invasive squamous cell carcinoma, and histopathology results were issued on 4 May 2025. The patient was referred to Ocean Road Cancer Institute for definitive staging and multidisciplinary management. **Conclusion:** Persistent vulvar symptoms or non-healing vulvar ulcers in postmenopausal women should prompt early biopsy. Delayed histological diagnosis may permit regional lymph node involvement, resulting in more advanced disease and poorer prognosis.

Subject Areas

Women's Health

Keywords

Vulvar Carcinoma, Vulvar Ulcer, Squamous Cell Carcinoma, Gynecologic Oncology

1. Introduction

Vulvar cancer remains a rare gynecological malignancy of the female genital tract of which its occurrence is estimated to be 0f 5% out of all cancers affecting the female genital tract. Furthermore, society of evaluating vulva cancer, International Federation of Gynecology and Obstetrics (FIGO) reported that squamous cell carcinoma carries 95% and only 5% carries the remaining cancer of the vulva, including melanomas, sarcomas and basal cell carcinomas [2].

Vulvar cancer is more frequently associated with women of advanced age including those above 50 years old, with the highest pick being an average age of late 70's, which is directly linked with the time of diagnosis [3].

Fortunately, women with vulvar cancer its survival rate depends on the time of its diagnosis specifically at the early stages but also the prognosis is expected to be good if both diagnosis and treatment are dependent on radical local wide surgical, which remains the effective form of management in early-stage disease [4].

Traditionally, according to the vulvar squamous cell carcinoma histopathological classification, it is observed to be divided into two types of which the first one is linked to be associated with high-risk human papilloma viruses, including genotypically number 16, 18 and 33 and significantly affects younger women. However, it represents about 30% of the vulvar squamous cell carcinoma. Unfortunately, the second type of squamous cell carcinoma is not linked with any type of human papilloma viruses but it is most frequently found in elderly women [3].

However, recently vulvar squamous cell carcinoma has been classified histologically into three types which are basaloid, warty and keratinizing. According to the various cancer society reported that keratinizing type is the most common and usually seen after menopause despite the other types that are seen before menopause [2].

Therefore, two main pathogenic pathways usually exist, of which the HPV-associated pathway, typically seen in younger women, involves high-risk human papillomavirus types 16 and 18 that are integrated into the host genome, leading to overexpression of viral oncoproteins E6 and E7 whereby these inactivate tumor suppressor genes p53 and Rb, promoting cellular proliferation and dysplasia [5].

The non-HPV-associated pathway, more common in older, postmenopausal women, is often linked to chronic inflammatory dermatoses such as lichen scle-

rosus, leading to a differentiated vulvar intraepithelial neoplasia (dVIN) that progresses to cancer through TP53 mutations and genomic instability [3].

The non-HPV-associated pathway, more common in older, postmenopausal women, is often linked to chronic inflammatory dermatoses such as lichen sclerosus, leading to a differentiated vulvar intraepithelial neoplasia (dVIN) that progresses to cancer through TP53 mutations and genomic instability [6].

Both pathways result in progressive dysplasia, invasion of the basement membrane, and eventual stromal invasion, angiogenesis, and potential lymphatic spread—especially to the inguinofemoral lymph nodes [7].

Clinically, the most common symptoms of vulva cancers vary in their presentation which includes vulvar ulcer bleeding, discomfort, and burning urination of which on examination various vulvar lesions could be seen as fresh ulcers, genital warts and inguinal mass with possibility of ulcerations [8].

Despite advances in gynecological oncology, vulvar cancer is often diagnosed late due to its nonspecific presentation and the stigma associated with reporting genital symptoms. Early symptoms like itching, pain, or discharge are frequently misdiagnosed as benign conditions, delaying definitive diagnosis and management [8].

Modern cancer management and various societies have been done with several work out concerns on its management and concluded that the VSC modality approach is primarily wide surgical excision and whenever possible should involve lymphadenectomy. Both radiotherapy and chemotherapy should also be recommended for individual women [9].

2. Case Presentation

We are presenting a 57-year-old, more than 10 years postmenopausal woman, para 7, living 5, presented at our facility with a one-year history of swelling on the left lower side of labial majora that was gradual in onset, and increased in size with time associated with on and off itching and pain localized to the left side of her vulva associated with a foul-smelling watery discharge.

This swelling was also associated with another non painful swelling of the left inguinal region that was increasing in size with time.

She reported multiple consultations at different health facilities for the past 6 months and received some oral medications whose names she could not recall but Symptoms persisted and worsened over time and hence decided to attend our facility.

She does not know HIV, and is not on any medications for a chronic disease. Also she denied the history of ever smoking.

On Local Examination

Had a 6cm by 8cm hard, smelly, tender ulcer with irregular margins on the left labia majora, the ulcer invaded the lower 3rd of the vagina at 4 o'clock on the anteriour part of the ulcer, it was surrounded by 3 small ulcers of 1 cm by 1.5 cm surrounding the left side of the large ulcer.

Also, the patient had a palpable firm, non mobile and non tender 6 by 6cm left inguinal lymphnode with no palpable right lymphadenopathy. Patient had a normal cervix, normal upper vaginal wall and clitoris (See Figure 1).

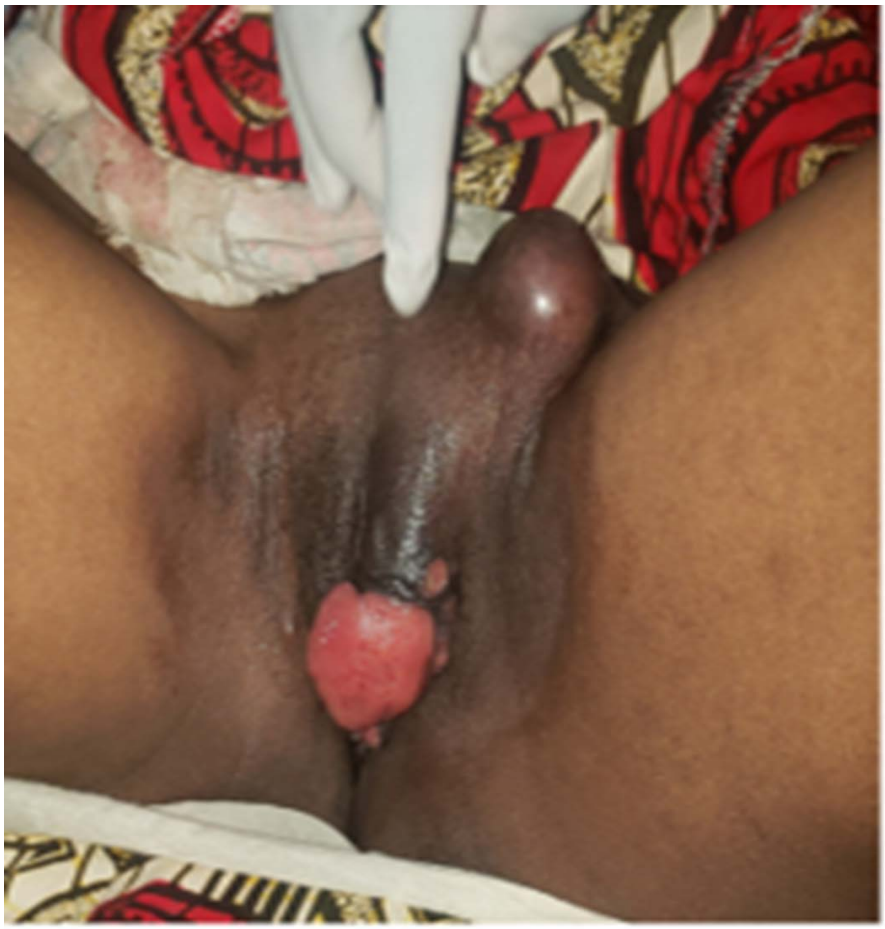

Figure 1. Showing the lesions in this case.

CVS, RS, CNS, Musculoskeletal systems were normal.

We had the provisional diagnosis of Vulvar carcinoma FIGO stage IIIa.

FBP was done which was normal with Hb of 11.1 g/dl and normal platelets count.

RFT, Blood glucose level, electrolytes and LFT were done and were all normal.

HIV test was negative.

HPV DNA was done and was negative.

Nodal ultrasound showed hypoechoic with heterogenous internal structure.

No tumour marker was done due to inavailability to our facility.

A biopsy of the lesion was taken on 14th April 2025 and the results on 4th, May 2025 showed an invasive Squamous Cell Carcinoma, Grade II patient was then referred to Ocean Road Cancer institute for Surgery, chemotherapy, and radiotherapy.

Follow-up information after referral could not be obtained because the patient continued management at the tertiary oncology centre (See Table 1).

Table 1. Summary of timeline of clinical events.

Date/Period	Clinical Event
In April 2024	Onset of left vulvar swelling associated with intermittent itching and pain
Following months	Progressive enlargement of vulvar lesion with foul-smelling watery discharge
October 2024 - April 2025	Multiple visits to peripheral health facilities; received unspecified oral medications with no clinical improvement
14 April 2025	Vulvar biopsy performed
4 May 2025	Histopathology confirmed Grade II invasive squamous cell carcinoma
May 2025	Patient referred to Ocean Road Cancer Institute for definitive staging and management

3. Discussion

Vulvar carcinoma remains a diagnostic challenge, particularly in low-resource settings where access to specialized care is limited. It commonly presents in post-menopausal women, with pruritus being the most frequent early symptom [10].

As in our case, delayed intervention often results from underreporting of symptoms and misdiagnosis.

Squamous cell carcinoma, the most prevalent histological type, often arises in the labia majora and can spread to regional lymph nodes, particularly the inguinal-femoral nodes, which is a significant prognostic indicator [4]

Marked inguinal lymphadenopathy in vulvar squamous cell carcinoma is clinically significant because lymph node involvement is the strongest independent prognostic factor for overall survival. Enlarged inguinofemoral nodes are associated with a substantially increased risk of pelvic nodal metastasis, disease recurrence, and reduced long-term survival. Consequently, careful assessment of regional lymph nodes should form part of the initial evaluation of every patient presenting with suspected vulvar malignancy [11].

Diagnosis is established through biopsy, which should be promptly performed in any suspicious or non-healing vulvar lesion. In our case, the delay in diagnosis resulted in disease progression to involve lymph nodes, worsening the prognosis.

This case also illustrates the consequences of delayed diagnosis, a challenge consistently reported in the literature, particularly in low-resource settings. Several published case reports have demonstrated that prolonged treatment of persistent vulvar symptoms as presumed benign inflammatory or infectious conditions frequently delays biopsy, allowing progression to locally advanced disease with regional lymph node involvement. Our patient experienced symptoms for approximately one year and underwent multiple healthcare consultations before histological confirmation, emphasizing the importance of maintaining a high index of suspicion and performing early biopsy for persistent vulvar lesions in postmenopausal women [2] [12].

Management depends on disease stage and may include radical local excision, vulvectomy, and lymphadenectomy, with or without radiotherapy and chemotherapy [13].

The prognosis for patients with early-stage disease is generally good, but cancer can spread from its original site to loco regional nodes and/or distant organs by lymphatic embolization or hematogenous diffusion, respectively. Lymphatic spread represents an early event in the course of the disease and involves ipsilateral inguinal, femoral, and pelvic lymph nodes, usually in a sequential manner. Lymph node status remains the single most important prognostic factor. The 5-year overall survival is more than 90% for patients without nodal involvement, which reduces to less than 60% in the case of nodal involvement [14].

This case underscores the importance of awareness among clinicians and patients about vulvar cancer and the need for early histological evaluation of persistent vulvar symptoms.

4. Conclusions

Vulvar carcinoma should be considered in postmenopausal women with chronic vulvar symptoms, especially when unresponsive to empirical treatment.

In high-risk women, particularly those over the age of 60 or those with risk factors such as human papillomavirus (HPV) infection, lichen sclerosus, smoking, or immunosuppression, should undergo regular pelvic examinations with careful inspection of the vulva.

Early detection is often based on patient-reported symptoms such as persistent pruritus, pain, or visible lesions. Visual inspection, biopsy of suspicious areas, and application of acetic acid or toluidine blue staining may aid in identifying premalignant conditions like vulvar intraepithelial neoplasia (VIN).

For HPV-associated lesions, HPV DNA testing and close follow-up of cervical or vaginal neoplasia may also be relevant. Increased awareness among both patients and healthcare providers remains the cornerstone of early diagnosis and improved outcomes [15].

Timely biopsy and referral for staging are essential for effective management.

Enhancing community and clinician awareness may reduce diagnostic delays and improve outcomes.

Strengths

- Highlights a classical yet often-missed presentation of vulvar carcinoma.
- Emphasizes the consequences of delayed diagnosis.

Consent

Written informed consent was obtained from the patient for the publication of this case report and any accompanying images, with full assurance of anonymity and confidentiality.

Conflicts of Interest

The authors declare no conflicts of interest.

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