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Vulvar intraepithelial neoplasia and vulvar squamous cell carcinoma: a clinicopathologic study of 18 cases

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Abstract

Background: The vulvar intraepithelial neoplasia is divided into two groups: usual type and differentiated type. The differentiated vulvar intraepithelial neoplasia which is frequently seen together with the invasive squamous cell carcinoma can be confused with some benign lesions. To analyse p16, p53, and Ki-67 expression characteristics of different histological types of invasive squamous cell carcinoma of the vulva and vulvar intraepithelial neoplasia is aimed in this study.

Methods: In this study, immunohistochemical analysis of 18 vulvectomy cases with p16, p53, and Ki-67 was performed.

Results: Of 18 patient who underwent vulvectomy, 9 had invasive squamous cell carcinoms and 9 vulvar intraepithelial neoplasia. 3 additional vulvar intraepithelial neoplasia lesions were found accompanying the invasive squamous cell carcinomas. Mean Ki-67 PI was 32,3% in usual type (human papilloma virus-related) vulvar intraepithelial neoplasia cases (n:3)(po-0.05). Mean p16 staining degree was 2,6 for usual type vulvar intraepithelial neoplasias. No p53 expression was present in squamous cell hyperplasia or lichen schrosis lesions.

Conclusions: Ki-67 PI does not have significant value in recognizing vulvar intraepithelial neoplasia usual type and differentiated vulvar intraepithelial neoplasia. p53 positivity can be of value in distinguishing especially differentiated type vulvar intraepithelial neoplasia from benign lesions.

Keywords: vulva, vulvar intraepithelial neoplasia, invasive squamous cell carcinoma

Background

Based on histological observations, approximately 90 % of all primary malign carcinomas of the vulvar tumors are invasive squamous cell carcinoma (ISCC) [1,2]. According to the currently popular classification system, vulvar invasive squamous cell carcinoma (ISCCV) is divided into 3 main histological groups: basaloid, warty and keratinizing ('conventional' or 'typical' keratinizing) types [1,3,4]. Conventional type is the most common histological type of ISCCVs. Basaloid and warty types of ISCCV are thought to originate from basaloid and warty type vulvar intraepithelial neoplasia (VIN). This type of VINs has strongly been associated with human papilloma virus (HPV) [4]. VIIN terminology was modified in 2004 by The International Society for the Study of Vulvovaginal Disease (ISSVD), and was mainly divided into two groups: VIN usual type and VIN differentiated (simplex) type. These terms account for VIN 2 and VIN 3 in the older terminology, and the term VIN 1 has not been used anymore [5,6-8].

ISCCVs are grouped into two general types according to their different clinicopathologic features. The first group is the type seen in young age groups (35-65 years old) and is associated with HPV, and the second group is the type seen mostly in older women (55-85 years old), is unrelated to HPV, and has different etiological factors (1, 2,9).

The type related to HPV accounts for 1/3 of all ISCCVs. The group named as classic VIN, whether warty or basaloid is characterized by accompanying highly differentiated VIN and high Ki-67 proliferation index (Ki-67 PI). In addition, there is increase in the risk of squamous neoplasia, particularly of cervix and other parts of lower genital tract. The patients in this group appear to have a better prognosis than the group of patients with ISCC unrelated to HPV [1,2,9].

The second group (unrelated to HPV) accounts for 2/3 of all ISCCs. The patients in this group typically develop a conventional (keratinizing) type ISCC associated with lichen sclerosis (LS) and squamous hyperplasia (SCH), and recent

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