

Giant Acrochordon of Labia Majora: An Uncommon Manifestation of a Common Disease

Dear Editor,

Acrochordon (fibroepithelial polyp or skin tag) is a common benign neoplasm seen predominantly in obese individuals with an average of 46% incidence in the general population.^[1] Measuring about 1 to 5 mm in size, they are usually located in the intertriginous areas. We report an unusual presentation of acrochordon.

A 50-year-old postmenopausal woman presented with a mass hanging from labia majora since 3 years. While cleaning her private parts she first noticed a lemon sized mass which gradually increased in size. Patient experienced discomfort while walking due to the weight and rubbing of the mass between her thighs and became apprehensive of its growing size. There was no pain, pruritus, fever, redness, ulceration, bleeding, discharge, sudden increase in size, aggravating/relieving factors or diurnal change in size.

Patient was overweight (body mass index 27.3 kg/m²). Dermatological examination revealed a single, skin-coloured, pedunculated, pear-shaped, non-tender, soft fleshy mass with wrinkled surface measuring 16 × 9 cm and arising from a thin stalk from posterior part of left labia majora [Figure 1] and distorting its shape. There was no redness, discharge or ulceration. The mass was nonpulsatile, nonreducible, with no impulse on coughing, no palpable thrill or bruit with no regional lymphadenopathy. Systemic and genitourinary examination was normal. Blood sugar and lipid profile were normal. The mass was diagnosed as acrochordon due to its pedunculated attachment, soft consistency and free mobility.

The lesion was elliptically excised. Histopathological examination revealed mature stratified squamous epithelium, increased fibrocollagenous tissue in the

stroma, thickened blood vessels, stellate fibroblast and sparse perivascular chronic mononuclear inflammatory infiltrate with no evidence of malignancy [Figure 1].

In women, genital acrochordon is more common in the vagina than vulva and cervix^[2] with peak incidence at 20-40 years of age. It is rare in postmenopausal women. Large lesions may arise due to proliferation of mesenchymal cells within the hormonally sensitive subepithelial stromal layer of the lower genital tract. Acrochordons are associated with type 2 diabetes mellitus, insulin resistance, obesity, dyslipidemias, pregnancy, genetic predisposition, human papilloma



Figure 1: Giant acrochordon of the left labia majora (a) preoperative (b) Immediate post-operative (c) Length of the excised acrochordon (d) and 20 days after surgery (e) Mature stratified squamous epidermis with the underlying stroma showing increase in the fibrocollagenous tissue, thick-walled blood vessels, stellate shaped fibroblast and sparse perivascular chronic mononuclear inflammatory cell infiltrate (H&E, 10×) (f)

virus 6 and 11, acromegaly, Gardner syndrome, Birt-Hogg-Dube syndrome and Nonne-Milroy-Meigs syndrome.^[3]

The vulval acrochordons reported in the literature have ranged in size from 2.3 to 30 cm.^[4,5] Ulceration, infection and inflammation can occur in giant acrochordons of vulva. Acrochordons rarely recur if not completely excised.^[3]

The differential diagnosis of vulval acrochordon includes hernia, hydrocele of canal of Nuck, neurofibroma, lipoma, fibroma, Bartholin's cyst, vulval varicosities, haemangiomas, angioneurofibroma, hamartoma, lymphadenoma, angiomyofibroblastoma, cellular angiofibroma, sarcomas, angiomyxoma and dermato fibro-sarcoma protuberans.

Malignancy should be excluded in every case of fibroepithelial stromal polyp. Stellate and multinucleate stromal cells present near the epithelial-stromal interface are the most characteristic feature of acrochordon. Stromal cells may be positive for desmin, actin, vimentin, oestrogen and progesterone receptors. On the other hand sarcomas have identifiable lesion margins, homogeneous cellularity and lack the stellate and multinucleate stromal cells near the epithelial-stromal interface.

We report an unusual presentation of a very common lesion presenting with large size, vulval location and appearance in postmenopausal overweight woman

with no associated factors. Surgical excision with histopathological examination serves as diagnostic and therapeutic modality for such lesions.

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