Case Report

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Urethral Cancer in Females

A Case History

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Key Word

Female urethral cancer

Abstract

A case of female urethral cancer with late diagnosis on account of concomitant complaints is presented. When persistent urethral symptoms or localized pain are found the diagnostic procedure should include urethrocystoscopy.

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Urethral cancer is a very rare cancer form in both sexes, with a female/male ratio of 5:1 [1]. It accounts for less than 0.02% of malignant tumors in females. The 5-year survival rate for both sexes is less than 40% [1]. This poor prognosis is probably partly due to late diagnosis. The symptoms are uncharacteristic and often thought to be derived from other urological or gynecological disorders. A case of fatal female urethral cancer with late diagnosis is presented.

Case Report

A 51-year-old female was admitted to the gynecological department with the diagnosis of ovarian tumor. For 3 weeks prior to admittance the patient had suffered from urological symptoms in the form of perineal pain with exacerbation during micturition, pol-lakisuria, nycturia and residue. Gynecological symptoms were in the form of metrorrhagia.

External examination revealed a 5 X 5 cm large palpable tumor in the suprapubic region.

Gynecological examination revealed a normal vagina, and an enlarged uterus (3 times normal size) with many irregular fibromas. Hb and se-creatinine were normal. Intravenous urography showed tumor masses in the pelvis.

Hysterectomy and bilateral salpingo-oophorectomy was performed with an uncomplicated postoperative period. Histological diagnosis: fibroleiomyoma uteri, no malignancy.

2 months later the patient was readmitted with urinary discharge in the vagina and unchanged perineal pain and dysuria. Urethrocys-toscopy showed a normal bladder, but two urethrovaginal fistulas situated 1 and 2 cm from the internal urethral orifice. Bioptic material from these areas was classified as squamous carcinoma, probably

primary urethral cancer. X-ray of the lungs, and lymphography, were without signs of metastases.

Cystectomy and urethral excision were performed with construction of an ureteroiliocutaneostomia (Bricker bladder).

Peroperatively the tumor was described as 5 cm in diameter, ensheathing the urethra and fixed to the posterior surface of the sym-physis pubis. No tumor invasion was seen of the bladder, and no metastatic lymphnodes paravesically, or in relation to the iliac vessels. No liver metastases. Histological examination confirmed primary urethral squamous carcinoma with penetration to the vagina.

The operative procedure was supplemented with external radiation therapy and internal cathethron treatment. At the end of this therapy the patient was considered without residual tumor and only slight perineal pain persisted.

10 months later the patient was again readmitted with large local tumor masses. No further therapeutic possibilities existed and death occurred 13 months after appearance of the first symptoms.

Autopsy showed large tumor masses in the pelvis without signs of generalized metastases.

Discussion

The earliest and most common symptoms of urethral cancer are urethral bleeding, persistent pollakisuria, and dysuria. More seldom is found dyspareunia, local pain and urinary discharge from the vagina. According to localization the urethral cancers are classified as anterior or posterior [1, 2]. The anterior tumors are derived from the distal one third, and the posterior from the proximal two thirds of the urethrae.

124

Ostri/Worning/Dalum

Histologically, 75% of the cancers found are squa-mous carcinomas, the rest being adenocarcinomas or tumors derived from the transitional cell epithelium [2, 6]. Urethral cancers often have regional lymph node metastases.

At time of operation, 30–50% of the patients have regional lymph node involvement [1, 2, 7].

Diffuse metastases are rare, but when found, are most often in liver, brain, and bone.

Grabstald [1], and Grabstald et al. [3] have suggested the following classification according to the tumor growth. Stadium A.: tumor only in submucosa. Stadium B: tumor penetrates tunica muscularis periurethrally. Stadium C: tumor has spread to vagina, vulva or bladder. Stadium D: metastases at regional lymph nodes or dispense metastases. According to this classification the patient described belonged to stadium C.

On account of the rarity of urethral cancer only few have presented large series. Small anterior tumors are usually treated with local excision or radiation therapy or a combination [2, 4, 6].

Posterior tumors are usually treated surgically with cystourethrectomy, at times combined with lymph node excision. Often surgery is supplemented with pre- or postoperative radiation therapy.

5-year survival is given as 50% in stadium A and less than 20% in stadium D [1]. The anterior tumors have a better prognosis than the posterior, possibly due to earlier diagnosis. The histological classification does not seem to influence the prognosis [1].

In patients with unaccounted for urethral irritation, dysuria, pollakisuria, and pain in the region, the diagnostic procedure should include urethrocystoscopy.

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