VULVAR CANCER IN HIV ERA

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Vulva cancer accounts for 3-5% of all female genital cancers and was until the last 20-30 years a disease of post menopausal women. Globally, in recent years, there has been a gradual increase of the incidence of vulva cancer. This increase has been in mostly young women less than 50 years.

Vulvar squamous cell carcinoma (VSCC) accounts for >90% of the malignant tumours of the vulva. VSCC has a pre-cancerous stage known as vulvar intraepithelial neoplasia (VIN). There are two types of VIN: the usual-type VIN (warty, basaloid, and mixed VIN), which is associated with HPV infection and often multifocal. The risk factors for usual type of VIN include oncogenic HPV subtypes, cigarette smoking, immunocompromised host, and younger age. The second type is the differentiated VIN (keratinising) and is not associated with HPV. It is more commonly seen in older women with vulvar dermatologic conditions (lichen sclerosus) and other chronic inflammatory conditions of the vulva.

HIV positive women have a higher prevalence of HPV infection than HIV negative women. At least 40% of vulvar cancers are known to be HPV related and this may be higher in Africa. This means HIV positive women are at a greater risk of vulva cancer. In 2010, 60% of the 22.9 million people living with HIV/AIDS in sub-Saharan Africa were women. HIV positive women are living longer, which means the incidence of vulva cancer in Africa will rise and many younger women will be affected. Mortality will also increase because treatment of vulva cancer, which includes surgery, chemotherapy and radiation, unfortunately, may not be optimal in many patients in the region because of advanced stage disease, inadequate/poor healthcare infrastructure and poverty.

HPV vaccination, improved access to HAART and early detection and treatment of VIN in HIV positive women will all go a long way to prevent VSCC.