CERVICAL PATHOLOGY IN YOUNG PATIENTS

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Summary: The Authors have studied 152 patients aged between 15 and 20 year old who underwent colposcopy and colpocytology. They have compared the incidence of white colposcopic lesions with the results of the cytology. According to litterature the results have pointed out that the very young patients are "at risk-patients" for serious cervical lesions and that depistage of gynecologic tumors must be done in all the other women.

The socio-economic and cultural evolution in our country today allows all levels of the female population to access, without great difficulty, to the structures concerned with the prevention of disease of the genital apparatus.

The widespread use and frequency of colpocytological and colposcopic controls have permitted the observation of patients belonging to increasingly young age-groups, patients who, until a few years ago, would not have submitted themselves to such checks if not on account of well-defined and evident pathological indications.

Undoubtedly the widespread use of safe contraceptive methods and the demand for greater understanding of their correct use has made a major contribution to this phenomenon.

But the fact remains that it is possible, through the study of the examinations carried out on young and very young patients, to modify judgement regarding the average age at which lesions appear, such as the white lesions colposcopic, the mosaic and the basis of leukoplakia and mosaic which, until a few years ago, were considered the almost exclusive apanage of women of relatively mature age, that is, those between 25 and 45 years.

With regard to sexual activity it is still possible be relatively in agreement in affirming that if it is precocious and frequent, the incidence of vulvo-vaginal phlogosis increases and the incidence of cervical lesions increases in consequence [1, 2].

The notable reduction of parity in the last ten years does not seem to have produced in any drastic way a reduction in the incidence of colposcopic and cervical lesions in general [2], even if the incidence of advanced cervical neoplasias has been reduced on account of more widespread and frequent checking.

The study of cervical pathology among young and very young women covers one importante particular in the prevention of cervical neoplasias in adult age, in that it allows for the selectioning of the women most at risk to be followed with great attention in the following years.

MATERIAL AND METHODS

152 patients were studied, whose ages ranged from 15 to 20 years and who were submitted to colpocytological and colposcopic examination.

In detail, 30 of the patients were aged from 15 to 17 years, and 122 were between 18 and 20 years.

From the collection of the anamneses it appeared that all of them had more or less frequent sexual activity, which had begun between six months and three years before coming to consultation.

The reason for seeking gynecological counsel was prevalently the wish for contraceptive advice, often combined with a characteristic symptomology of vulvovaginitis.

The socio-economic conditions of the patients was noted as middle to upper middle, and the educational level reached was good (middle - to high - school).

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Table 1. — *Colposcopic Lesions and Age of the Patients: no. 152.*

Age	No. pat.	Colposcopy pictures: Normal	Ect.	Typ. trans.	A.R.Z.	Mosaic	Punct.	Leuko.
15 - 17	30	13 (43'33)	12 (40)	—	—	3 (10)	2 (6'67)	
18 - 20	122	19 (15'5)	39 (32)	2 (1'5)	1 (1)	34 (28)	5 (4)	22 (18)
Total	152	32	51	2	1	37	7	22

Table 1 shows the incidence of colposcopic lesions separately for the two age-groups under consideration.

If the percentage of pictures of the colposcopically normal portio is decidedly higher in the very voung, the cases of lesions, above all of white lesions (10% of the mosaic pictures) in the first group of patients studied, should not be undervalued.

Passing to the second group of patients, the percentage of white lesions appears clearly increased, showing in fact 28% of the mosaic pictures and 18% of the leukoplakias, a decidely high level, above all in relation to the age.

Table 2. — *Cytologic finding and Colposcopic Lesions (age 15-17): no. 30.*

Cytology	Colposcopy pictures: Normal	Ect.	Typ. trans.	A.R.Z.	Mosaic	Punct.	Leuko.
Normal	13	3	—	—	—	—	—
Phologosis	—	9	—	—	3	3	—
Slight atypia	—	—	—	—	—	—	—
Total 30	13	12	—	—	3	2	—

Table 3. — *Cytologic finding and Colposcopic Lesions (age 18-20): no. 122.*

Cytology	Colposcopy pictures: Normal	Ect.	Typ. trans.	A.R.Z.	Mosaic	Punct.	Leuko.
Normal	19	11	2	—	5	—	18
Phlogosis	—	28	—	1	26	5	4
Slight atypia	—	—	—	—	3	—	—
Total 122	19	30	2	1	34	5	22

Examining table 2 it is clear that the colposcopic pictures of white lesions all correspond to a cytological pattern characterised by active phlogosis, while table 3 indicates a certain number of white colposcopic lesions also with normal cytological pictures.

In the second group (table 3) the cytology has shown slight atypical evidence in three cases; these patients having undergone biopsy of the portio, the histological examination in all three cases only showed chronic aspecific cervicitis without dysplasia.

The only case with a colposcopic picture of the atypical zone of reconstruction was also submitted to biopsy, resulting equally negative for dysplasia.

CONCLUSIONS

The incidence of important colposcopic lesions in the group of young women considered, agrees with the results of the majority of analogous research conducted in this field.

Some Authors, in a large-scala study of adolescents reported 12% of class III Papanicolau, and in 6 of the cases considered had had to submit the very young patients to conization ([1]).

Other Authors described significant cervical lesions and a high incidence of viral and venereal infections ([3]).

The results from literature and from the present research confirm the necessity for not eliminating, as sometimes still happens, these patients from periodical checking of colpocytology and colposcopy on account of their young age.

The hypothesis that precocious initiation of sexual activity as one of the risk-factors of cancer of the neck of the uterus has been recognised for many years.

An increase in cervical dysplasias up to the limit of carcinoma in situ in adolescents has also bee underlined ([4, 5, 6]).

Without dramatisation, these data remain of fundamental importance in assuring that these adolescents, in ever increasing numbers, have access to contraceptive consulting centres and that the gynecological consulting centres also submit them to screening for cervical pathology, as is already widespread thoughout national territory, and at low cost.

This attitude will lead to correct preventive action even for this most neglected age group which is neverthless equally at risk for genital neoplasias.

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FECAL PERITONITIS IN PREGNANCY

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Summary: The Authors report a case of fecal peritonitis caused by perforating appendicitis in a patient in the 16th week of pregnancy. Appendectomy was performed and the patient successfully delivered a normal sibling weighing 2850 grams in the 37th week.

Key words: pregnancy, complication, peritonitis.

Perforating appendicitis with fecal peritonitis is rare in pregnancy and is usually due to delayed diagnosis. The authors report a case studied at the Department of Emergency Surgery, Vittorio Emanuele Hospital, Catania University, Catania Italy, with successive delivery at the 37th week of a normal sibling.

CASE REPORT

N. M. gravida 2, para 1, 30 years old.

The patient, in the 16th week of pregnancy, complained of pain for the past two years in the iliac fossa, increasing in intensity in the last six hours, radiating to the whole abdomen, and accompanied by nausea and vomit. The general condition of the patient was good on physical exam. Blood pressure was 105/75 mmHg, heart rate 86 bpm. There was no fever.

The abdomen was immobile during respiration and painful on palpation. Uterine fundus was 10 centimers above the pubic symphysis. Auscultation did not demonstrate intestinal peristalsis and percussion was tympanic. Urinalysis and routine blood count and chemistry were normal except for leukocytosis (25000 with neutrophilia).

Right pararectal incision was performed and pus and stool were found in the inferior right quadrant of the abdominal cavity. The cecum

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was normal, while the base of the appendix was perforated. The size of the uterus was correspondent to gestational age. After appendectomy pus and stool were removed from the iliac fossa and pus from the subphrenic space; the peritoneal cavity was repeatedly washed with saline solution medicated with antibiotics.

Postoperative course was uneventful, with administration of antibiotics and progesterone (20 mg per day).

The patient was discharged on the seventh day after admission and echography showed a single pregnancy in normal evolution. She delivered a normal sibling weighing 2850 grams at the 37th week of pregnancy.

DISCUSSION AND CONCLUSION

Peritonitis is a rare complication of pregnancy. It occurs more frequently in the second trimester of gestation and causes abortion in 50% of cases, and maternal mortality in 1.8% to 3% of cases ([1, 2]). The case described is the only case of perforating appendicitis out of the 11 reported from 1967 to 1985 in this department. On laparotomy the appendix was easily removed and no drainage was applied, contrary to methods reported by other authors. In the post-operative course antibiotics and progesterone were administered. According to some authors the usefulness of progesterone in prevention of abortion is doubtful, and the dose used by us was very low. The patient delivered a normal sibling at the 37th week of pregnancy, thus in this case appendectomy in pregnancy did not cause fetal or maternal mortality.

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SJÖGREN'S SYNDROME AND VULVAR CANCER

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Summary: In the vulvar pathology surgery unit we have come across 3 patients with Sjögren's syndrome. Two of them also now show the presence of vulvar carcinoma, and one of them shows the presence of vulvar dystrophy with dysplasia.

This has induced us to consider the possible connections between the 2 pathologies.

All 3 of the patients, at different times and in different periods have been treated with steroids for the original disorder.

The connections between the 2 affections are presumably to be found in the possible autoimmunitary genesis of the original disease and in the concomitant use of steroids.

Sjögren's syndrome, first described in 1933 and typically characterized by the association of xerophthalmia, xerostomia and chronic arthritis, has also been called keratoconjunctivitis sicca or dacryosialoadenopathy ([5]). Manifestations in internal organs, especially lung, kidney and

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liver, are not infrequent, and are related to a decrease in exocrine secretion and widespread involvement of small vessels ([1, 5, 7]). Sjögren's syndrome mostly occurs in post-menopausal middle-aged women both as an isolated disease and in association with other connective tissue disorders, such as rheumatoid arthritis, LES, polymyositis sclerodermis or polyartritis nodosa. However, it may also be associated with skin manifestations, such as porpora and urticaria most frequently, and nodular and maculated erythema, telangiectasia and petechiae less frequently ([1, 2, 3, 4]). From a pathological point of view, these lesions are all related to vasculitic and perivasculitic processes which affect the post-capillary venules and small arterioles with characteristic neutrophilic and mononuclear cell infiltration ([1, 3]). More rarely, processes of necrotizing angiitis are involved with fibrinoid necrosis of the vascular wall, hemorrhagic extravasation and the presence of inflammatory infiltrates in the reticular and papillary layers of the corium ([2, 3]).

MATERIAL AND METHODS

Three patients with Sjögren's syndrome presented themselves in our out-patient clinic for vulvar disease; evidence of vulvar carcinoma was found in two, and vulval dystrophy with atypia in a third.

A. B., age 72 years, para 2002, had Sjögren's syndrome for about 4 years, and had been treated regularly with steroids. She came to the clinic because a pre-existing pruritus had recently flared up and a painful sore had developed in the vulvar area. Physical examination revealed an ulcerated lesion about 4 cm in diameter on the internal side of the labia minora. The lesion was subsequently diagnosed as II stage poorly differentiated epidermoid carcinoma. The patient underwent non mutilating radical vulvectomy and lymphadenectomy, and has since been free of disease.

M. S., age 52 years, para 0000, had Sjögren's syndrome for about one year. She came to the clinic because of vulvar swelling and numerous painful sores, which she said had evolved from nodular type formations in the space of 15 days. Physical examination disclosed conspicuous edema and severe, widespread ulcerated lesions in the vulvar area; biopsy revealed an undifferentiated carcinoma of the vulva. The patient refused any treatment, and died shortly after.

S. L., age 60 years, para 1001, had Sjögren's syndrome for about 4 years. She presented severe and persistant itching of a few months duration.

Physical examination disclosed a picture of dystrophy involving the external genitals almost entirely, and a small ulcerated area, which was biopsied and diagnosed as dysplasia. Following topical treatment with testosterone propionate, the dystrophy improved and the presenting symptoms disappeared.

CONCLUSION

These observations led us to consider the possible connections between the two diseases most probably related to the association of several factors: 1) disorders in cutaneous trophism secondary to the vasculitic process typical of Sjögren's syndrome and responsible for a generalized picture of cutaneous dystrophy involving particularly the vulvar region, rendered more sensitive by concomitant menopause; 2) contemporary use of steroids, and 3) intense and continuous pruritus. However, the evolution of the dystrophic lesion to dysplasia and subsequently neoplasia, in our opinion, is triggered by the steroid therapy which, with the descrease in immune defenses and especially the alterations in the immune system, favored this passage, in agreement with literature reports ([1, 2, 6, 7]). This leads to the conclusion primary or more generally, that all patients with primary or therapy-induced immune disorders should be considered at risk, and consequently followed closely in order to avoid neoplastic evolution of dystrophic lesions, or the particularly unfavorable and short-term evolution of vulvar lesions, as we observed in one of our patients.

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