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**Case Report**

# A giant fibroepithelial polyp of vulva

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## ABSTRACT

Fibroepithelial stromal polyps (FEPs) are benign mesenchymal lesions commonly found in cutaneous folds and the lower female genital tract. They are typically small and asymptomatic, but rarely may grow to a large size and mimic other vulvar tumors. We report a case of a giant fibroepithelial polyp of the vulva in a 48-year-old postmenopausal woman presenting with a painless, progressively enlarging pedunculated mass arising from the right labia majora for 2.5 years. The lesion measured approximately 9×5×13 cm and caused discomfort during daily activities. Complete surgical excision under local anaesthesia was performed. Histopathological examination confirmed fibroepithelial stromal polyp. Giant vulvar fibroepithelial polyps are rare and may clinically mimic more aggressive lesions; therefore, histopathological confirmation and surgical excision are essential for definitive diagnosis and treatment.

**Keywords:** Fibroepithelial stromal polyp, Vulvar mass, Giant polyp, Benign mesenchymal lesion, Surgical excision

## INTRODUCTION

Fibroepithelial stromal polyps (FEPs) are benign mesenchymal neoplasms which are most frequently observed in cutaneous folds.[1] They are also known as acrochordons or skin tags.[2,3] Fibroepithelial polyps show a wide spectrum of clinical appearances. They may present as small, papillomatous lesions that are either skin-colored or hyperpigmented, or as larger, pedunculated growths with a smooth surface. These lesions are influenced by hormonal factors and are frequently observed in women of reproductive age, particularly during pregnancy or in premenopausal women undergoing hormone replacement therapy.[1] When present in the lower genital tract, these lesions are more often observed in the vagina and only rarely involve the vulva or cervix.[1] The precise cause and mechanism of development are not fully understood; however, factors such as hormonal effects, obesity, insulin resistance, chronic irritation, and lymphatic stasis are thought to play a role.[2,3] Vulvar fibroepithelial polyps are usually small and asymptomatic; however, in rare instances, they may attain unusually large dimensions and are then referred to as giant fibroepithelial polyps. Lesions exceeding 5 cm are considered giant, with exceptional cases in the literature reporting sizes up to 42 cm.[4] We report a rare case of a giant fibroepithelial polyp of the vulva to highlight its clinical features and management.

## CASE REPORT

A 48-year old female presented to surgery OPD with a large, painless and pedunculated mass present on right vulva present for 2.5 years. Initially it was a small skin tag and gradually increased in size to the current dimension. There was no associated pain, ulceration, bleeding or discharge. The large mass caused discomfort while walking and sitting as well was causing cosmetic concern.

There was no history of trauma, local infection, similar lesion elsewhere or any previous vulvar surgery. The patient achieved menopause 2 years ago and had no history of hormone replacement therapy. Her medical and surgical history were otherwise unremarkable. There was no family history of any gynaecological malignancy.

On local examination, a large pedunculated polypoidal mass was seen arising from right labia majora, measuring approximately 9×5×13 cm. The surface of the mass was wrinkled and lobulated with areas of skin discolouration. The mass was soft to firm in consistency, non tender and freely mobile, with a long pedicle attached to vulvar skin. The surrounding vulvar skin appeared normal. Bilateral inguinal lymph nodes were not palpable. Transabdominal ultrasound was done to rule out any herniation and intraabdominal and pelvic pathologies.

Surgical excision of the lesion was performed under local anaesthesia after obtaining informed written consent from the patient. The base of the polyp was infiltrated with 2% lignocaine for adequate analgesia. Complete surgical excision of the mass was performed, with subsequent vulvar reconstruction. Haemostasis was achieved.

Upon pathological examination, a macroscopic observation revealed a polypoid mass with corrugated surface. Histopathological examination revealed tissue lined by keratinized stratified squamous epithelium on the surface. The underlying stroma was hypocellular and devoid of skin appendages.

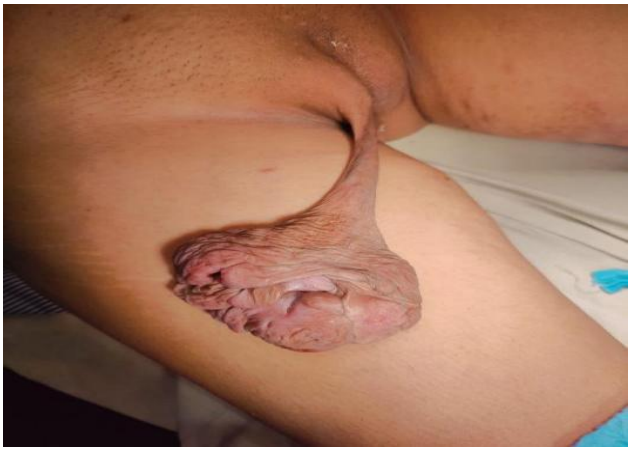

**Figure 1: Giant FEP on a stalk arising from the right labium majus.**

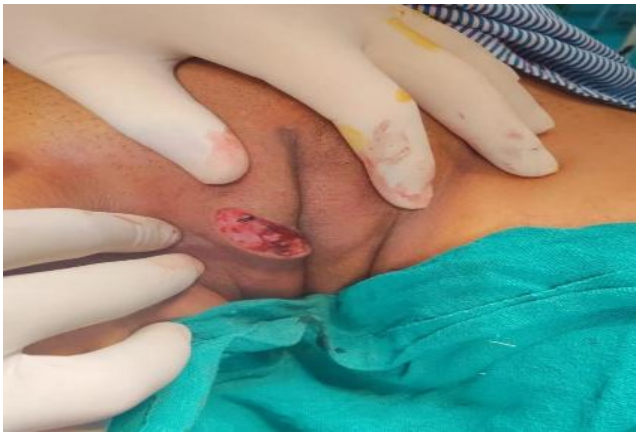

**Figure 2: Intraoperative image after resection of FEP with its stalk.**

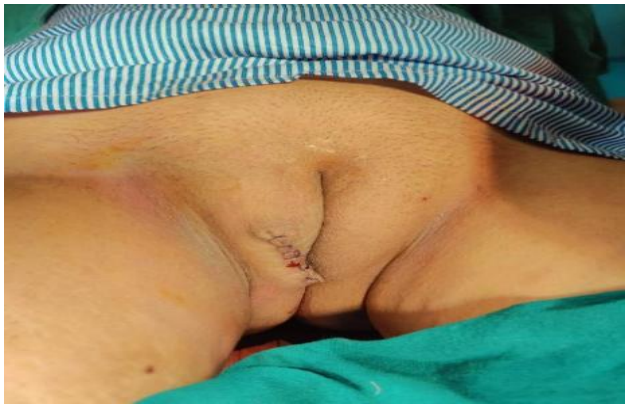

**Figure 3: Wound after suturing.**

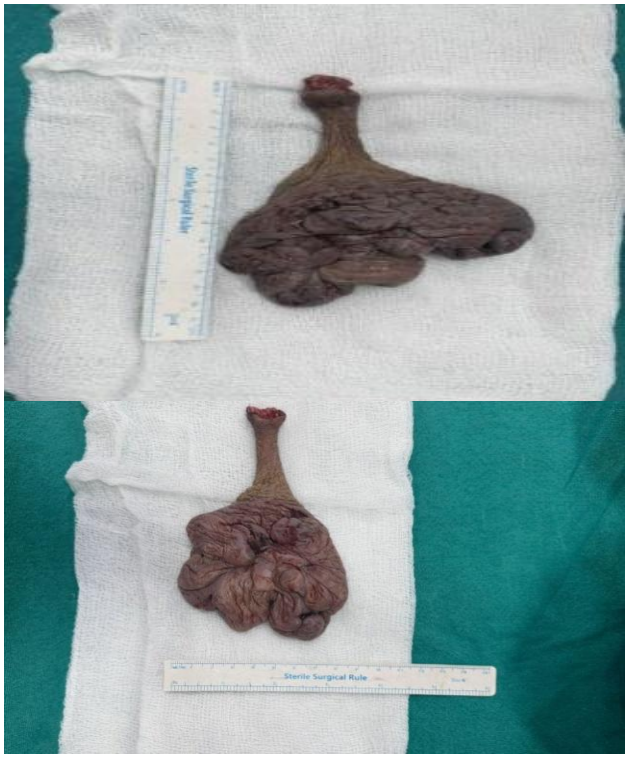

**Figure 4: Image of FEP after excision.**

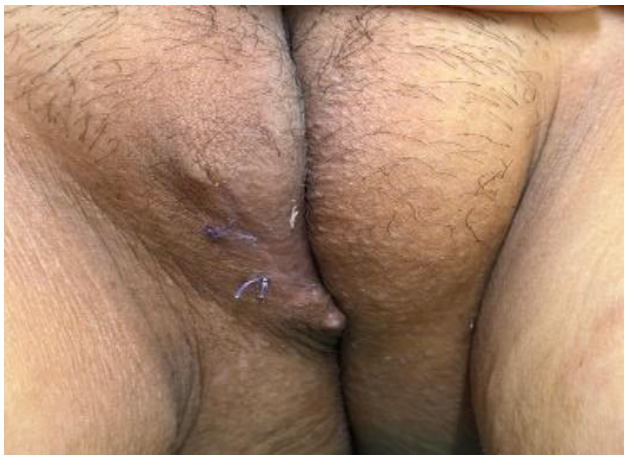

**Figure 5: Post operative image after 2 weeks.**

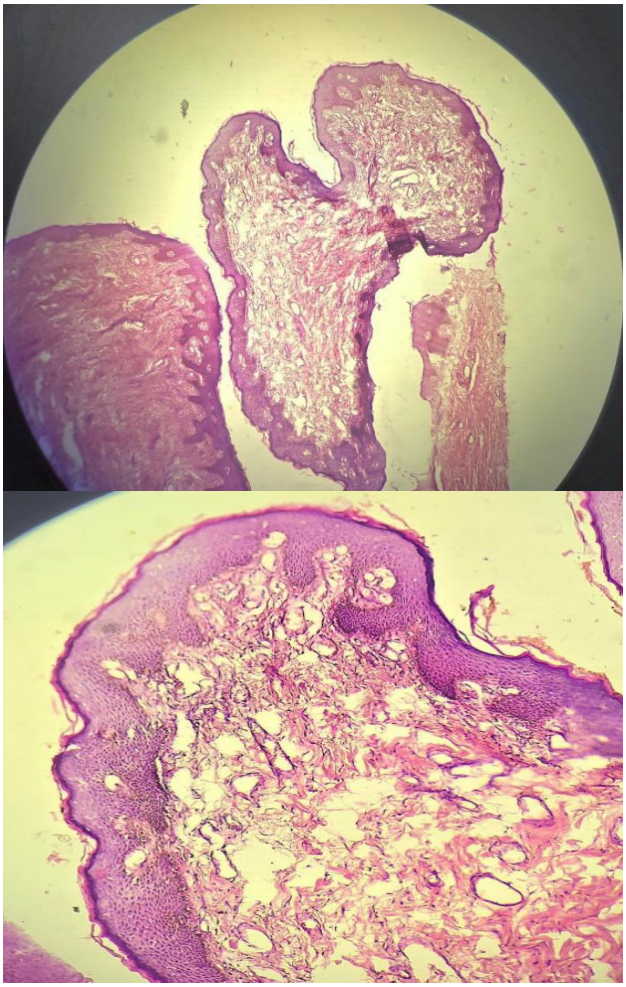

**Figure 6: Microscopic image of hematoxylin and eosin stained photomicrograph of the FEP.**

## DISCUSSION

FEPs of the vulva are uncommon benign mesenchymal lesions and are typically small, incidental findings.[1,5] When these lesions attain large dimensions, as in the present case, they pose distinct diagnostic and management challenges. The prolonged history of gradual enlargement over 2.5 years, absence of pain or bleeding, and lack of systemic symptoms in our patient are consistent with the indolent behavior expected of benign vulvar lesions, yet the size and location necessitate careful evaluation to exclude malignant or locally aggressive conditions.[6]

Clinically, large pedunculated vulvar masses raise a broad differential diagnosis that includes aggressive angiomyxoma, angiomyofibroblastoma, lipoma, Bartholin gland pathology, and vulvar malignancies.[8,9] In the present case, the slow growth pattern, well-defined pedicle, absence of ulceration or fixation, and normal surrounding vulvar skin favoured a benign etiology. Imaging was employed primarily to exclude herniation or associated pelvic pathology rather than to establish a definitive diagnosis, highlighting the limited role of radiology in such superficial soft-tissue lesions.

Histopathological evaluation remains the cornerstone for definitive diagnosis.[1,6] In our case, the presence of keratinized stratified squamous epithelium lining the lesion and a hypocellular stroma devoid of skin appendages supported the diagnosis of a fibroepithelial stromal polyp. The absence of cytologic atypia, infiltrative margins, or increased mitotic activity was particularly important in excluding malignant mimickers. Given that certain mesenchymal tumors of the vulva may share overlapping clinical features but differ markedly in prognosis and management, histopathology is essential for accurate classification.

Although fibroepithelial polyps are often described as hormonally influenced lesions, our patient was postmenopausal and had no history of hormone replacement therapy.[1,11] This finding suggests that while hormonal factors may contribute to lesion development or growth in some patients, they are not obligatory for the occurrence of giant lesions. Chronic mechanical irritation and local tissue factors may have played a contributory role in the progressive enlargement observed in this case.[2,3]

Complete surgical excision is the treatment of choice for giant fibroepithelial polyps and serves both diagnostic and therapeutic purposes.[6,7] In the present case, excision under local anaesthesia was feasible due to the pedunculated nature of the lesion and absence of deep tissue involvement. Adequate excision at the base of the pedicle is important to minimize the risk of recurrence, which has been reported in cases of incomplete removal.[13] The postoperative outcome was favourable, with resolution of symptoms and satisfactory cosmetic results.

This case underscores the importance of considering giant fibroepithelial stromal polyp in the differential diagnosis of large vulvar masses, even in postmenopausal women. Awareness of this rare presentation can prevent overtreatment and unnecessary anxiety, while emphasizing the role of thorough clinical assessment and histopathological confirmation in guiding appropriate management.[9]

## CONCLUSION

Giant FEPs of the vulva are rare benign lesions that can attain significant size and cause functional and psychological discomfort despite their indolent nature. Although typically associated with reproductive age and hormonal influence, this case demonstrates that such lesions may also occur and progressively enlarge in postmenopausal women without hormone exposure. Their unusual size and location can mimic more aggressive or malignant vulvar pathologies, making careful clinical evaluation and histopathological

confirmation essential. Complete surgical excision remains a simple, effective, and curative treatment, providing both symptomatic relief and definitive diagnosis. Reporting such uncommon presentations is important to increase awareness among clinicians, facilitate timely diagnosis, and avoid unnecessary extensive investigations or overtreatment.

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