Introduction
Angiomyofibroblastoma is a rare benign mesenchymal tumour usually occurs in peri-menopausal women around vulvar and vaginal areas. In 1992, Fletcher and his colleagues first described angiomyofibroblastoma. Clinically, these tumours are slowly growing, painless masses, confused as a Bartholin’s cyst and aggressive angiomyxoma. Histology shows spindle-shaped cells with production of collagen fibres with hypercellular areas, usually around the vessels. Immunohistology is helpful in excluding other differential diagnosis.

Case Report:
A 35 years with obstetric score P2L2 and tubectomised; came with a history of swelling in the labia major left side since 6 months. She had regular menstrual cycle. Initially the swelling was small in size and it gradually increased to reach the present size. Local examination revealed a soft, non tender mass in anterior aspect of left labia major, which was mobile, measuring about 10x8cm. (Fig-1) Skin over the swelling appeared normal. No palpable inguinal lymph node was seen. Her past medical and family history were not significant. General and systematic examination was unremarkable. The patient underwent complete surgical excision of the tumor. Macroscopically, tumour looks reddish in colour measuring about 7.5x6.5x5.5cm, and was soft in consistency (Fig-2). The sample was sent for Histopathological examination (Fig-3).

Discussion:
Normally the AMF is found in vulval region; but it can also be found in vagina, cervix or retroperitoneum. This tumour may vary in size between 2cm to 15cm. AMF is misdiagnosed as Bartholin’s cyst or lipoma. The tumour is always asymptomatic and normally patient complains of pelvic discomfort. The treatment of AMF is surgical excision, which is usually complete because the tumor is well encapsulated. Where as AAM is borderline and aggressive tumor.
This tumor is associated with local infiltration, which results in entrapment of nerves and mucosal glands, which makes excision incomplete. So adjunctive therapy like GnRH agonist can be used after incomplete excision or in case of recurrence. Histological findings shows alternating hypercellular stromal area and hypo cellular edematous area. Stromal cells are spindle or epitheloid shaped, gathered around abundant vessels. (fig-3) Immunohistochemistry will be positive for Vimentin & desmin. Oestrogen and Progestrone receptors shows hormone dependent of the tumour. AMF and AAM are originated from myofibroblastic or fibroblastic cells.

The differential diagnosis of AMF includes smooth muscle tumors, peripheral nerve sheath tumor, myxoid malignant fibrous histiocytoma and myxoid liposarcoma. In this case Immunohistochemistry was not done.

**Conclusion:**

AMF is benign mesenchymal tumor both pathologically and clinically. AAM must be ruled out before surgery and requires resection with tumor free margins to prevent recurrence.

**Acknowledgement:**

Authors acknowledge the scholars whose articles are cited and included in references of this manuscript. The authors are also grateful to authors/editors/publishers of all those articles and journals from where the literature for this article has been reviewed and discussed.

**References:**

1. Mohammad Shahid Iqbal, Angiomyofibroblastoma of Vulva. A Rare Tumor Entity IOSR Journal of Dental and Medical Sciences (IOSR-JDMS) Volume 8, Issue 3 (Jul.- Aug. 2013), PP 36-38