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Case Report

A Case of Large Cervical Leiomyoma

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Abstract

Uterine Leiomyoma or Myoma or commonly favorite named Fibroid is a most common entity of genital organ tumor. It is almost benign tumor of smooth muscle origin where smooth muscle fiber and fibrous connective tissue intermingled together often found in uterus. Although it is a disease of nulliparous but in perspective of our country it diagnosed in patient's having one or two child because of early marrital status. Tumor varies in number 1-200 and also varies different clinical features and severity depending site of presentation. Leiomyoma is generally slowly progressive disease but sometimes it grows very rapidly. With the advent of Ultrasonography it is incidentally diagnosed often with asymptomatic cases. Usually Ultrasonography is the single most predictor of investigation[1] from very early cases although MRI is helpful.

Asymptomatic large Fibroid present with various unusual symptoms like pressure symptom of surrounding structure or feeling of heaviness of lower abdomen or fullness of abdomen. Large cervical Fibroid is a uncommon presentation with mainly urinary difficulties where patients chief complaints is frequent micturation and incomplete voiding of urine without significant menstrual abnormalities. The described cases for urinary complain patient consulted with urologist and referred as a large cervical Fibroid diagnosed by sonography. This article illustrates a case of 34 years old lady present with frequent micturation and incomplete voiding of urine that developed last 5-6 months duration. Total abdominal hysterectomy performed, histologically the specimen showed benign uterine leiomyoma. Post operative circumstance uneventful evaluation occur and patient back to home with normal duration hospital stay.

Keywords: Leiomyoma, large cervical Fibroid

Introduction

Cervical Fibroid is not a common entity although other varities of myoma is most common benign tumor in reproductive age group.[1] Being oestrogen dependency rare before menarche and physiologically regression occur after menopause.[2] Large scale of sonography invention of presence of tumor at very initial stage of the tumor. Gynaecologist receiving to serve the patient only when presence with complications or symptoms appear. Major symptoms often correlate with the localization, severity and number of the tumor. Most frequent presentation heavy menstrual flow, heavyness of lower abdomen is an unusual variant symptom otherwise bigger size.[3] Infertility and frequent micturation even large asymptomatic Fibroid left uncared absence of emergence. However, severe complications arise during surgery of Illustratedcase of such large cervical Fibroid because of question of injury of important structures like ureter and uterine artery.[4] A uncared interesting case of large cervical Fibroid is presented here.

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Case Report

A 40 years multiparous lady hailing from Boalmari, Fardipur presented in DAMCH with incomplete voiding of urine and frequent micturation without significant history of menorrhagia lasting for previous 5 months. There was no history of nausea, anorexia and weight loss or appetite. Regarding menstrual history menarche established at 13 years of age, her cycle was not disturbing except last 5-6 months which is not significantly increased. Regarding obstetric history she got married at her 20 years old and become mother of 3 child without any hazards. Reporting her last child is being 12 years. She got complain of frequent micturation and incomplete voiding of urine and consulted local doctor repeatedly. History of slight menorrhagia which was ignored by the patient and for repeated recurrent UTI treated accordingly locally. Finally for complicated UTI she consulted with Urologist and her cervical Fibroid was incidentally diagnosed by routine sonography. Such she was advised to Gynaecologist for appropriate management. Regarding past medical history she was diagnosed case of Type-II Diabetes Mellitus for 10 years and also Essential Hypertension for 5 years. She was on regular insulin and antihypertensive drugs. She had also significant surgical history that is previous 3 caesarian sections. On attending the patient she is mildly anaemic anxious and depressed. On per abdominal examination revealed no abnormalities. Per vaginal examination showed a firm rounder non tender movable mass which is moved from side to side also felt no gap between mass and

uterus. The mass displaced cervix posteriorly and fornix obliterated without any visible inflammation in cervix. Per rectal examination also revealed large globular lump.

Her haemoglobin level was 9 gm/dl and ultrasonography findings showed bulky uterus contain large hypoechoic mass lesion about (11.9 x 11.3)cm and volume about 58ml present in lower part of uterus. After correcting anaemia with 1 unit of blood and after proper control of diabetes and hypertension operation done with the aid of necessary investigations done for Anesthesia. Extra 2 unit of blood kept ready before operation. Her anticoagulant also stopped 7 days before commencing the confirmed OT date.

Planned for TAH lower transvers incision is made along her previous caesarian scar. There was difficulty to enter the abdominal cavity because of previous caesarian adhesion of omentum and urinary bladder with uterus. Removal of adhesion gently and expose the uterus clearly both ovaries and fallopian tubes are preserved. And after 1st clamping large myoma enucleate from cervix and 3 others small sized myoma also enucleate from broad ligament and different areas.As large cervical Fibroid distorted the surrounding structure so special attention for prevention of any uneventful circumstances of important structures and dissection during enucleation of such myoma done very cautiously and gently. Uterine artery and ureter are more prone structure to injury during enucleation procedure

Histopathology send an report showed benign leiomyoma of uterus. Patient post operative recovery was uneventful and discharged 3 days after operation. Post discharged follow up was also uneventful when she comes back 7 days later.

Discussion

Myoma/Leiomyoma/Fibroma/Fibroid is the commonest benign uterine tumor and accounts for the most common indication for Hysterectomy.[5] These tumors are presents in approximately 1/3 of reproductive life.[6] Although physical examinations revealed the presence of tumor but various Imaging procedure made it easy for diagnosis. Sonography is the most widely used procedure even very smaller one. Tumors are truly depended on oestrogen hormone as they commence the sign symptom in reproductive age. Although post menopausal ladies presentation is not rare.[7] Patients mostly appear Gynaecologist due to heavy menstrual flow or anaemia caused by menorrhagia, others common presenting symptoms are infertility and pressure symptom like heaviness of lower abdomen or frequent micturation due to bladder pressure effect.

Described cases patient attend with recurrent UTI and incomplete voiding of urine. Though such unusual presentation illustrated cases present with mild hidden anaemia. In spite of wider availability of USG initial scanning was delayed and diagnosed after developing greater complications. Although MRI has been judged to be the most expensive modalities for further evaluation like number/specific location/surrounding structures involvement[8] but it was not proceed further due to poverty.

Described case histopathology shows leiomyoma but no degeneration or sarcomatous changes are not identified. Now a days suitable different modalities of treatment option includes GnRH agonist like ulipristole, uterine arteries embolization are more convenient[9]. Surgical removal of large uterine Fibroid is the traditional treatment they may causes infertility and in the presence of pregnancy they may affect the outcome.[10] Illustrated cases as future fertility does not matter so more convenient total abdominal hysterectomy is decided. Though various challenges faces during operation specially to secure uterine artery and ureter and also surrounding structures and unavoidable massive blood loss. Long term medical treatment is associated with high cost, menopausal symptoms, and bone loss, increased risk.[11] Uterine Artery Embolization (UAE), as a pre-surgical treatment to decrease intraoperative blood loss, was found to be effective in some studies. UAE was reported to be more cost effective than myomectomy and hysterectomy.[12] Embosphere Microsphere; the most clinically studied embolic, provide consistent and predictable result for effective fibroids, hypervascular tumors or arteriovenous malformations.[13] Myolysis including mono or bipolar cautery, Nd-YAG laser vaporisation or cryotherapy is currently experimental.[14]

Conclusion

Although Leiomyoma is very common tumor and usually derived from uterine smooth muscle. But uncommonly may arise from an unusual site and present with unusual symptom. Tactful and prompt treatment causes rapid solution of symptom and ensure better quality of life of the patient.

References

1. Karim T, Kundan P, Panchal A, Basu C, Presentation and management of giant fibroid uterus in an adolescent girl, Open Access Surgery 2010:33 13-15.
2. Kjerulff KH, Rhodes JC, Langenberg PW, Harvey LA, Patient satisfaction with result of hysterectomy.Am J ObstetGynecol 2000: 183: 1440-7.
3. Bahri U et al, Is uterine artery embolization prior to myomectomy for giant fibroids helpful, DiagnIntervRadiol 2007: 13: 210-212.
4. Kirsch RW, et al. The fibroid Registry for Outcomes Data (FIBROID) for Uterine Embolization Short Term Outcomes: Obstetrics & Gynaecology: 2005: 106(1).
5. Van voorish B. A 41-year-old woman with menorrhagia, anemia, and fibroids: Review of treatment of uterine fibroids. JAMA. 2009;301(1):82-93.
6. Corton M, Cunningham F, Gala R, Hoffman B. Aspect of gynecologic surgery. In: Schorge J, et al, editors. Williams gynecology, Chapter 38-40. 1st ed. McGraw-Hill; 2008: p. 773-865.

7. Donnez J, Squifflet J, Polet R, Nisolle M. Laparoscopic Myolysis. Hum Reprod Update. 2000;6(6):609-13.

8. Van Roorhis BJ, Romitti PA, Jones MP. Family history as a risk factor for development of uterine leiomyomas: result of a pilot study. J Reprod Med. 2002; 47:663-669.

9. Fields KR, Neinstein LS, Uterine myomas in adolescents: Case reports and a review of the literature.JPediatrAdolesc Gynecol. 1996;9:195-198.

10. Basnet N, Banerjee B, Badani U, Tiwari A, Raina A, Pokharel H, Yadav P, Agrawal A, Chhetri S. An unusual presentation of huge cervical fibroid. Kathmandu University Medical Journal 2005; 3(2): 173-174.

11. Hoffman B, Pelvic mass. In: Schorge J, et al editors. Williams Gynecology, Chapter 9. 1st Ed. McGraw-Hill; 2008: p. 197-224.

12. Courbiere B. Carcopino X. Fibromesuterins. In: Gynecologic Obstetrique. 6th ed. Verna-zobres-Greco; 2006-2007; p. 359-365.

13. Pitkin J. Uterine fibroids. In: Obstetrics and Gynaecology. Ed. Churchill Livingstone; 2003. p. 118-119.

14. Jonas HS. Giant uterine tumors: case report and review of the literature. Obstet Gynecol. 1977; 50 (1 Suppl):2s-4s.

15. Grapsa D. A giant uterine leiomyoma simulating an ovarian mass in a 16 -year-old girl: a case report and review of the literature. Eur J GynaecolOncol. 2006; 27(3): 294-6.

16. Rice JP, Kay HH, Mahany BS. The clinical significance of uterine leiomyoma in pregnancy. Am J obstetgynecol 1989; 160: 1212-6.