



PROLAPSED CERVICAL LEIOMYOMA PRESENTING AS GYNAECOLOGICAL EMERGENCY

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ABSTRACT

Leiomyomas are the most common benign tumors of the uterus which have a wide and varied spectrum of presentation. Also the myomas may become necrotic, infected and gangrenous because of inadequate blood circulation. In this report, we present a 40-year old multiparous woman with a huge prolapsed cervical fibroid. The patient underwent vaginal myomectomy. As in the present case, vaginal myomectomy is a feasible, easy and effective procedure with minimal associated morbidity in patients with large fibroid polyp.

KEYWORDS: Leiomyoma, Cervical fibroid, Vaginal myomectomy

INTRODUCTION

Uterine leiomyomas are the most common tumor of the reproductive tract in women of reproductive age accounting for one-third of all cases of gynecological admissions.^[1,2] Mostly they are asymptomatic, however, uterine leiomyomas may cause debilitating symptoms in many women, such as abnormal uterine bleeding, abdominal pain, urinary frequency, constipation, pregnancy loss, dyspareunia, and in some cases infertility.^[1,2] They are oestrogen dependant.^[1] They may originate from the cervix or pass through the cervical canal while still attached by a stalk.^[1,2] When this occurs, they may prolapse out of the introitus as was seen in the present case.

CASE REPORT

A 40 year old lady, para three with live issue three with history of previous three caesarean sections presented to the emergency with 1 hour history of a progressively increasing mass protruding from the vagina, lower abdominal pain and heavy vaginal bleeding. She had complaint of bleeding per vaginum off and on for past 3 months. On examination patient was anxious, in painful distress, pallor was present, pulse rate was 100 beats per

minute, BP was 104 systolic and patient was afebrile. The abdomen was soft, non tender and showed a midline scar. Local examination revealed a large firm mass of 7×8×8 cm in size, irregular, with dirty areas of necrosis and haemorrhage and bleeding profusely on touch (Figure 1). On per vaginal examination uterus was slightly bulky and mass was felt arising from anterior lip of cervix by a thick short pedicle about 1.5-2 inches in thickness. One month prior to presentation, she was seen in our gynecology clinic and noted to have a large cervical leiomyoma which was inside the vagina and lips of the cervix could not be felt then. Ultrasound was done then which revealed a large cervical fibroid (Figure 2). She was scheduled for surgery but due to anemia her hemoglobin was being built up by injectable iron and she was prescribed tranexamic acid to control bleeding. Now, due to profuse bleeding, patient was immediately taken up for vaginal myomectomy/hysterectomy after taking consent. Fibroid polyp was enucleated and the pedicle was clamped and ligated (Figure 3,4). Uterine curettage was done. Haemostasis was achieved. 1 unit packed red blood cells was transfused per operatively, and the procedure was successfully completed. Post operative course was

uneventful and patient was discharged in good condition after 4 days. Histopathology reported it to be leiomyoma with areas of degeneration and necrosis.



Figure 1. Prolapsed cervical leiomyoma with dirty areas of haemorrhage and necrosis



Figure 2. Ultrasound showing cervical fibroid



Figure 3. Fibroid polyp removed with ligated pedicle

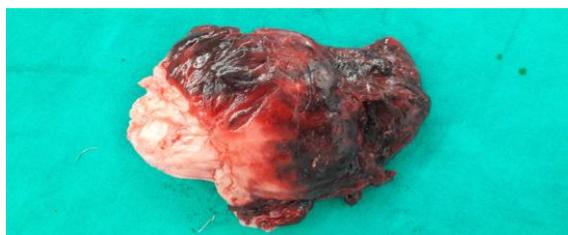


Figure 4. Removed fibroid polyp

DISCUSSION

Leiomyoma, commonest benign solid tumour in female, is composed mainly of smooth muscle cells but it also contains various amount of fibrous connective tissue. The tumour is well circumscribed with a false capsule. Its true incidence cannot be determined but asymptomatic fibroids are present in approximately 40 to 50% women older than 35yrs of age.^[3] The incidence is higher in black women than white but there is no explanation for this racial differences. Its aetiology is unclear but prevailing hypothesis is that it may arise from single neoplastic smooth cell of myometrium.^[4] The stimulus for transformation may be chromosomal abnormality or some polypeptide growth factor that may stimulate the growth either directly or via estrogen. There is often family history suggesting gene coding for their development.^[4]

Cervical fibroid is rare and accounts for 2% of all uterine myomas. Supravaginal cervical fibroid may be interstitial or sub-peritoneal variety and rarely polypoidal. Depending upon the position it may be anterior, posterior, lateral and central. Interstitial growths may displace the cervix or expand it so much that external os is difficult to recognise. All these disturb the pelvic anatomy and cause displacement of the ureter. Vaginal cervical fibroid is usually pedunculated and rarely sessile.^[5]

Symptoms in cervical fibroid are predominantly due to pressure effect on the adjacent structures especially on the bladder causing frequency and retention of urine.^[6] Bladder symptoms like frequency or even retention of urine are more common with anterior cervical fibroid while posterior cervical fibroid produces rectal symptoms in the form of constipation. Lateral cervical fibroid causes vascular obstruction which may lead to hemorrhoids and edema of legs. Ureter is pushed laterally and below the tumor. In central cervical fibroid, cervix is expanded on all sides and uterus sits on the top of expanded cervix which gives Lantern on St.Paul's cathedral appearance.^[7]

Women with fibroids are only slightly more likely to experience pelvic pain than women without fibroids. Fibroid degeneration causes pelvic pain. As fibroids enlarge, they may outgrow their blood supply, with resulting cell death. Types of degeneration determined both on gross and microscopic examination include hyaline degeneration, calcification, cystic degeneration, and hemorrhagic degeneration. Clinical symptoms appear to be unrelated to type of degeneration.

For symptomatic women, management depends on an accurate assessment of the number, size and position of fibroids. MRI allows evaluation of the number, size, and position of submucous, intramural and subserosal fibroid and can evaluate their proximity to the endometrial cavity, bladder and rectum. Ultrasonography is the most

readily available and least costly imaging technique to differentiate fibroids from other pelvic pathology.

Treatment of huge cervical fibroid is either by hysterectomy or myomectomy and needs an expert hand.^[8] Myomectomy may be tried if the patient is young and desirous of having a baby. Preoperative GnRH analogues administration for 3 months facilitate surgery and improve the hemoglobin status.^[9]

In our case, the growth of the fibroid may have outgrown its blood supply which caused its extrusion as fibroid polyp. Vaginal myomectomy was resorted for removal of the prolapsed cervical leiomyoma. This was a quick and safe procedure with reduced operating time, anaesthetic exposure and intraoperative bleeding in this ill-anemic patient than abdominal myomectomy.

CONCLUSION

Leiomyoma are mostly asymptomatic. Symptomatic leiomyomas are managed with either medical therapy or surgical management in the form of myomectomy or hysterectomy. Newer therapies like uterine artery embolization and hysteroscopic resection are gaining popularity but vaginal myomectomy with minimal associated morbidity still remains the mainstay treatment especially in large fibroid polyps.

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