EUROPEAN JOURNAL OF BIOMEDICAL AND PHARMACEUTICAL SCIENCES
http://www.ejbps.com

ISSN 2349-8870
Volume: 9
Issue: 1
372-373
Year: 2022

CERVICAL LEIOMYOMA: A CASE REPORT

[1]Dr. Shikha Sharma, [2*]Dr. Akshay Sharma, [3]Dr. Gagan Acharya and [4]Dr. Anupam Sharma

[1]MS OBG, Medical Officer, Regional Hospital, Bilaspur, HP.
[2]MD Radiodiagnosis, Medical Officer, Civil Hospital, Shahpur, HP.
[3]MD Medicine, Pandit Jawaharlal Nehru Govt Medical College, Chamba,HP.
[4]MS OBG, Medical Officer, Regional Hospital, Bilaspur, HP.

***Corresponding Author: Dr. Akshay Sharma**
MD Radiodiagnosis, Medical Officer, Civil Hospital, Shahpur, HP.

Article Received on 10/11/2021 **Article Revised on 01/12/2021** **Article Accepted on 21/12/2021**

ABSTRACT
Leiomyoma are most common tumors of uterus, usually presenting in the reproductive age group. However, only 1-2% fibroids are confined to cervix. Cervical leiomyoma is mostly single and are sub serous or interstitial in origin. They arise either from supravaginal or vaginal portion of cervix. We report a case of 42 year old female with complaint of heaviness in pelvic region and pelvic pain and was diagnosed with cervical fibroid . She had a firm, non-tender mass of 12-14 weeks size pregnant uterus with restricted mobility. Laparotomy showed a large mass arising from the posterior lip of cervix. Total abdominal hysterectomy was done. Large cervical fibroids are rare, presenting with surgical difficulties underwent enucleation followed by total abdominal hysterectomy. We conclude that cervical fibroids are a challenge to the gynaecologist due to close proximity to the ureter and bladder. Careful dissection is needed in the management of such cases.

KEYWORDS: Leiomyoma; Cervical fibroid; laparotomy; Total abdominal hysterectomy.

INTRODUCTION
The incidence of leiomyoma in the reproductive period is 20%. Only 2% of these arise from the cervix.[1] Cervical fibroids are classified depending on their location as anterior, posterior, lateral and central. They can be further classified as interstitial, subserosal and submucosal polypoid.[2] Anterior fibroid causes urinary retention whereas posterior fibroid compress rectum and results in constipation.[3] Lateral cervical fibroid burrows in broad ligament and expands it. Central cervical fibroid equally expands in all directions and produces mainly pressure symptoms.[4] Due to their close proximity, there is increased risk of bladder and bowel injuries along with risk of intraoperative bleeding.

CASE
A 42-year-old female, P2L2, presented with complaints of heaviness in pelvic region and pelvic pain for 2 months. No complaints of any menstrual abnormality, urinary retention, urgency, constipation or mass per vagina. On Examination: Vitals were stable. On per abdominal examination, a mass of 12-14 weeks size gravid uterus, firm in consistency, non-tender with restricted mobility was noted. Lower margin could not be reached. Per speculum examination showed a large solid mass arising from the posterior lip of cervix. Bimanual examination showed a large solid mass filling the pelvic cavity and uterus could not be felt separate from the mass. Investigations revealed Haemoglobin 10 gm%. On ultrasound: A subserosal fibroid 6*5cm on posterior side of uterus. Bilateral adnexa were normal. On MRI: A large exophytic soft tissue mass arising from posterior wall of cervix measuring 6*5*4 cm. Mass was predominantly solid with areas of cystic degeneration and foci of haemorrhage seen within. Patient was planned for hysterectomy. The patient underwent abdominal hysterectomy with bilateral salpingectomy. The postoperative period was uneventful. At the postoperative evaluation visit the patient was clinically well.

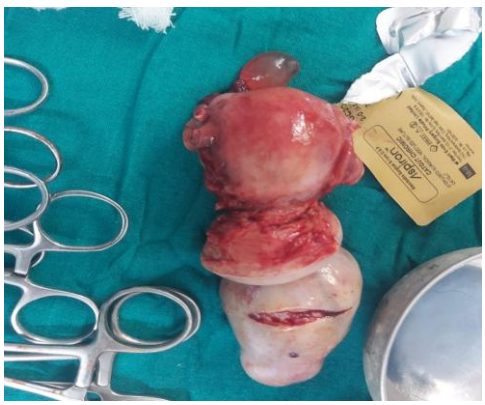

Figure 1: Uterus with cervical fibroid arising from posterior lip of cervix.

DISCUSSION

Cervical fibroids can be classified into subserosal and intramural. Some complications associated with this pathology are described, such as abnormal uterine bleeding, compression of the urethra and bladder, pelvic or abdominal pain, uterine prolapse, leiomyoma torsion or infection. Its diagnosis is sometimes difficult and may require endovaginal ultrasound and sometimes magnetic resonance imaging (MRI).[1] The treatment is surgical and depends on the characteristics of the uterus, concomitant uterine pathology and the characteristics of the myoma itself, number and location.[5] It may be considered abdominal or vaginal hysterectomy.

CONCLUSION

Treatment of huge cervical fibroids is either by hysterectomy or myomectomy. Myomectomy can be tried in young patients. Pre-operative treatment with GNRH analogues for 3 months can be tried. During surgery, due to proximity of ureters, careful enucleation followed by dissection should be done. During enucleation, limiting dissection to within the capsule is the key to preventing ureteric injury.

REFERENCES

1. Tiltman AJ. Leiomyomas of uterine cervix: A Study of frequency. Int J Gynaecol Pathol, 1998; 17(3): 231- 4.
2. Jeffcoate N. Tumors of corpus uteri. In: Bhatla N (ed). Jeffcoate's Principles of Gynaecology, 6 th Ed. Delhi, Arnold Publication, 2001; 466-497.
3. Bhatla N. Tumours of the corpus uteri. Jeffcoats principles of gynaecology 6th Edn. Arnold Printers, London, 2001; 470.
4. Sharma S, Pathak N, Goraya SP, et al. Large cervical fibroid mimicking an ovarian tumour. Sri Lanka J Obstetr Gynaecol, 2012; 33.
5. Shirsagar SN, Laddad MM. Unusual presentation of cervical fibroid: Two case reports. Int J Gynaecol Plastic Surg, 2011; 2: 38-9.