Case Reports

A case of axial torsion of uterus with a large haemorrhagic leiomyoma

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Abstract

Management of uterine fibroids is common in day today practice of gynaecologists, but a large haemorrhagic leiomyoma with axial torsion of uterus is a rare occurrence. We report a case of 52-year old female presented with abdominal distension and pain. An enlarged twisted haemorrhagic uterus was identified at laparotomy which was successfully removed. Histopathological examination showed a benign leiomyoma with focal congestion. The patient had an uneventful postoperative recovery.

Key words: uterine torsion, leiomyoma, laparotomy.

Introduction

Uterine fibroids (leiomyoma) are the most common tumours found in women. Their occurrence increases with age; they occur in 20-50% of women over the age of 30 years[1]. But an axial torsion of the uterus with a large haemorrhagic uterine fibroid is uncommon. We report a case of successful management of a 52-year old menopaused woman who had a twisted uterus with a large haemorrhagic uterine fibroid at District General Hospital, Nuwaraeliya.

Case report

A 52-year old menopaused female with history of one miscarriage presented with sudden onset dull abdominal pain for one day duration. She had no urinary symptoms. Her bowel habits were normal. There was no per vaginal bleeding. She had recent loss of weight and there was no loss of appetite. She had regular periods and menopaused at the age of 42 years. Her surgical history was not significant. On examination, she was pale and her abdomen was distended. There was a regular abdominal mass which was compatible with 34 weeks size gravid uterus, filling up to the epigastric region, tender and solid in consistency. Her vaginal examination was normal. On investigations, her haemoglobin was 6.8 grams per deciliter and her blood film showed a leukoeruthroblastic picture with moderate normocromic normocytic anaemia. The ultrasound scan suggested a heterogeneous mass arising from left adnexa extending up to epigastric region with solid and cystic consistency, with an appearance of a left ovarian tumour with ascitis. She was planned for laparotomy and optimized for surgery with blood transfusion. CA-125 was within the normal range.

At exploratory laparatomy under general anaesthesia an enlarged twisted haemorrhagic uterus (about 34 weeks gravid uterus size) was found (Figure 1) with bilateral attached necrosed ovaries and tubes. Omentum was adhered at one place and easily sepe-rated. Uterus was 9 kgs in weight. Liver, diaphagrm under surface and omentum were clinicaly normal. No enlarged pelvic or paraaotic lymph nodes were identified.

Total abdominal hysterectomy and bilateral salpingo-oopherectomy was performed without difficulty. The patient had an uneventful recovery. Histopathological report confirmed enlarged and congested uterus and cervix with bilateral tubes and ovaries. Macroscopically, The uterus measured 22×20×15 cm. A large intramural fibroid measuring 18×18×13 cm was present. Microscopically, the endometrium, bilateral tubes were severely congested and nonviable. A benign leiomyoma with focal congestion and hyalinization was seen. There was no malignancy.

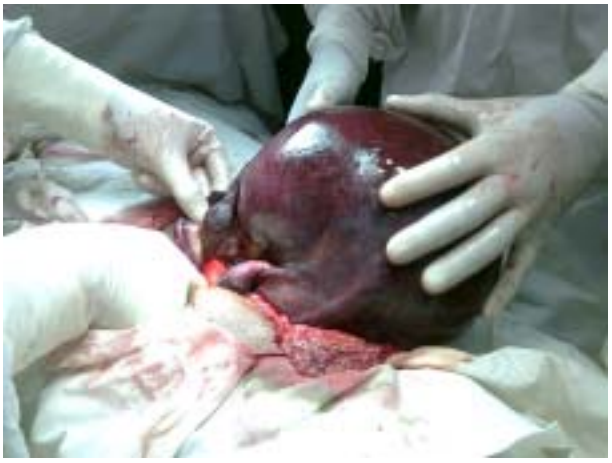

Figure 1.

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Discussion

Torsion of the uterus is defined as rotation of more than 45 degrees around the longitudinal axis of the uterus and ranging 60 to 900 degrees have been described[2]. It is more common in animals, and in case of humans most often seen in pregnant women, and is extremely rare especially in non gravid uterus. Uterine torsion is normally prevented by round and broad ligaments, and it is difficult to explain the mechanism of axial torsion of normal uterus.The causal factors are not well understood, but the presence of pathological and abnormal conditions in the uterus or adjacent structures, especially uterine leiomyomas are usually regarded to be responsible[3].

Clinical manifestations varies from acute to chronic symptoms. Abdominal pain is the most common symptom and which was the presenting complaint in our patient as well. Our patient had a large twisted congested fibroid uterus with bilateral attached nercrosed ovaries and tubes. The ultrasound scan failed to diagnose the condition correctly but other modalities of imaging such as a CT scan would have been helpful to diagnose it correctly before the surgery but it was not easily available.

After initial assessment, laparotomy with hysterectomy or myomectomy is necessary in almost all non gravid cases. Our patient had a total abdominal hysterectomy with bilateral salpingo-oopherectomy at laparotomy as she had a chronic torsion leading to non viability of internal genital organs.

References

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