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Case Study

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LARGE CERVICAL FIBROID- A CASE REPORT

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ABSTRACT

Fibroids are benign, monoclonal tumors of the smooth muscle cells of the myometrium. Fibroids arising from cervix are rare tumours consisting 2% of all uterine tumours. Cervical leiomyoma is mostly single and are sub serous or interstitial in origin. They arise either from supravaginal or vaginal portion of cervix. Here we report a case of a 52 years old female presented with secondary dysmenorrhoea with urinary symptoms and was diagnosed to have huge anterior cervical fibroid of size 20x15x13cm, underwent total abdominal hysterectomy successfully without any injury to bladder and ureters.

KEYWORDS: myometrium, supravaginal, tumours.

INTRODUCTION

Although leiomyomas are the most common pelvic tumors presenting in the reproductive age group, cervical fibroids are rare and it accounts for 2% of all uterine fibroids. Cervical fibroid develops usually in its supra vaginal portion. Huge cervical fibroid may push the uterus upwards. These tumors can frequently present with retention of urine, menstrual abnormalities, constipation, and sometimes can present only as an abdominal mass without any other symptoms.[2]

CASE REPORT

52 years old multipara came to Gynaecological OPD at Dr. S.C.G.M.C. Nanded with complaints of excessive pain during menstruation with no menstrual irregularities but with urinary symptoms like intermittent retension of urine. Her previous cycles were regular with average flow of 4-5 days, not associated with clots passage. No history of post coital bleeding, any drug intake or presence of chronic illnesses.

On examination, general condition of the patient was moderate, vitals were stable.

Per abdomen: uterine mass of size corresponding to 24 wks was palpable, which was hard in consistency,non tender.
Per speculum: cervix, vaginal appeared healthy.

per vaginal examination: uterus size corresponds to 24 wks. a hard mass felt along the anterior lip of cervix growing towards the anterior wall of uterus and both the fornices, moves along with the cervix uterus not felt sepertely s/o ? anterior cervical fibroid.
Per rectal examination was found to be normal.

Blood investigations were within normal limits.

Ultrasound: bulky uterus with large uterine fibroids of size 18.2x16.4x15.5cm and other 4.4x3.6cm in fundal region of uterus.

Patient was informed about her condition, and patient worked up for surgery. posted for TAH as family was completed.

Laprotomy was done. e/o anterior huge cervical fibroid of size 20x15x13 cm occupying the entire pelvic cavity with uterus sitting on top of it giving typical appearance of lantern on st. Paul's dome. **(figure 1)**. 2 small fibroids of size 5x 3x2cm noted in the posterior wall of uterus. **(figure 2)**

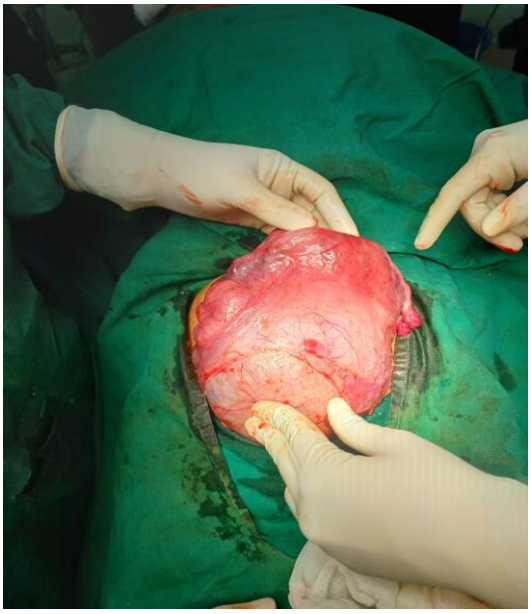

Figure 1: anterior cervical fibroid of size 20x 15x13cm with uterus sitting on top of it, "Lantern on st. Paul's dome" appearance.

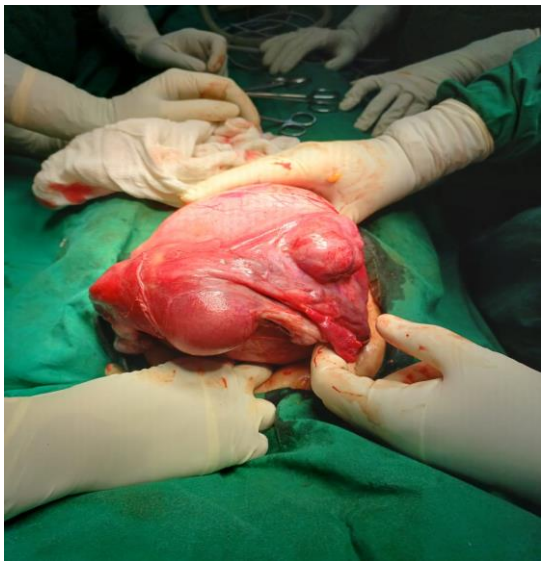

Figure 2: two small posterior wall fibroids of size 5x 3x2 cm.

Bilateral round ligament clamped, cut and transfixed. Bilateral infundibulopelvic ligament clamped, cut and ligated. Uterovesical fold of peritoneum identified, cut and bladder pushed down. Bilateral ureters were traced and course identified in the pelvis. Hysterectomy done by serially ligating and cutting and transfixing bilateral uterine vessels, mackenrodt's and uterosacral ligaments as close to the uterus. Vault suspension done. And uterus with bilateral salphinx removed and sent for histopathological examination.**(figure 3)**

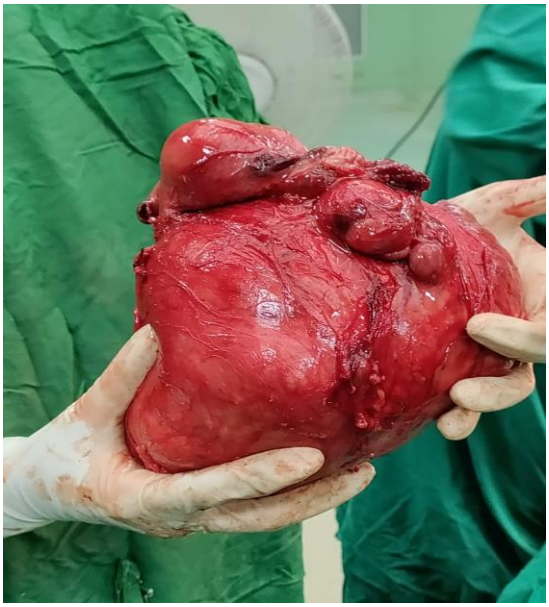

Figure 3: uterus with fibroids sent for HPR.

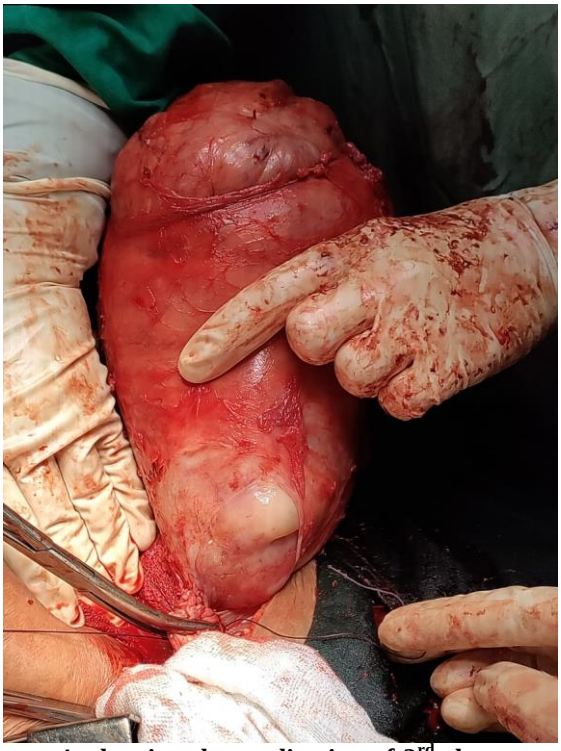

Figure 4: showing the application of 3rd clamp at the level of mackenrodt's and uterosacral ligaments.

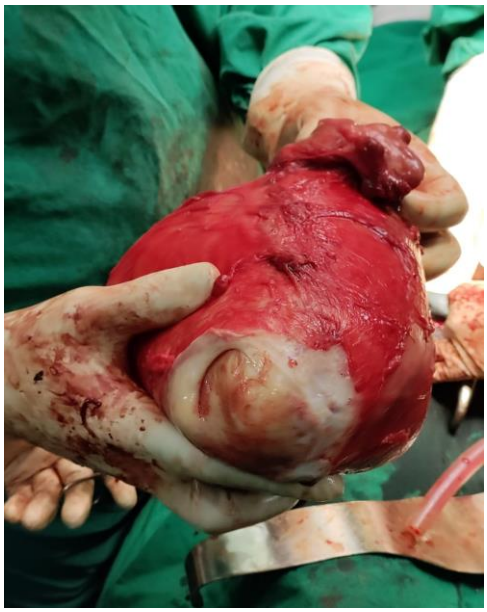

Figure 5: inferior aspect of uterus post operatively showing cervical fibroid.

Intraoperatively 3 pint PCV and 4 FFP transfused. Post operative period was uneventful. Surgical sutures were removed on day 8 and patient was discharged on day 9.

DISCUSSION

Cervical fibroid is a rare benign condition, this patient presented with dysmenorrhoea. Cervical fibroid may be classified as anterior, posterior, central and lateral according to their position. Anterior fibroid bulges forward and undermines the bladder causing urine retention and frequency. Posterior fibroid flattens the pouch of douglas compressing rectum against sacrum resulting in constipation. Lateral cervical fibroid starting on the side of cervix burrows out into the broad ligament and expand it. Central cervical fibroid expands the cervix equally in all direction but produces mainly bladder symptoms.[1] diagnosis of cervical fibroid may be difficult even with advanced ultrasound and other radiological techniques and confirmation diagnosis can be made by laprotomy with typical "lantern on st. paul's dome "appearance. Myomectomy in such cases again faces difficulty due to distorsion of pelvic anatomy and increased risks of bladder injury. It is always better to trace the course of ureter retroperitoneally before removing such huge fibroids or applying clamps while doing hysterectomy.[1]

CONCLUSION

In our case patient had a huge anterior cervical fibroid presented with dysmenorrhoea with urinary symptoms Inspite of fibroid being huge and deeply impacted, surgery was successful without any injury to bladder and ureters which was a great advantage to the patient. Thus we conclude that proper pre operative evaluation and better knowledge of pelvic anatomy and skill is required to perform myomectomy or hysterectomy in a case of cervical fibroid.

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