ejpmr, 2024, 11(7), 409-410

SJIF Impact Factor 7.065

EUROPEAN JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.ejpmr.com

Case Study

ISSN 2394-3211

EJPMR

HUGE CERVICAL FIBROID – CASE REPORT

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Article Received on 13/05/2024 **Article Revised on 03/06/2024** **Article Accepted on 23/06/2024**

INTRODUCTION

Leiomyomas are the most common pelvic tumors in reproductive age. Fibroids are often asymptomatic: about 30%–50% of the premenopausal women who had no previous diagnosis have ultrasound evidence of fibroid tumors.[1] Nevertheless, among 15–54-year-old-women, fibroids accounts for 29% of gynecologic hospitalizations.[1] In majority cases fibroids are small and multiple, huge uterine fibroids (>10cm) are rare and complicated to manage. Large uterine fibroids 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

A 40-year-old multipara, came to our Gynecology OPD at Dr. S.C.G.M.C Nanded with complain of lump in abdomen for 6 months. Initially there were no associated complains, 3 months after there was rapid increase in the size of lump which was associated with dysmenorrhea. She also complained of intermittent urinary retention. Her previous menstrual cycles were regular, with moderate flow for 3-4 days and she used 1-2 pads each day. There was no history of weight loss, any drug intake. She had no associated co-morbidities.

On examination, general condition of the patient was fair and she was vitally stable.

On per abdomen examination, a mass of approximately 32-week uterus size (~40cm), hard in consistency, non-tender and with restricted mobility was palpable.

On per speculum examination, cervix and vagina was healthy.

On per vaginal examination, mass of 32 weeks uterus size, hard in consistency felt with anterior fornix fullness. Uterus couldn't be palpated separately. Bilateral adnexal structures and fornices were not palpable separately. Findings suggestive of (?) anterior wall fibroid.

Blood investigations were with normal limit.

USG finding suggestive of large heterogenous lesion in abdomen and pelvis of size 40*30 cm with no internal vascularity. Bilateral ovaries couldn't be visualized separately, s/o ? solid malignant ovarian tumor

CECT(A+P) a well-defined lesion of 35*30*25 cm with solid enhancing areas seen, s/o neoplastic ovarian mass, where as her CA125, AFP and CEA were within normal limits.

Patient was informed about her diagnosis and was prepared and was posted for TAH+BSO as her family was complete.

Laparotomy was done, e/o of huge anterior wall fibroid of size 38*30*25 cm was seen occupying the abdominal and pelvic cavity (figure 1). The fibroid weighed around 6kg (figure 2).

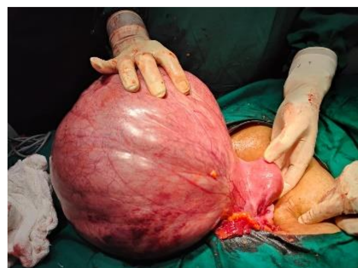

Figure 1- Anterior uterine wall fibroid of size 38*30*25 cm

Figure 2- Fibroid weighing approximately 6 kg.

Bilateral round ligament clamped, cut and transfixed. Bilateral infundibulopelvic ligament clamped, cut and ligated. Prophylactically, bilateral anterior branch of internal iliac artery was ligated. Uterovesical fold of peritoneum identified, cut and bladder pushed down. Hysterectomy was done by serially ligating, cutting and transfixing bilateral uterine vessels, mackenrodt's and uterosacral ligaments. Vault closure was done. Uterus with fibroid and bilateral salphinx removed and sent for histopathological examination. (figure 3). Intra operatively 1 pint PCV was transfused, post operative period was uneventful. Stapler sustures removed on day 10 and patient discharged on post operative day 10.

Figure 3: Uterus and cervix sent for Histopathology report.

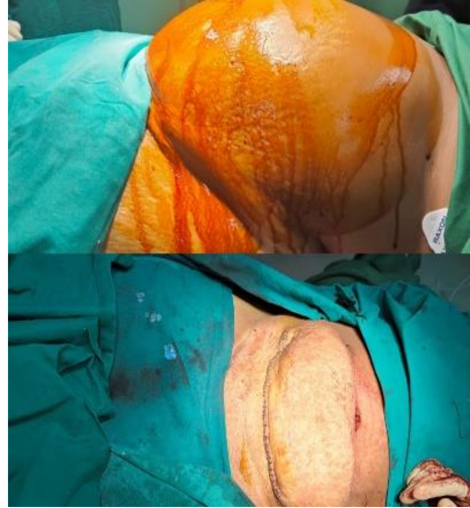

Figure 4: Pre-operative and post operative photo of the patient`s abdomen.

DISCUSSION

Cervical fibroid is a rare, benign condition. Cervical fibroids are classified according to their positions, namely- 1. Anterior 2. Posterior 3. Central and 4. Lateral. Patients with such huge cervical fibroids can present with a variety of symptoms, our patient presented with a lump in abdomen associated with dysmenorrhea and urinary complains. The urinary complains are due the pressure effect of the mass on the bladder/ ureters. The only line of management is such cases is surgical, i.e total abdominal hysterectomy with bilateral salpingo-oopherectomy (decision to remove ovaries taken after considering patient`s age). Different position of the fibroids can cause different symptoms, for example an anterior fibroid like one in this case can cause pressure symptoms on bladder, a posterior fibroid can lead to bowel complains, a broad ligament fibroid can cause pressure symptoms on the ureter. A central cervical fibroid expands in all directions but mainly produces bladder pressure symptoms (3). Even with modern day radiological advances, early and timely diagnosis of cervical fibroid is still a challenge. Cervical fibroid causes distortion of the pelvic anatomy which makes surgical excision even more challenging. Moreover, myomectomy in cases of such huge fibroids is almost impossible due to completely distorted pelvic anatomy. The common difficulties faced during this operation are torrential bleeding and risk of injury to ureter. Both of these can be prevented by bilateral internal iliac artery ligation and tracing the ureter retroperitoneally, respectively. Another way to avoid injury to ureter is DJ stenting pre-operatively (3).

CONCLUSION

In my case, patient had a huge cervical fibroid and she presented with symptoms such as lump in abdomen, dysmenorrhea associated with urinary retention. The huge size of the fibroid lead to a number of intra-operative challenges all of which were tackled systematically and without any complications due to thorough knowledge of pelvic anatomy and expert surgical skills. Hence, we would like to conclude that proper pre-operative evaluation, pre-anesthetic checkup and expert surgical skills are required to tackle such difficult cases without causing any complication.

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