DOI: 10.5958/2319-5886.2014.00437.8

International Journal of Medical Research & Health Sciences

www.ijmrhs.com Volume 3 Issue 3 Coden: IJMRHS Copyright @2014 ISSN: 2319-5886

Received: 14th May 2014 Revised: 7th Jun 2014 Accepted: 17th Jun 2014

Case report

A HUGE CERVICAL FIBROID CAUSING UTEROVAGINAL PROLAPSE – AN UNUSUAL PRESENTATION, DIAGNOSTIC DILEMMA AND AN OPERATIVE CHALLENGE

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ABSTRACT

We report a rare case of a 35 yr Indian woman presenting with a mass per vagina since 2yrs and acute urinary retention since one day secondary to prolapsed cervical fibroid (15x8cm) which was mimicking chronic inversion and was making the anatomy unclear. It was managed by clear delineation of structures on the operating table. We believe that it is the first case of its own kind as the diagnosis could only be confirmed intraoperatively. Cervical fibroids present with varied manifestations posing difficulties in diagnosis and management. Thorough preoperative evaluation and anticipating operative challenges and judicious treatment help in relieving the misery for the patient.

Keywords: Mass per vagina, Prolapsed cervical fibroid, Acute urinary retention, Uterovaginal prolapse,

INTRODUCTION

Leiomyoma is the commonest of all pelvic tumors, being present in 20% of women in reproductive age group 30-35yrs.[1] The paucity of smooth muscle in the cervical Stroma makes leiomyomas in the cervix uncommon.[2] Though a rare entity 1-2% of them are located in cervix and usually in the supravaginal portion.[3] Fibroids may be anterior, posterior, lateral or central in location involving either the vaginal or supravaginal portion of the cervix. Central cervical fibroid expands the uterus equally in all directions and the cavity of the pelvis is more or less filled by a tumour, elevated on top of which is the uterus like 'Lantern on the dome of St. Paul.

Uterine fibroids are benign clonal tumours arising from the smooth muscle cells of the uterus and contain an increased amount of extracellular matrix for which they are also referred as leiomyoma. Their location in the cervix is not common and cervical fibroid belongs to Type 8 category in the new (International federation of gynecology and obstetrics) fibroid classification system.[4]

Cervical mayomas with excessive growth may cause pressure symptoms.[5] They present with abdominal mass[6], incarcerated procidentia[7], retention of urine, constipation, sensation of something coming down, foul smelling discharge per vagina and other variety of symptoms depending on location. Usually there is no evident menstrual abnormality associated with cervical fibroid. A large cervical fibroid may cause obstruction during Labour.[5] Cervical leiomyoma causing uterovaginal prolapse with thick hypertrophied vaginal walls mimicking chronic inversion is rare. Large fibroid arising from the vaginal part of the cervix is often confused with

chronic inversion of uterus. Cervical fibroids prove to be a challenge to the clinician in view of their close proximity to important pelvic structures and of their likelihood to cause complications and difficulty in removal. Unusual presentations as in our case pose challenge to the clinicians and have to be kept in mind.

CASE REPORT

A 35 yr Indian woman P3L3 presented with mass protruding from vagina since 2 yrs, gradually increasing to present size of 15x8cm (Figure 1) associated with foul smelling discharge and acute urinary symptoms since one day. On examination, she was anemic, malnourished and had a firm mass of about 15x8cm from the introitus, which was irreducible, congested and inflamed with surface bleeding.

The exact origin of the mass couldn't be recognized and cervix and external OS couldn't be located. Ultrasonography revealed both ovaries were normal in size and situated in the midline posterior to bladder along with bilateral hydronephrosis but uterus couldn't be visualized.

The differential diagnosis of infected submucous fibroid polyp or chronic inversion was made and was managed with continuous drainage of bladder, parenteral antibiotics, local antiseptics and regular dressings. Two weeks later she was posted for surgery after correction of anemia.

Diagnostic laparoscopy before surgery revealed no evidence of chronic inversion, intraoperatively a bold incision was made on the posterior vaginal wall and pouch of douglas opened, and uterus with intact fundus was felt ruling out chronic inversion and an intraoperative diagnosis of huge fibroid from anterior lip of cervix was confirmed (Figure 2). The uterus was pushed posteriorly, and vaginal wall and uterovesical fold were opened anteriorly and bladder was pushed up safely and steps of hysterectomy were followed. Uterus with fibroid specimen was removed and sent for histopathological examination (Figure 3 & Figure 4). The procedure and post operative period were uneventful. HPE confirmed diagnosis of fibroid and patient was discharged on 5th day.

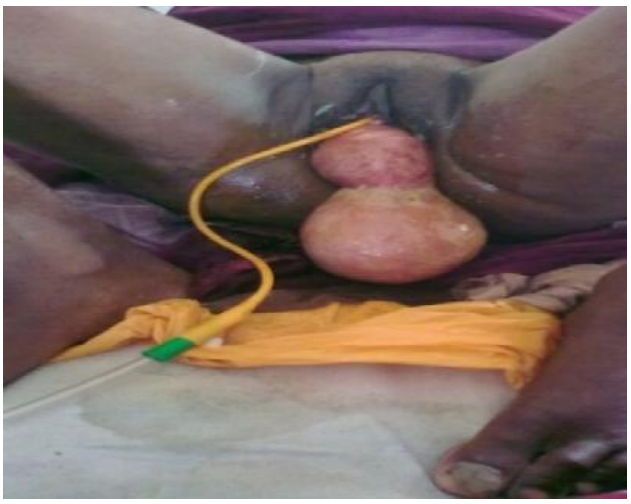

Fig 1: Huge mass per vagina making clinical diagnosis difficult

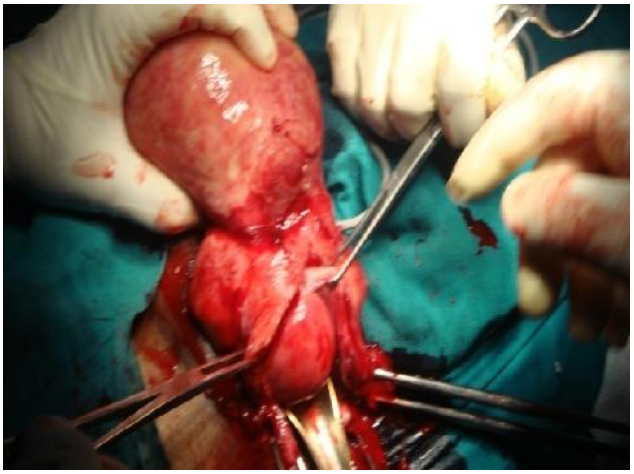

Fig 2: Thick posterior vaginal wall cut open, retracted to show the uterus

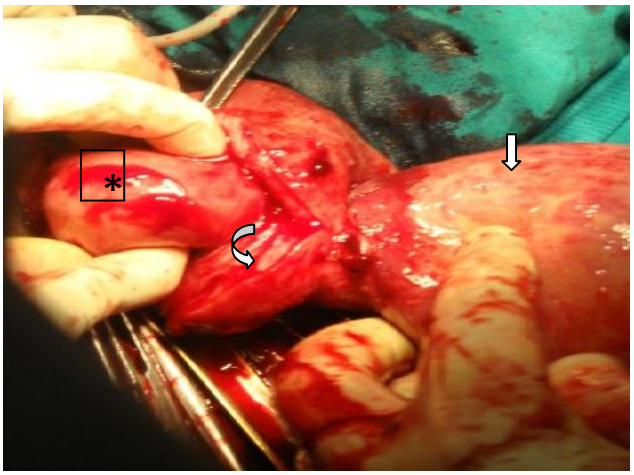

Fig.3: Anatomical delineation of structures showing uterus(*), cervical fibroid (straight arrow) and thickened vaginal wall (curved arrow)

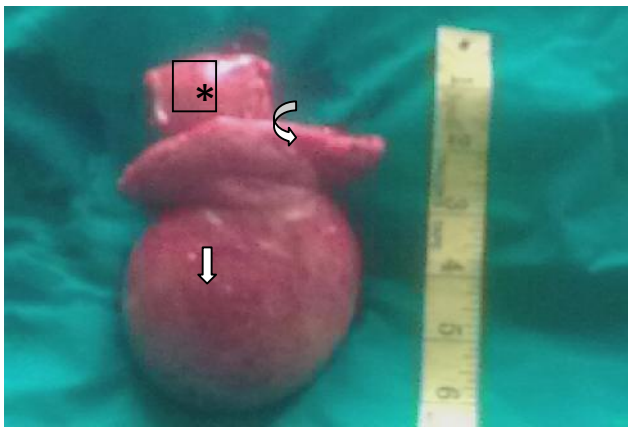

Fig 4: Specimen of cervical fibroid (straight arrow) with hypertrophied vaginal wall (curved arrow) and normal sized uterus (*)

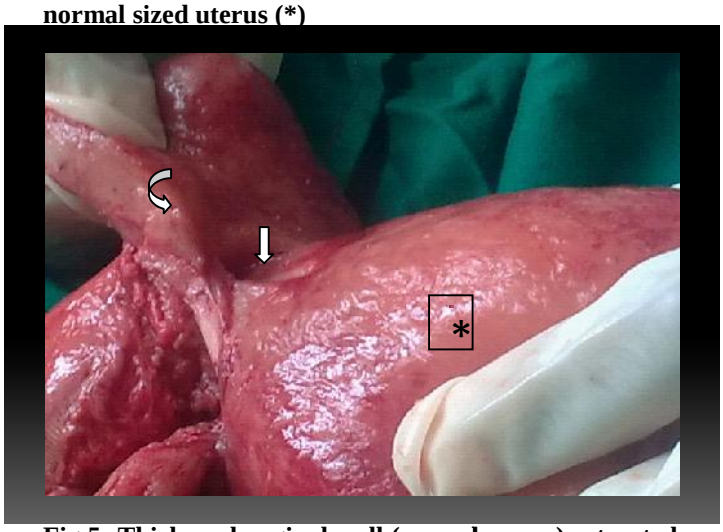

Fig 5: Thickened vaginal wall (curved arrow) retracted to show external OS (straight arrow) and showing fibroid from anterior lip of cervix (*)

DISCUSSION

Differential presentations and sizes of cervical leiomyomas have been reported in literature. The most common presentation of fibroid is menstrual disturbances and Dysmenorrhoea. But broad ligament and cervical fibroids generally present with pressure symptom like bladder and bowel dysfunction. [6-8.] We report an unusual case of huge cervical fibroid causing uterovaginal prolapse mimicking chronic inversion of uterus and presenting with acute urinary retention.

Fibroids arising from supravaginal portion becoming pedunculated and prolapsing into vagina are reported[9] as against our case of fibroid arising from ectocervix expanding the cervix, flushing with vagina and causing uterovaginal prolapse, the hypertrophied vaginal walls enclosing the prolapsed uterus made the anatomy even more unclear. Utero-vaginal prolapse can be caused by traction on to the cervix by heavy myoma.[9] Uterine prolapse refers to the uterus descending down into the vagina. It typically descends in stages until, at some point in time; it actually appears at or behind introitus. Vaginal prolapse refers to the dropping of other organs into the vagina and each one of these organs has their own name for this occurrence like cystocele, cystourethrocele, rectocele & enterocele. Utero-vaginal prolapse can be caused by traction on to the cervix by heavy myoma.[8] Symptoms from vaginal prolapse include bladder weakness with urine leakage, urinary tract infections, a feeling of downward pressure in the vagina, pressure on the rectum and inability to completely empty all fecal matter. Dealing with prolapse can range from using a pessary (a rubber device inserted into the vagina to support the uterus in place), to surgery that repairs the muscles and ligaments and repositions the pelvic organs, to vaginal hysterectomy.

We would like to suggest that rare pathological changes like fibroid expanding into cervix and vagina with uterovaginal prolapse and hypertrophy of vaginal wall should be kept in mind while diagnosing and also while operating. In our case sticking on to anatomical spaces and clear delineation of anatomy on table helped to successfully complete the surgery without any complications, relieving the misery of the patient.

CONCLUSION

Although Cervical fibroid incidence is low (1-2%), encountering a cervical fibroid in gynecology clinic is not uncommon in gynecologist's life. They present with varied manifestations posing difficulties in diagnosis and management. Thorough preoperative evaluation and anticipating operative challenges and judicious treatment help in relieving the misery for the patient.

Conflict of interest: None

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