BJ MEDICAL COLLEGE

UTERINE FIBROID PRESENTING AS HUGE ABDOMINOPELVIC MASS WITH SEVERE ANAEMIA

Year : 2021 | Volume : 1 | Issue : 0 | Page :

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Date of Web Publication 26-Apr-2021

Keywords

fibroid, prolapse

Abstract

Uterine leiomyoma(fibroid) arises from uterine smooth muscle, is the most common benign gynecologic tumor of the female pelvis. These leiomyomas are diagnosed in approximately 25%of women, the prevalence increases during reproductive age, decreases after menopause. We present case of huge prolapsed submucous fibroid. 45year, nulligravida presented with complaints of something coming out of vagina since 4 years with Mass felt per abdomen since 1 year, Whitish PV discharge since 1 month, Difficulty in passing urine andinability to pass urine completely since 1day.Abdominal examination revealed a firm massof 24-26 weeks size with restricted mobility arising from the pelvis.(Fig.1) On local examination 15x12 cm sized mass was seen coming out of vagina with foul smelling discharge. She was severely anaemic. After investigations and optimizationExploratory laparotomy was done. Uterus with Fibroid weighing almost 4.2kg was removed. The patient recovered well in postoperative phase. In spite of fibroid being huge ,vascular and deeply impacted in pelvis, surgery was performed successfully. Such cases are surgically challenging hence knowledge of altered anatomy is of utmost importance while performing surgery in such cases.

Introduction:Leiomyomas(fibroids) are common benign smooth muscle tumors which may develop anywhere within wall of uterus. Fibroids are almost never associated with mortality, but they may cause morbidity and significantly affect quality of life. Fibroids (leiomyomas, myomas) are an important

health care concern because they are the most frequent indication for the performance of hysterectomy. It could be submucosal, intramural or subserosal depending on its location. Submucous fibroid account for 15% to 25%. Uterine contractions sometime push a polypoidal submucous fibroid through the cervix into the vagina leading to prolapsed fibroid. Gravitational force on huge prolapsed fibroid may further enhance its descent beyond the vagina. A few cases of prolapsed uterine fibroid have been reported in the literature; although the incidence is unknown, it is uncommon.Different approaches to treatment have been described in the literature for prolapsed fibroid depending upon presentation and nature of fibroid prolapsed. The case presented here had different presenting feature and had different approach to surgical management that best suited the characteristic of the individual prolapsed fibroid.**Case History**: 45 year, female, unmarried, nulligravida with history of 1 year amenorrhoea, presented with complaints of something coming out of vagina since 4 years with Mass felt per abdomen since 1 year, Whitish PV discharge since 1 month, Difficulty in passing urine and burning micturition since 4days. She presented to our health facility due to inability

to pass urine and inability to walk due to mass and with lower abdominal pain that was described as severe, dragging in nature, and radiating to back. She was admitted at private health care facility 4years back where she was diagnosed as Uterine fibroid following evaluation, and she was counseled for surgery. She however, declined surgery. On examination, general condition of the patient was moderate. She was in intermittent painful distress, febrile. Cachexia with severe pallor was present. She had tachycardia; blood pressure was 100/60mmhg. As she had presented with urinary retention urethral catheter was passed with difficulty and about 2000ml of urine was drained. After draining the bladder her abdominal examination revealed 24-26 weeks size abdominopelvic mass, firm in consistency. Lower margin could not be reached, mobility was restricted. There was no ascites and bowel sounds were normal. On local examination 15x12 cm sized mass was seen coming out of vagina which was firm in consistency. Serosanguinous discharge was coming from mass which was foul smelling. Necrotic patches were present on it with keratinisation. Mass was non reducible. (Fig.1) Per speculum or per vaginal examination was not possible. On per Rectal

examination, anteriorly mass felt, soft to firm in consistency, rectal mucosa free.Clinical impression of septic huge prolapsed uterine fibroid with very severe anemia was made.Her haemoglobin was 3gm %. Liver and kidney function test was normal.USG Abdomen and pelvis showed large heterogenous lesion in endometrial cavity of 9.6x9.6x16cm, well defined with internal vascularity. With another 2.5x3 cm sized intramural fibroid in fundal region. MRI Abdomen and pelvis (Fig.2) showed large intramural mass measuring 9.6x8.4x34cm arising from anterior myometrium. Multiple areas of blooming were noted on GRE likely suggestive of slow flow vessel voids/ blood products. It showed post contrast enhancement. Overlying serosa was intact. Fat planes with adjacent structures appeared normal.She was started on antibiotics. Over the time she was transfused with 8 PCVs for building up Hemoglobin along with 8 FFPs. Daily dressing was done and antibiotics were changed as per culture and sensitivity report to control the sepsis. After optimization and control of sepsis patient was posted for exploratory laparotomy. Patient was given lithotomy position during surgery as she had big Mass (15×12cm) which was prolapsing through vagina. At laparotomy, large mass of size

24x12x10cm was seen occupying the pelvis with altered uterine contour. Mass which was prolapsing from vagina was removed vaginally by applying clamp and transfixing pedicle. Even after removal of mass still vagina was occupied by the large mass. Hysterectomy started, Rutherford Morrison technique was used in which uterus was bisected from fundus, after reaching endometrial cavity wide base of submucosal fibroid was clamped with multiple clamps and released from uterus. After releasing the huge mass was delivered vaginally. Abdominal hysterectomy with bilateral salpingoophorectomy was completed thereafter without any complication. Total of 4.2 kg mass removed from abdomen and outside vagina. The patient had an uneventful postoperative period. The histopathology report revealed uterine fibroid with degenerative changes. The patient required prolonged hospital stay due associated sepsis n severe anemia preoperatively. She was discharged home in good condition after about one month of hospital stay. **Discussion** : Leiomyomas are common benign smooth muscle tumors with prevalence of upto 25%. Prolapsed submucous myoma is a rare presentation because often a submucous myoma would have manifested with heavy menstrual

bleeding and would have been removed surgically before it grows big and prolapses. This patient under review had earlier presented to health facility and was counselled for surgery but she declined surgery due to personal and family problems, which led to neglect of her disease condition until it reached an enormous size and prolapsed into the vagina. The usual presenting feature of patient with prolapsed myoma are symptom of mass in vagina or mass outside the vagina with abnormal uterine bleeding and dysmenorrhea. Heavy menstrual vaginal bleeding, infection, shock, severe anemia, obstructive/ irritative lower urinary tract symptoms and pressure symptom are usually feature of delayed presentation. These were the features that this patient presented with except menstrual complaints as she had amenorrhea instead. Our patient belonged to very poor family and was malnourished also. She was staying with her mother who was blind hence neglected her complains until she landed up in emergency situation like retention of urine. This tells us that in developing country like ours the issue of delay in seeking health care when disease conditions are at their early stage still persist leading to life threatening complications. Ignorance and lack of economic and social

empowerment have been identified as significant contributor to poor health seeking behavior of patients which holds true for our patient. As found in this patient, a prolapsed myoma may become infected and necrotic because of inadequate blood supply to the pedicle. These can lead to offensive odor, vaginal discharge, and contact bleeding leading to suspicion of genital malignancy. Complication that may be associated with prolapsed myoma include uterine inversion due to gravitational pull on uterus, fistula and urinary retention as a result of the compression effect of mass. Most cases of prolapsed submucous myoma reported in the literature were associated with chronic nonpuerperal uterine inversion. This patient did not have uterine inversion but had urinary retention. Management option for prolapsed submucous fibroid include vaginal myomectomy, abdominal myomectomy, abdominal hysterectomy usually following the removal of the prolapsed myoma and vaginal hysterectomy. The choice of surgical procedures in patient with prolapsed fibroid is dependent on the accessibility of the pedicle vaginally and broadness of base. Prolapsed polypoidal submucous myoma can be removed vaginally because they are usually easily accessible

due to their long pedicle, produces little bleeding . However, large myoma with broad base may be less accessible vaginally, may bleed heavily and pose a risk for uterine inversion during their removal and hence require a hysterectomy. The results of these treatment modalities has been good in cases reported so far. This case presented here had different approach to surgical treatment that best suited the characteristics of this individual prolapsed fibroid. Myoma in our case had broad base and was situated in upper part of uterine body. To access this, we had to use Rutherford Morrison technique that is bisection of uterus which made removal of fibroid easy without causing trauma to surrounding structures. Thus, in this case we first removed prolapsed part of fibroid vaginally followed by hysterectomy by Rutherford Morrison technique which helped in accessing fibroid and its removal by vaginal route with bilateral salpingoophoectomy. Removal of this mass vaginally is important as it will help in reducing chances of peritonitis postoperatively.**Conclusion:** It is found that patients with large leiomyomas have various unusual symptoms or clinical manifestations in addition to the common ones. Negligence from patients' side, as in our case lead to enormous enlargement of fibroid with

septicemia and very severe anemia. This led to requirement of multiple blood transfusions with its associated risks and prolonged hospital stay. Hence symptoms should not be disregarded or underestimated. In spite of fibroid being huge, vascular and deeply impacted in pelvis, surgery was performed successfully. Thus, we conclude that knowledge of altered anatomical structures is important for doing surgery in such cases and prior optimization before operative intervention is also very important for successful outcome.**References:**

[1]J.M. Novi, A. Shaunik, B.H. Mulvihill, M.A. Morgan, Acute urinary retentioncaused by a uterine leiomyoma: a case report, J. Reprod. Med. 49 (2004)131e132.[2]A.A. Ozsaran, I.M. Itil, C. Terek, M. Kazandi, Y. Dikmen, Giant myomaanderythrocytosis syndrome, Aust. N. Z. J. Obstet. Gynaecol. 39 (1999) 384e386.[3]S.R. Driessen, L.C. Haans, J.B. Puylaert, Uterinefibroids complicated by hae-matometra, Ned. Tijdschr. Geneeskd. 156 (2012). A5398.[4]R. Foissac, N. Sautot-Vial, L. Birtwisle, et al., Torsion of a huge pedunculateduterine leiomyoma, Am. J. Surg. 201 (2011) e43e45.[5]M.H. Dahan, R. Ahmadi, Spontaneous subserosal venous rupture overlying auterine leiomyoma. A case report, J. Reprod. Med.

47 (2002) 419e420.[6]I. Amber, G. Kennedy, H. Martinez, J.M. Pearson, E. Jimenez, A leiomyoma in acachectic woman presenting as a giant abdominal mass, J. Radiol. Case Rep. 3(2009) 23e29.[7]F. Migishima, T. Jobo, H. Hata, et al., Uterine leiomyoma causing massive as-cites and left pleural effusion with elevated CA 125: a case report, J. Obstet.Gynaecol. Res. 26 (2000) 283e287.