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Case Report

SUCCESSFUL RETURN OF REGULAR MENSTRUAL FLOW AFTER REMOVAL OF A HUGE CERVICAL FIBROID: A CASE REPORT

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Abstract

Fibroids are the commonest benign neoplasm of the uterus and have long been implicated as a cause of complication during pregnancy and delivery. Fibroids arising from uterine cervix constitute only less than 2% of all fibroids and a very large cervical fibroid is even rarer[1,2,3]. This is case report of pregnancy with a huge cervical fibroid that necessitated caesarean section delivery. This unusually large fibroid (20 x 17 x 16 cm) was grown from the cervix that pushed up the uterine body upward. During initial caesarean operation the surgical team could not ascertain about the origin of the mass and closed the abdomen without remony the man. Subsequent laparotomy three months after caesarean section finally confirmed the diagnosis of the huge cervical fibroid. It was dissected out from the surrounding adhesion followed by end-to-end anastomosis of the gap between uterus and cervix. The postoperative period was uneventful with smooth recovery. The patient was followed up couple of times after discharge and reported to be well with return of her normal menstrual and reproductive function.

Introduction

Fibroid are the commonest benign tumour of the uterus and is one of the most common neoplasm of women. Its other names in the medical practice are, fibroma, myoma, fibromyoma, leiomyoma. Fibroids usually arise in the muscular wall of the uterus and vary in size from minute seedling growths to large masses which may even occupy nearly the whole abdominal cavity. They are often multiple and at the onset, they lie in the substance of the uterine wall. They arise far more often in the body of the uterus than in the cervix, and can remain exclusively within the myometrium of the uterus for as long as 5 to 10 years growing silently. Fibroids can project to other parts of the uterus more especially to the mucous the endometrium where it distorts the normal shape of the inner cavity and disturbs pregnancy. However, it may project to the outside of the uterus and become pedunculated in the abdomen. Such growth into the abdomen may be so huge that it may be mistaken for normal pregnancy. Many women have carried such fibroid for many years regarding it as pregnancy[4,5].

A few cases (<2%) of fibroid arise in the cervix. These are called cervical fibroids. They are usually single, although there may be other tumour growth in the body of the uterus[1,2,3]. They cause distortion and elongation of the cervical canal and displace the body of the uterus upwards. A large cervical fibroid may cause complete obstruction and blockage of the cervix. Menstrual abnormalities are the most common symptoms associated with uterine fibroids. Submucosal tumors are often a cause of menorrhagia; they produce a dysregulation of local growth factors, causing vascular abnormalities that may also contribute to menorrhagia[4,5]. Pelvic pain and pressure are less commonly attributed to uterine fibroids. Individual case reports have described very large tumours that result in pelvic discomfort, urinary symptoms, and constipation[6]. During pregnancy, the combination of large fibroid tumours and uterine

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enlargement can result in symptoms of urinary tract obstruction, abdominal pain[6,7]. The role of fibroids in infertility is not clear due to lack of absolute evidence of their role in conception. However, submucosal & intramural fibroids that distort the uterine cavity, fibroids larger than 5 cm, and multiple fibroids are often treated in patients with otherwise unexplained infertility[8,9].

The management of uterine leiomyoma during pregnancy is largely expectant and its surgical removal is generally delayed until after delivery. Women are at increased risk of bleeding and postoperative morbidity during myomectomy due to increased vascularisation of the uterus during pregnancy. However, some reports have shown that myomectomy during caesarean delivery could be done in selected cases[9,0].

Case Report:

This is a rare case of a very large symptomatic cervical fibroid diagnosed during pregnancy which was delivered by caesarean section first in a district hospital and later managed by cervical myomectomy at the BSM University hospital.

A 25 years old woman of average family background was admitted to BSM University hospital with the complaints of a very big mass in lower abdomen along with low grade pain in the pelvic region. On general physical examination she looked mildly anaemic with pulse and blood pressure within normal range. Per abdominal examination revealed uniformly enlarged abdomen with a huge mass of about 34 week pregnancy size. The mass was dull on percussion with restricted side to side and above downward mobility. On per vaginal examination the cervix was apparently healthy looking. The uterus was difficult to be palpated separately probably because of that big mass and all fornices were full. Ultrasound report showed an elongated uterus along with a large solid mass (20 x 17 x 16 cm) in the pelvic cavity pushing the uterus anteriorly.

Her obstetric history indicated she was para 1+2 (M.R). Her menstrual cycles were regular without any unusual symptoms. She had no routine antenatal check-up during pregnancy and had experienced no unusual symptoms until premature labour pain. She delivered a female baby nine months ago by caesarean section at local district hospital. It was a 35 weeks pregnancy with premature rupture of membrane (PROM). During caesarean operation a big fibroid was found in the anterior wall of the uterus and the fibroid was not removed. Two months after of LUCS an ultrasound examination of the abdomen revealed a pelvic mass but the origin of which could not be delineated properly. The uterus & the adnexal region were found normal. Laparatomy was done in a local clinic and revealed a large solid mass in the pelvic cavity that was densely adherent to gut, omentum and anterior abdominal wall. The origin of the mass could not be identified properly. A general surgeon was called for help, who also did not proceed further and decided to close the abdomen without removing the mass. The growing intra-abdominal mass gradually causing her a sense of fullness, pain with serious discomfort. She visited a local doctor who referred her to BSM Medical University hospital for further management and treatment.

The patient presented into BMSSU Gynae Out Patient Department six months following previous laporatomy. After admission, through assessment of the patient was done with a further ultrasound and routine blood examination and operation theatre was scheduled immediately. During operation the abdomen was opened by right paramedian incision and it was difficult to open the parietal peritoneum. A very big mass, occupying the whole lower and major part of upper abdomen was adherent with the utero vesical pouch and anterior abdominal wall. The body of the uterus, both ovaries and fallopian tubes were healthy and were situated on the top of the tumour which was arising from the uterine cervix (figure 1).

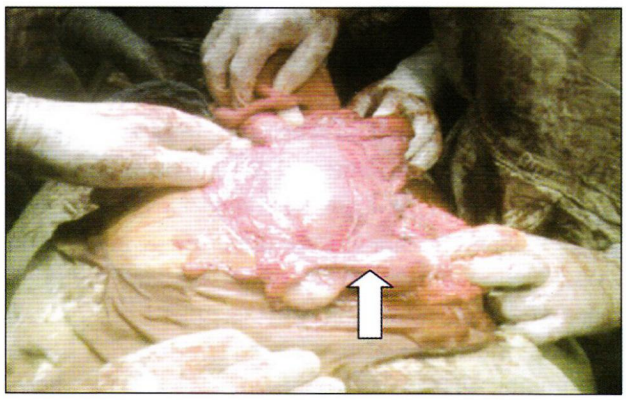

Fig.-1: *The uterus at the top of the tumour (arrow)*

The mass was carefully dissected out and removed with meticulous attention to the ureters. There was a gap found between the body of the uterus and the lower uterine segment after the tumour mass was removed. An end-to-end anastomosis was done in

between the two parts of the uterus keeping a Foleys catheter in situ. The abdomen was closed in layers. There was average bleeding during operation. The whole specimen was sent for histopathology and the report came as lieomyoma.

The post operative period was uneventful and the patient recovered well. The Foleys catheter was removed on 14th postoperative day. She was followed up couple of times after discharge and reported to be well with return of her normal menstrual flow.

Discussion:

Pregnancy along with a large fibroid is a high risk pregnancy, which may lead to complications. The potential effects of these tumours on pregnancy are frequent clinical concern since fibroids are commonly detected in women of reproductive age. Mechanical difficulties due to site of the fibroids may be encountered during labour and fibroids may be associated with malpresentation of the foetus (5,6,7,8) If a caesarean section is required, it is unwise to attempt myomectomy because of the associated vasculatily of the organs during pregnancy and possible bleeding. Caesarean hysterectomy may be considered if there are multiple fibroids and the women has completed her family but the operative morbidity is greatly increased and this procedure should generally be reserved for emergency circumstances[9,10,11].

Cervical fibroids constitute only < 2% of all fibroids and this kind of huge cervical fibroid are even rarer. Mostly they are situated in the supravaginal portion of the cervix. Cervical fibroids are similar to those fibroids found in other parts of the body of the uterus. In this case, the cervical fibroid clinically mimicked ovarian tumour as patient had no pressure symptoms, urinary or bowel complaints. She had distension of abdomen and loss of weight. Large cervical fibroids pose a surgical difficulty due to their distorted anatomy and close relationship to the ureters and bladder. Although there was a no ureteric injury in this patient but ureteric injury during surgery have been reported[12,13]. Large abdominal mass on examination and the CT findings of solid mass suggesting a probable ovarian mass but this turned out to be a rare manifestation of huge cervical fibroid. This case also exemplifies that although the new diagnostic modalities like ultrasound and CT scan have improved the accuracy of pre operative diagnosis, but in some cases the final diagnosis can only be made at laparotomy.

Fibroids during pregnancy may lead to increase in the rate of caesarean section related to increased incidence of dysfunctional labour and malpresentation. They are also associated with increased risk of postpartum haemorrhage, so obstetrician dealing with such patients should be well experienced to handle with any probable untoward events/complications that may occur during surgery and postoperative management[14,15].

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