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ENORMOUS MASS IN PELVIS OF A PREGNANT WOMAN WITH HEPATITIS B: CHALLENGES!!!

Gynaecology

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ABSTRACT

The broad ligament is the commonest extra uterine site for the occurrence of leiomyoma but with a very low incidence . Because of its overall low incidence, it is both clinical and radiological difficult to in differentiating with ovarian tumors. We report a case of a 36-year-old married since 12 years who presented with chief complaint of abdominal fullness since 1.5-month, history of progressive abdominal swelling with history of two months of amenorrhea with HBsAg positive. Examination of the abdomen showed mass which was multiple cystic and solid of huge size approx. 32-34 weeks present upto 3cm above umbilicus,firm in consistency, non-tender, restricted mobility and Uterus was not felt separately.on PerVagina examination Cervical Os was not felt and cervix pulled up behind the anterior fornix, Uterus size cannot be delineated due to the mass. Ultrasonography showed 10.2 weeks of gravid uterus with huge mass of approx (28x26x15) cms with solid and cystic components with vascularity noted in the pelvis occupying the POD. We managed the patient by removing mass without any complication.

KEYWORDS

Broad ligament mass, cystic changes, clinical and radiological diagnosis, leiomyoma.

Introduction

Fibroid or leiomyoma is the commonest of all uterine tumors. They are most common in women of child-bearing age. Their classification is determined by their origin and direction of growth [1].Leiomyoma is a benign smooth muscle tumor[4].Extrauterine leiomyomas are rare and often present as a challenging diagnostic problem for the clinician and the radiologist[6].Broad ligament is the most common extra uterine site for the occurrence of leiomyoma; the incidence is < 1% [3]. Leiomyoma in the broad ligament has been reported to reach a huge size which can mimic ovarian malignancy [5].

Case Report

Patient ABC, 36 years old, married since 12 years, G3P2L2, 8.5 weeks by date, 8.1 weeks with scan, came with chief complains of abdominal fullness since last 1.5 months. No H/o Bleeding P/V, no h/o any other major surgical or medical illness. There are no such complaints in the past.

Menstrual History: her LMP was on 22/11/2016 which was regular, normal flow and painless.by LMP she was 8.5Weeks.EDD was on 29/08/2017.

Her Past Menstrual History was regular at the time of conception
In Personal History, Diet was mixed and no Bladder &Bowel habits complaints. Sleep was Normal.

Her Obstetric History she is G3P2L2, *first* Male child 11yrs,FTND,Institutional Delivery, Alive and well. *Second* Female, 9yrs,FTND,Institutional Delivery, Alive and well, Gravida *3 was* Present Pregnancy; Unregistered.

On Examination General Condition was Fair, Afebrile, Pulse was 80bpm.BP was 110/80 mmHg, and No Pallor. CVS and RS examination were normal.

On Per Abdomen examination, multiple cystic and solid mass of huge size approx. 32-34 weeks present upto 3cm above umbilicus, firm in consistency, non-tender, restricted mobility and Uterus was not felt separately.

On Per Speculum examination, Cervix was not seen but bulging in posterior fornix was seen.

Per Vaginal,Cervical Os was not felt and cervix pulled up behind the anterior fornix. Acute anteversion of uterus, Uterus size cannot be delineated due to the mass. Mass felt in both lateral and posterior fornix . Mass appears to be originating from pelvis with restricted mobility.
Her blood investigations were in normal limit. LFT and RFT were normal.

Her HB 13.9g/dl Serum TSH 0.74mU/L and Tumor markers were normal.

Radiological investigation USG *(*Abdomen/Pelvis*)* showed 10.2 weeks of gravid uterus with huge mass of approx. (28x26x15) cms with solid and cystic components with vascularity noted in the pelvis occupying the POD and bilateral adnexa pushing the uterus anteriorly and superiorly. The mass extends upto the epigastric region; B/L ovaries cannot be seen separately.

Impression was ???Ovarian mass with live intrauterine gestation of 10.2 weeks. MRI *Pelvis was* S/o large heterogeneous intensity solid, cystic mass lesion, probably of ovarian origin seen in pelvis with extension into the abdominal cavity superiorly. Uterus is seen to be pushed anteriorly and superiorly by the lesion with intrauterine gestational sac and fetal pole within it. Mass effects on adjoining structures and presents as: Bowel loop displaced to periphery and superiorly. Both ureters were seen compressed and displaced laterally by mass. Mass effect on urinary bladder, Compression on IVC also seen.

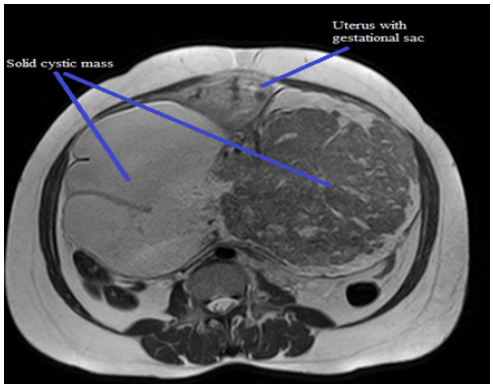


Figure: 1 MRI of abdomen and pelvis

She was HBsAg positive we took Medicine reference they advised HBV DNA load Target which was not detected, all other viral marker were negative.

(HBeAg Negative (0.05),HEV : Negative,HAV : Negative,HCV : Negative)

Pre anesthetic fitness was taken.

Patient counseling was done. Patient was given the option of

continuation of pregnancy versus termination after explaining all pros and cons.

Decision of First Trimester MTP with exploratory laparotomy with ovarian cystectomy was taken i/v/o G3P2L2 with 8.5 weeks gestation with? Ovarian mass



Figure: 2 Pre-incision abdomen

Pre-incision, Dilatation and Suction was tried before abdominal incision but cervix was neither seen nor palpated. Hence decision to do MTP under vision was taken after opening the abdomen.

Abdomen opened in layers, Intra-operative abdominal findings were Ascites seen, and fluid collected and sent for cytology. Uterus was 8weeks size, acutely anteverted, Large lump felt extending upto xiphisternum, adherent to uterus, appeared to be arising from uterus. Bladder advanced, Ovaries cannot be felt separately

Intra-operative per Vaginal findings was done. Cervix was high up so we could not do MTP.We finally removed mass with difficulty.

Figure3: Anterior view pregnant uterus with huge mass and normal ovary & fallopian tube

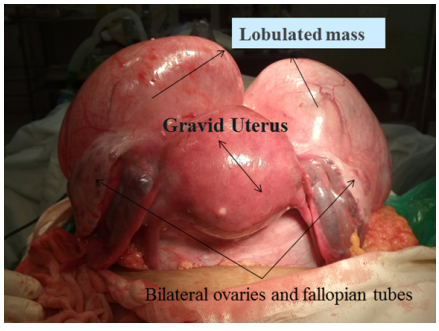
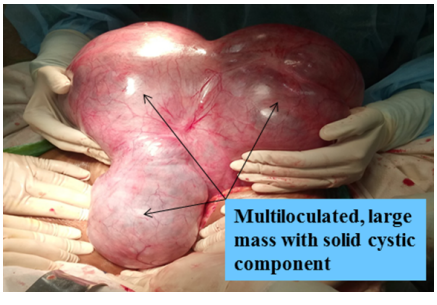


Figure4: Posterior view pregnant uterus with huge mass and normal ovary & fallopian tube



Lump found densely adherent to uterus from posterior wall .it was involving the myometrium. Profuse Bleeding started from the site of adhesions to uterus.

Lots of plain were dissected to remove mass from adhesion. She started bleeding from all side of adhesion .the mass had serous & mucinous and degenerative like component.

We suspected malignancy with lump involving both the sides of uterus. So decision for obstetric hysterectomy with B/L Salping ooopherectomy with pelvic lymphnode palpation was taken Obstetric Hysterectomy was done with difficulty .Specimen of Gravid uterus with cervix with b/l tubes ovaries and huge mass of 5.3 kg removed and sent for histopathological reporting along with ascetic fluid for cytology.

Right sided retro peritoneum opened through right broad ligament ,right ureter and right iliac artery inspected, right iliac group of lymph nodes palpated .Similarly done on the Left side ,None of the group of lymph nodes were enlarged. One pint blood transfusion was given intra op.

Post-operative period was uneventful. Two pints of whole blood transfused slowly in 2 days. Patient discharged on day five .Suture removal done in OPD and Wound was healthy.

Histopathological report was Suggestive of leiomyoma with cystic degeneration. Cytological findings were Suggestive of inflammatory effusion with plenty of lymphocytes and polymorphs with reactive mesothelial cells.

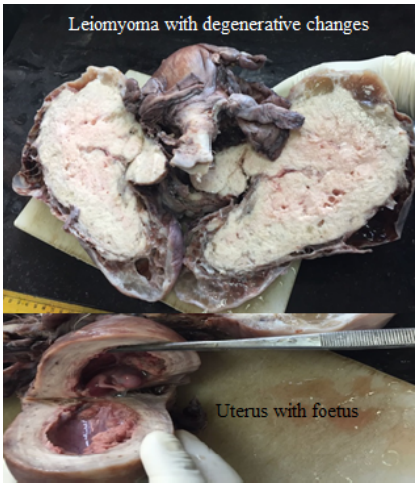


Figure: 5 Gross appearance of specimen

Discussion

Leiomyoma in the broad ligament has been documented to reach an enormous size which can mimic ovarian malignancy[6].

These benign tumors in the broad ligament are usually asymptomatic but if neglected for a long time, it can reach an enormous size resulting in chronic pelvic pain, compression of contiguous structures like the bladder and the bowel and resulting in bladder and bowel dysfunction[1].

Our case was a huge true broad ligament fibroid with marked cystic degeneration with pregnancy.Leiomyoma occasionally occurs with unusual growth pattern or in unusual locations that makes their identification more challenging, both clinically and radiologically[2].

Enlargement of the leiomyoma can cause upward displacement of the uterus and it can become impacted in the pelvis leading to ureteric obstruction, urinary retention and or constipation[6]. In our case patient had huge broad ligament myoma that pushed her uterus upward and that's why cervix was not visualized on per speculum and it was not possible to do MTP. She did not however present with obstructive urinary symptoms and constipation.

Intraoperatively the irregular shape, solid cum cystic appearance and the left lateral extension often mass caused difficulty in distinguishing from retroperitoneal malignant encroachment of tumor.

Preoperative identification of feeding or draining vessels arising from the myometrium could be helpful in distinguishing an intraligame ntary leiomyoma from a retroperitoneal tumor[5].

Knowledge of unusual presentation of the benign degenerated fibroids is essential to the clinicians; to help differentiate benign from malignant tumor entities [6].Intraoperative finding of ascites with the huge tumor mimicked ovarian malignancy. However, the attachment of the tumor to the lateral border of uterus along with bridging vessel sign can provide a clue to the diagnosis of degenerated broad ligament

fibroid[7].

The differential diagnosis for broad ligament leiomyoma includes masses from ovarian origin – benign or malignant, broad ligament cyst, lymphadenopathy and tubo-ovarian masses. In our cases on clinical and radiological investigation it was suspicious of ovarian neoplasm. The serum levels of cancer antigen CA 125 were done which was in normal range. In our case also the tumor was of large size but serum CA 125 was normal[5]. When they grow large in size secondary changes may occur. Most common secondary changes in leiomyoma are degeneration, infection, hemorrhage and necrosis. The cystic changes in lesion mimic the metastatic malignant ovarian tumors[4].

Our case was more challenging in many aspects. First MTP was not possible because of the acute anteversion of uterus; visualization of cervix was not possible due to the mass effect of the lump.

In this case, mass was densely adherent the adjacent structure of the uterus. At the time of adhesiolysis, she started bleeding very profusely, probably because of the pregnancy and congestion.

Because of increased vascularity to the mass and adjacent structures of the uterus, we couldn't save her uterus and we had to do her Obstetric Hysterectomy.

Ovaries could not be preserved due to the distorted anatomy and increased vascularity.

She was also HBsAg positive, hence universal precautions were taken.

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