

Original Research Paper

Obstetrics & Gynecology

HUGE CERVICAL FIBROID & ITS ASSOCIATION WITH BILATERAL OVARIAN VEIN THROMBOSIS - A RARE CASE REPORT

 Sneha Sethy
 Assistant Professor, OBGY, GGMC, Mumbai

 Vilasrao N Kurude
 Associate Professor, OBGY, GGMC, Mumbai

Introduction

Cervical fibroids account for 2% of all fibroids. They are classified as anterior, posterior, lateral, central. A central cervical fibroid usually arises from supravaginal portions of the cervix so that it expands the cervix equally in all directions & displaces uterine vessels & ureters. On laparatomy it can be recognised at once, as it fills the pelvis, with uterus on top of tumor like "the Lantern on top of St. Pauls Cathedral ". A 42 yr old, para 2 living 2, tubectomised woman reported at GOPD with the complaints of increased amount of bleeding per vaginum since 4-5 months. General, systemic examinations were normal. Per abdominal examination revealed mass of size 22 weeks, firm, mobile. On per speculum examination cervix was not visualised clearly, mass was seen protruding through vagina. On per vaginal examination mass of size 22 weeks felt, cervix bulky mobility restricted, uterus not felt separately, fullness in all fornices. On USG (A+P) – uterus 8 x 10 x 12 cm, ante verted, large heterogeneous lesion of size 15 x 8.7 x 12.7 cm noted in uterus. Other investigations were within normal limit-CBC, LFT, RFT, urine, thyroid profile, BT, CT, PT, INR, aPTT, HIV, HBV. She was advised abdominal hysterectomy. Intra operative findings large mass of size 15 x 10 x 12 cm was seen occupying the pelvis with normal uterus perched on top with typical appearance of Lantern on top of St Pauls Cathedral appearance. The fibroid along with uterus, bilateral tubes, left ovary was removed. HPR confirmed the diagnosis of fibroid.





Post operative

Patient developed fever on 3rd day. Investigations- CBC, urine r/m, fever profile, USG (A+P), pelvic venous doppler, serum electrolytes, BT, CT, PT, INR, aPTT, chest X ray was advised. Injection paracetamol infusion, sponging, injection artesunate 120 mg stat then repeated after 12 hours and then after 24 hours OD for 6 days. Medicine reference was done – injection piperacillin tazobactam 4.5gm TDS, Tab azithromycin 500 mg od was started, blood c/s, USG (A+P), investigations like CBC, LFT were repeated. Investigations were within normal limit. USG – few non compressible venous channels in bilateral adnexa with no flow on doppler could suggest acute thrombosis, advised follow up after 48 hours.

Surgery reference, CVTS reference, urology reference was done. Injection heparin 5000 IU 6 hourly was started for 48 hours & tab wafarin 5 mg OD to continue there after. Fever resolved subsequently. Follow up scan- no change is seen as compared to previous scan, no progression noted.

CECT- partial thrombosis of bilateral ovarian veins extending into their tributaries. partial thrombosis seen in distal internal iliac vein extending into their tributaries.

Suture removal done, it was healthy

Antibiotics, tab wafarin continuing. USG was done – it revealed resolution of pelvic vein thrombosis. CVTS reference was done , they advised INR. INR was WNL, so tab warfarin was stopped and pt was discharged.

Discussion

Uterine myoma is the most common indication of hysterectomy. Cervical fibroids arise from supra vaginal, vaginal portions of cervix. Supra vaginal fibroids can be central surrounding the entire cervical canal & lying centrally in pelvis displacing the ureters. Uterine myoma is a very rare cause of venous thromboembolism. Only 9 reports of myoma associated with venous thromboembolism have been reported, 3 patients had pulmonary embolism. Iliac venous thromboembolism is secondary to extrinsic compression by uterine myoma.

The most common site of venous compression is common iliac vein. 1 case of ovarian vein thrombosis was seen in a case of uterine myoma.

Conclusion

Inspite of the fibroid being huge, vascular, impacted in pelvis, the whole tumor was removed successfully without any significant haemorrhage. Acute pelvic thrombosis was identified promptly & treated meticulously. The patient was discharged without any residual complications. So, the rare complications should not be ignored.

References

- 1. European journal of Obstetrics & Gynaecology Dec 2011 vol 159, pg 485-7
- Bonito M, Gulemi L, Basili R, et al. Thrombosis associated with a large uterine myoma: case report. Clin. Exp. Obstet. Gynecol. 2007;34(3):188–9. [PubMed]
- Dekel A, Rabinerson D, Dicker D, et al. Thrombosis of the pelvic veins associated with a large myomatous uterus. Obstet. Gynecol. 1998;92 (4 Pt 2):646–7. [PubMed]
- Falcone M. Serra P. Massive pulmonary embolism in a woman with leiomyomatous uterus causing pelvic deep venous thrombosis. Ann. Ital. Med. Int. 2005; 20(2): 104–7. [PubMed]
- Kutsukata N, Mashiko K, Matsumoto H, et al. A case of successful treatment of acute iliofemoral venous thrombosis caused by giant myoma through combination of simultaneous hysterectomy and thrombectomy. Ann. Vasc. Dis, 2009;2(2):114–17. JPMC free article] [PubMed]
- Kuwano T, Miura S, Nishikawa H, et al. Venous thrombosis associated with a large uterine myoma. Intern. Med. 2008; 47 (8): 809. [PubMed]
- Nishikawa H, Ideishi M, Nishimura T, et al. Deep venous thrombosis and pulmonary thromboembolism associated with a huge uterine myoma – a case report. Angiology, 2000;51 (2):161–166. [PubMed]
- Phupong V, Tresukosol D, Taneepanichskul S, et al. Unilateral deep vein thrombosis associated with a large myoma uteri. A case report. J. Reprod. Med. 2001; 46(6): 618–620. [PubMed]
- Toru S, Murata T, Ohara M, et al. Paradoxical cerebral embolism with patent foramen ovale and deep venous thrombosis caused by a massive myoma uteri. Clin. Neurol. Neurosurg. 2013;115 (6):760–761. [PubMed]