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Original Research Paper

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# RARE PRESENTATION OF HUGE CERVICAL FIBROID –CASE REPORT

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**ABSTRACT** Most of the leiomyomas are situated in the body of uterus. Fibroids arising from cervix are rare tumours accounting for 2% of all fibroids. Cervical leiomyomata are mostly single and are subserous or interstitial in origin. Generally these tumors present with retention of urine, constipation, sensation of something coming out of vagina and rarely at times present with abdominal mass which may mimic ovarian cancer. We report a case of 55 yr. married patient with complaints of something coming out of vagina and postmenopausal bleeding of short duration. Provisional diagnosis was a huge cervical fibroid protruding through the introitus on examination. Vaginal hysterectomy was done for patient along with removal of cervical fibroid which was confirmed on histopathology as leiomyoma. Conclusion: Huge cervical fibroids are rare entity and treatment is surgical removal.

**KEYWORDS :** cervical fibroid , fibroid polp, chronic inversion of uterus, postmenopausal bleeding.

## INTRODUCTION

Leiomyoma are the most common benign uterine and pelvic tumors. They usually develop during reproductive age group (30-50 yrs.) when estrogen levels are highest and regress during menopause. The usual anatomical location is body of uterus with incidence of cervical leiomyomas which is very less of around 1-2%.[1]They arise either from supravaginal or vaginal portion of cervix. They are classified as anterior, posterior, central and lateral depending on their site of origin. Symptoms include menstrual irregularities, urinary retention, dyspareunia and post coital bleeding, sensation of something coming down . Cervical myomas with excessive growth may cause pressure symptoms and may present as abdominal mass, incarcerated procidentia. Reproductive sequelae include infertility due to anatomic blockage, recurrent pregnancy loss , and obstructed labor due to dystocia leading to high rates of cesarean delivery , postpartum hemorrhage and cesarean hysterectomy . Uterine fibroids are benign clonal tumors 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.[2]. Usually there is no evident menstrual abnormality associated with cervical fibroid. A large cervical fibroid may cause obstruction during Labor. Ultrasonongraphy (transvaginal) is reliable for evaluation. However, CT and pelvic MRI can be used in complicated cases. Treatment is myomectomy or open hysterectomy or laproscopic hysterectomy. Cervical fibroids prove to be a challenge to the clinician in view of their close proximity to important pelvic structures and the approach needs to be modified depending on location of myoma because of their likelihood to cause complications and difficulty in removal , poor access to operative field ,difficulty in suturing , increased blood loss and distortion of anatomy of vital neighbouring structures in pelvic cavity. Very rarely they attain huge dimensions and in that case, they protrude out of vagina through introitus.

## CASE STUDY

A 55 yr. female referred from subcentre in view of uterocervical mass in emergency with complains of something coming out of vagina since 2 days, postmenopausal bleeding since 2 days with no history of altered bowel and bladder habits. She was para 2 live 2 both full term normal delivery last child birth 30 yrs. back . She was postmenopausal since 2 years. On clinical examination she was pale, systemic examination within normal limits. On abdominal examination, abdomen was soft non tender, no organomegaly. On local examination, large multilobulated, variegated mass seen with areas of congestion and necrosis with dilated veins. Mass was very friable and fragile. External OS can't be appreciated. On per speculum examination, large pedunculated mass of approx. 10*10 cm size arising from posterior lip of cervix. On bimanual palpation, Uterus was not palpable. No adnexal mass felt.

Transvaginal Ultrasonography was suggestive of cervical fibroid and with bilateral ovaries obscured. Patient was started on broad spectrum antibiotics and local antiseptics and regular dressing .Patient was taken for vaginal hysterectomy with fibroid enucleation one week later after correction of anemia.

Because of huge cervical fibroid, there was surgical difficulty by virtue of relative inaccessibility and proximity to anterior bladder and posterior rectum . The principle followed was enucleation of fibroid by identifying the stalk of pedunculated fibroid and clamping , cutting and removing it .Procedure further proceeded with vaginal hysterectomy as there was no distortion of pelvic structures .Procedure was uneventful.

Postoperative patient was stable and discharged on day. Vaginal vault was healthy. Histopathology report was suggestive of leiomyoma.

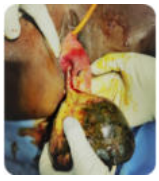

**Figure 1: large pedunculated cervical fibroid**

**FIG 2. Large multilobated , variegated pedunculated mass with areas of congestion and necrosis on per speculum examination**

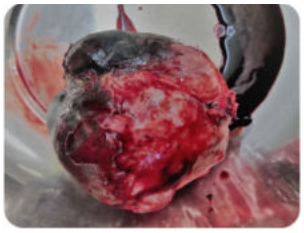

**Fig 3 Post operative specimen of cervical fibroid**

## DISCUSSION

Huge cervical fibroid in a postmenopausal women is a rare entity. Because fibroids usually occur in reproductive age group when ovaries are active and producing estrogen and regress in menopause due to drop in estrogen production. Risk factors in postmenopausal women include high blood pressure, low vitamin D levels, family history of fibroids, obesity, use of hormonal replacement therapy.[3] Presence of isolated fibroid in cervix with intact uterus is infrequent. These fibroids grossly and histopathologically are identical to those found in corpus. Cervical fibroid may be classified as anterior, posterior, central and lateral according to their position. Anterior fibroid bulges forward and undermines the bladder causing urine retention and frequency. Posterior fibroid flattens the pouch of Douglas compressing rectum against sacrum resulting in constipation. Lateral cervical fibroid starting on the side of cervix burrows out into the broad ligament and expand it. Central cervical fibroid expands the cervix equally in all direction but produces mainly bladder symptoms. On laparotomy they give a typical appearance of "Lantern on St Paul's Dome."[4] Differential diagnosis includes uterine inversion, cervical carcinoma, cervical polyp and prolapse of uterus. Uterine inversion can be differentiated from cervical fibroid by abdominal and bimanual examination will reveal dimpling of fundus and sounding not possible in inversion of uterus. Cervical carcinoma will be diagnosed by imaging and histopathology. Cervical fibroid are firm in consistency with no cough impulse and can be differentiated from prolapse of uterus. Treatment of cervical fibroid is either myomectomy or hysterectomy. [5] They give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter. The knowledge of this fact can turn potentially dangerous procedures into a relatively safe one. Preoperative GnRH analogue administration for 3 months reduces intraoperative blood loss and facilitates surgery [6]. Principle to be followed during surgery is enucleation followed by hysterectomy.[7]

## CONCLUSION

In our case patient had a huge posterior cervical fibroid with a short duration of postmenopausal bleeding without any altered bowel habits which is very uncommon for such fibroid. Inspite of fibroid being huge ,vascular with necrosis , there was no injury to adjacent structures because of stepwise procedure which was a great advantage to patient . Thus we conclude that proper preoperative evaluation, preparation and knowledge of altered anatomical structures are important for performing hysterectomy for cervical fibroid.

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