RESEARCH PAPER | Medical Science | Volume : 6 | Issue : 4 | April 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

Unusual Presentation of Cervical Fibroid

KEYWORDS: fibroid, cervical, leiomyoma.

DR. SHRADHA
Junior Resident, MD, Department of Obstetrics and gynaecology, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, India.

DR (PROF.) P. B. SAHAY
Professor and Head of department, MS, FICOG, Department of Obstetrics and gynaecology, Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, India.

ABSTRACT *Leiomyoma is the commonest of all pelvic tumours, being present in 20% of all women of reproductive age group. Only 1-2% of these are confined to cervix and usually to supravaginal portion. Cervical leiomyoma is commonly interstitial or subserous, rarely does it become submucous and polypoidal. These tumours usually present with retention of urine, constipation, sensation of something coming out or foul smelling discharge per vaginum. At times though rarely it can present solely as an abdominal mass without other symptoms and may mimic an ovarian tumour as in the present case.*

Here we present a case of a seventeen years nulliparous female with huge abdominal lump and pain during menses for last six months. On examination there was 34 weeks size firm well defined abdominal lump arising from pelvis. Ultrasonographic findings were suggestive of an ovarian mass.CA125 was within normal limits and there was no ascitis. Our differential diagnosis was leiomyoma and ovarian tumour. However the diagnostic confusion got cleared only on exploratory lapratomy where a huge cervical fibroid with a normal sized uterus sitting at top of it was found. This was referred to as lantern at the dome of st paul's cathedral. Myomectomy was then performed with great difficulty. Postoperative period was uneventful; patient was discharged with advice for follow up visits.

Cervical fibroid with excessive growth is very uncommon and this case presented only as a huge abdominal mass with dysmenorrhoea leading to a diagnostic dilemma. Final diagnosis was made only at laprotomy. Myomectomy in this case was technically challenging as the pelvic anatomy was distorted and there was increased risk of injury to bladder, ureter and also an increased risk of intra operative bleeding. Moreover anatomical and functional restoration of cervix to achieve objective of future reproduction was limited. In the modern era such cases can be managed by laparoscopic surgery.

INTRODUCTION

Uterine leiomyoma is the most common benign tumour of uterus affecting 20% of all women of reproductive age group[1] and leading to 1/3rd of gynaecological admission in hospitals. Cervical leiomyoma accounts for 1 to 2% of uterine myomata[1] and is confined usually to the supravaginal portion of cervix[2]. This is commonly single and is either subserous or interstitial in origin, rarely does it become submucosal or polypoidal[1]. These tumour can present frequently with urinary retention, constipation, dyspareunia, sensation of something coming out or foul smelling discharge per vaginum[3,4]. At times, though very rarely it can present only as an abdominal mass without any other symptom and may mimic ovarian tumour as in the present case.

CASE HISTORY

A 17 years old unmarried nulliparous girl was admitted on 30th September 2013 from Gynae OPD RIMS with complain of lump abdomen which had grown over period of 6 months. There were no menstrual abnormalities, bladder and bowel habits were also normal. Her general examination was unremarkable except for mild degree of pallor. On abdominal examination, a 34 weeks size, firm to hard, non-tender lump with smooth surface, regular margin and restricted above downward mobility was found. Clinically, there was no ascitis. On rectal examination, hard lump was felt through anterior wall. She was admitted with provisional diagnosis of ovarian tumor, with uterine leiomyoma as differential diagnosis.

INVESTIGATIONS

All preoperative investigations were done. Except for Hb%-9.8gm%, all other hematological and biochemical investigations were within normal limit. USG report showed a large solid heterogeneous mass of size 18x20x20cm with increased vascularity arising from the pelvis. Uterus and ovaries could not be separately delineated suggestive of mass of ovarian origin, but CA125 was 12IU/ml.

MANAGEMENT

Exploratory laparotomy was done under general anaesthesia on 8th October 2013 which revealed a cervical fibroid of 18x20x20cm arising from anterior wall of cervix with normal size uterus sitting at the top of it often referred to as *"LANTERN AT THE DOME OF SAINT PAUL'S CATHEDRAL"*. Both ovaries and tubes were normal.As the patient was nulliparous, decision of myomectomy was taken. Peritoneum of uterovesical pouch was incised transversely and bladder was pushed down. Incision was given on expanded cervix to reach the myoma which was then enucleated in toto by blunt and sharp dissection. The redundant cervical flaps were then cut and refashioned. During surgery, the uterine cavity got opened at the level of internal os which proved to be rather helpful. A metal dilator was inserted through this defect into the cervical canal which guided us to repair the uterus and cervix without the endometrial cavity and cervical canal being obliterated by sutures at any level. Uterus was repaired with utmost care to avoid injury to intramural portion of fallopian tube. Intraoperatively, patency of both fallopian tubes were tested which was found to be normal.Postoperative period was uneventful. Patient was discharged on day8 of surgery and was

Volume : 6 | Issue : 4 | April 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

called for follow up after 1 month.

Histopathological report showed leiomyoma with hyaline degeneration. Patient reported to us after 40 days, wound was healthy and patient had attained her normal menstrual functions. USG revealed bulky uterus with long cervical canal.

DISCUSSION

This is a rare presentation of cervical fibroid. Large cervical fibroid are rare and only handful of cases has been reported in literature[5]. In the case presented, cervical fibroid grew not only to occupy the pelvic cavity but became a huge abdominal mass pushing the uterus above the umblicus. It is very easy to diagnose and treat benign condition like leiomyoma but as the above case suggest there may be diagnostic dilemma. Even after thorough clinical examination and investigations we were able to diagnose it only at laparotomy. This shows that though the new diagnostic modalities such as ultrasound and MRI has improved the preoperative diagnosis, the final diagnosis is always at laprotomy. Myomectomy in this case was technically very difficult as there was increased risk of ureteric and bladder injury and intraoperative bleeding as well[6]. Also it was a great surgical challenge to reconstruct that nulliparous cervix which would anatomically and functionally connect with endometrial cavity not jeopardizing her future obstetrical career.

Sharma et al of Sri Lanka reported a case of cervical fibroid that clinically resemble an ovarian tumour. Patient presented with abdominal distension and loss of weight. During surgery, left ureter was damaged, so ureteric anastomosis was done. Basnet et al from Nepal also reported a similar case of huge cervical fibroid with an unusual presentation. In their case patient presented with gradual abdominal distension, scanty menses but no bladder and bowel complaints. During surgery, there was bladder injury which was repaired. There was profuse bleeding from the myoma bed for which internal iliac artery ligation was done.

Similar case was also reported in UP, India where a 42 years female presented with gradual distension of abdomen and urinary symptoms. On exploratory laprotomy, small sized uterus was sitting on the dome of cervical fibroid. TAH+BSO was done for the same.

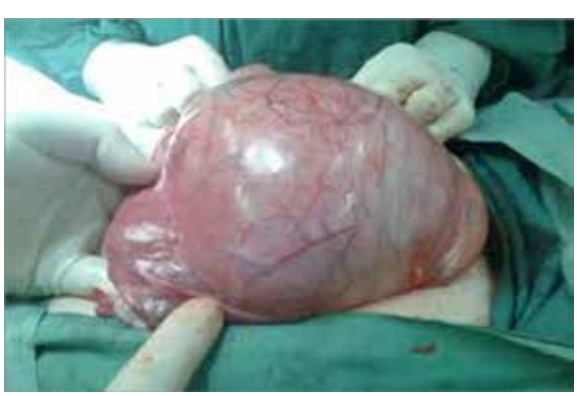

Figure 1: Small size uterus sitting at the top of huge cervical fibroid referred to as Lantern ant the dome of St Paul's Cathedral.

Figure 3: Uterus after reconstruction following myomectomy.

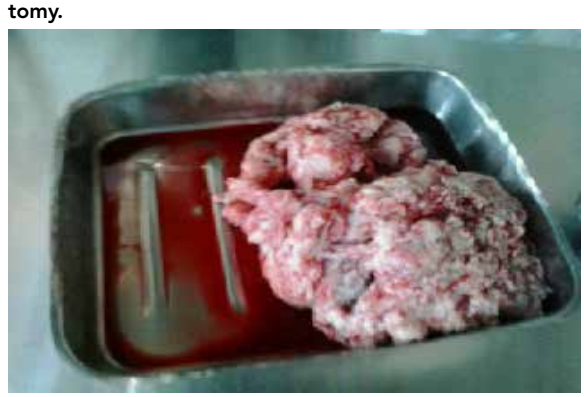

Figure 4: Specimen of fibroid after myomectomy.

REFERENCES

1. Bhatla N. Tumours of corpus uteri.In Jeffcoate's Principles of Gynaecology.. 7th Ed.London: Arnold publisher P. 488-91.
2. Tiltman AJ. Leiomyoma of uterine cervix: A study of frequency. Int J Gynaecol 1998;17:231-4.
3. Suneja A, Taneja A,Guleria K, Yadav P, Ararwal N. Incarcerated procedentia due to cervical fibroid; An unusual presentation. Aust N Z J Obstet Gynaecol2003,43252-3.
4. Dutta DC. Benign lesion of uterus. In textbook of gynaecology including contraception. 4th ed India. New central book academy limited.
5. Kshirsagar SN, Laddad MM. Unusual presentation of cervical fibroid. Two case reports. International Journal of Gynae Plastic surgery,2011,3[4]:38-39.
6. Kaur AP, Saini AS, Kaur D, Madhulika Dhillon SP. Huge cervical fibroid. An unusual presentation. J Obstets Gynaecol India2002;52;164-5.
7. Sharma S, Pathak N,Goraya SP, Singh A, Mohan P. Large cervical fibroid mimicking an ovarian tumor. Sri Lanka J Obstet Gynecol 2001;33;26-27.
8. Basnet N. Banargee B, Badani U, Tiwari A, Raina A, Pokharel H, et al. An unusual presentation of huge cervical fibroid. Kathmandu Univ J (KUMJ), 2005,3;173-4.
9. Davis A. Hart R, Magos AL: The excision of uterine fibroid by vaginal myomectomy. A Prospective Study. Female Sterlity,1999,7[5]961-964.
10. Ornan Bukulmez, Kevin J Doody. Clinical features of myomas. Obstetric Gynecology Clin N am 33[2006] 69-84.