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Submucous Fibroid Masquerading as an Intramural Fibroid: a Diagnostic Challenge.

KEYWORDS: Submucous leiomyoma, heavy menstrual bleeding

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ABSTRACT *Submucous leiomyomas are a challenging diagnosis to the consultant gynaecologist and present with varied symptomatology. We narrate a presentation of 40 years old female who was under evaluation for heavy menstrual bleeding and dysmenorrhea and was diagnosed to be having intramural fibroid which turned out to be submucous leiomyoma.*

INTRODUCTION –

Leiomyomas are the commonest benign uterine tumors, with an estimated incidence of 20%–40% in women during their reproductive years [1,2].They are monoclonal tumors of the uterine smooth muscle cells and consist of large amounts of extracellular matrix that contain collagen, fibronectin, and proteoglycan [3,4].They are classified by their location relative to the layers of the uterus (as subserous, intramural, or submucous) and can be single or multiple. It is generally perceived that the symptoms of heavy menstrual bleeding, infertility and recurrent pregnancy loss largely occur as a result of lesions that distort the endometrial cavity that are therefore adjacent to the endometrium and consequently referred to as submucous leiomyoma.

CASE REPORT

40 year old female P1L1 presented to hospital with complaints of spasmodic dysmenorrhea and menorrhagia since 1 year. She gives history of soakage of 4 to 5 pads/day with heavy menstrual flow which is associated with passage of clots.

Menstrual History –

her last menstrual period was 5 days ago. Her past cycles were heavy blood flow with soakage of 5 pads per day with passage of clots and spasmodic dysmenorrhea.

Obstetric History –

P1L1 – 15 year old female child delivered vaginally. The patient did not use any mode of contraception.

On examination –

Her general condition was fair, pulse – 100/min, BP – 120/70 mmHg, severe pallor present, CVS – S1S2 were normal, RS – AEBE and clear, P/A – soft and non tender

Per Speculum examination – cervix and vagina healthy

Per Vaginal examination – uterus was corresponding to 10 weeks of gestation, retroverted, firm in consistency, 5X5 cms fibroid in posterior wall, bilateral fornices were free and non-tender.

On Investigation –

Hb- 6.7 gm%, TSH – 0.9 μIU/ml.

Ultrasonography revealed uterus measures 13 X 7 X 8.6 cms in size. Myometrial echotexture appears normal. An intramural fibroid measuring 6 X 3.5 X 4.3 cms is noted in the posterior wall of the fundus. Fibroid is vascular. Fibroid is indenting and compressing the endometrial echo complex. Endometrial echo is visualized at the fundus, it is not well delineated in the body. Cervix appears normal.

Patient was willing for hysterectomy and was transfused 3 packed cell volume pre-operatively.

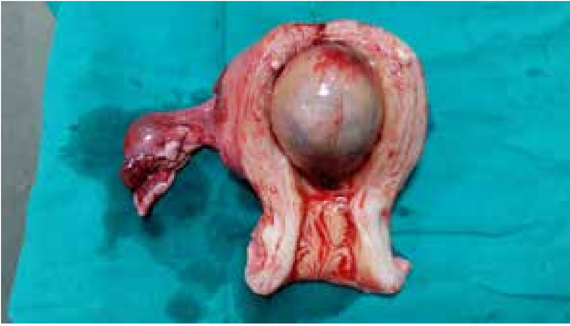
Intra operatively there was a posterior wall fibroid and urinary bladder was advanced. There was difficulty in clamping the uterine arteries and the mackenrodt ligaments.

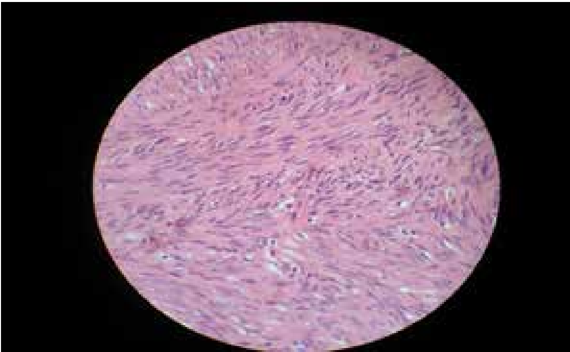
The specimen was cut open (Figure 1) and it revealed a 5 X 5 cm submucous fibroid. Histopathology revealed (Figure 2) whorled appearance and spindle shaped cells.

The patient required 1 unit packed cell transfusion post operatively and was discharged on day 8 after the sutures were removed.

DISCUSSION –

Submucous leiomyomas present a difficult diagnosis. A large submucous fibroid may masquerade as an intramural fibroid. Meticulous ultrasound examination with proper assessment of the topography of the fibroids is a must in these situations. Proper pre-operative evaluation prevents intra-operative surprises as in this case.





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