



Large Uterine Fibroid in Young Woman – A Case Report

KEYWORDS

Benign uterine leiomyomas ,fibroids.

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ABSTRACT *Benign uterine leiomyomas (fibroids) are the most common pelvic tumor in women. The incidence of uterine fibroid tumor increase as women grow older and they may occur in more than 30 percent of women 40 to 60 years of age. Risk factors include nulliparity, obesity, family history, black race, and hypertension. Uterine fibroid presents with abnormal uterine bleeding, pelvic pain, and pressure symptoms and impaired fertility in women of reproductive age. The location of fibroids is implicated to play a role in infertility and miscarriages, with intramural and submucous locations identified as major risk. The differential diagnosis of an enlarged uterus includes both benign and malignant conditions. We present a case report of 31 year old nulligravida, complaining of menorrhagia and mass per abdomen.*

INTRODUCTION :

Uterine fibroid is a common gynecological problem among women of reproductive age, and there are conflicting reports of its effect on fertility and pregnancy outcome.

The majority of women with uterine fibroids are generally asymptomatic at the early stage and consequently get less clinical attention due to undiagnosed disease, while symptomatic women typically complain of abdominopelvic mass with or without abnormal uterine bleeding- mainly menorrhagia . Studies have shown that women with myomas are more likely to present with abdominal mass and menorrhagia , and may also present with dyspareunia, dysmenorrhoea, abdominal discomfort or bloating, painful defecation, back ache, urinary frequency or retention, and infertility. During pregnancy, fibroids may be a cause of miscarriage, bleeding, abnormal lie and presentation. (1,2,5-6)

Differential diagnosis includes both benign and malignant conditions:

Historically, hysterectomy was the mainstay of treatment for women with a uterine mass. In current practice, women with presumed benign leiomyomas are treated with a variety of medical and conservative surgical or interventional procedures. Non-excisional therapies for fibroid-related symptoms are hormonal contraception, GnRH analogues, endometrial ablation, interventional radiology procedures. In addition, techniques that disrupt a uterine mass are myomectomy, or hysterectomy. Minimally invasive surgeries are offered to low risk patients. (3,4).

Case history

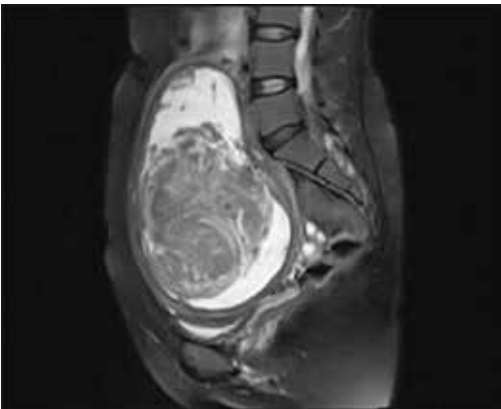
A 31 years married, nulligravida, housewife and resident of Kolhapur came to our OPD with complaints of menorrhagia since 2-3 months bleeding for 3-4 days in 30 days interval, regular, with passage of clots and not associated with dysmenorrhoea. She complains of weight loss over last 3 months. She had no history of white discharge per vaginam, fever, pain in abdomen, backache or dyspareunia and no bowel or bladder disturbance. She was averagely built, poorly nourished with BMI: 17.1Kg/m². Pallor was present, pulse Rate:100/min, regular, B.P.: 112/64mmHg.

Per abdomen she had a supra pubic bulge extending up to umbilicus, corresponding to 24 weeks of gravid uterus, firm to cystic (variegated) in consistency with smooth surface, regular margins, superior and lateral borders could be made out, lower pole was not palpable. Mobility from side to side was present but above downward mobility was absent. No dilated veins or sinuses were seen on the surface. On per speculum examination, cervix and vagina were healthy, cervix was pulled up and no discharge was seen. Per vaginam, there was firm to cystic mass corresponding to 24 weeks size of gravid uterus, bilateral and posterior forniceal fullness was present. Uterus was not felt separately from the mass, vaginal mucosa was free. No nodularity was felt on per rectum examination. Her blood picture showed Hb 7.8 gm%, WBC 5100, platelet count of 3.89 lakhs. PAP smear showed NILM. TSH 2.4µIU/ml. Ultrasound of abdomen and pelvis (trans abdominal and trans vaginal study) showed enlarged uterus with a large heterogeneous mass (13x8x11cms) with cystic changes and internal vessels in it s/o large fibroid with degenerative changes/ neoplastic mass. Tumour markers were within normal range. MRI of pelvis showed. A fairly large well defined intramural mass lesion in the anterior wall of uterus (14.5 x 8.3 x 12.1cm) displacing endometrial cavity posteriorly with thin subendometrial transition zone of myometrium measuring about 2.5cm. So our final diagnosis was 31yrs nulligravida with degenerative fibroid. Following investigation and pre-operative preparations, myomectomy was done. Intra operative findings were A large intra mural fibroid ≈ 16x 10 cms arising from anterior wall of uterus. Evidence of cystic degeneration in myoma. Bilateral fallopian tubes and ovaries are normal. Post operatively, antibiotics and inj. Dexamethasone 4 mg IV 12 hourly for 2 days and 1 unit PCV transfused. Post transfusion blood picture: Hb: 11gm%, WBC: 8600, platelets: 4.72 lakhs. Patient was discharged on post operative day 9 on Inj. Leuprolide 3.75 mg IM monthly for 3 months. Histopathology report showed leiomyoma with degenerative changes. On discharge, she was advised regular follow up, contraception for 2 years and elective lower segment caesarean section if she conceives.

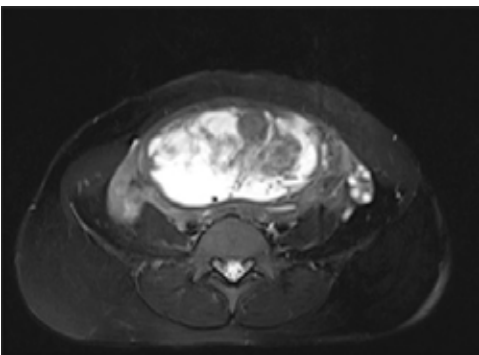
USG abdomen and pelvis



MRI images: Transverse



Sagittal section



Myomectomy: intra-op



Gross appearance: Outer surface



Inner surface



DISCUSSION:

The uterine fibroid is the most common tumor of the female pelvis in the reproductive age group and one of the commonest causes of hysterectomy. Though exact etiopathogenesis is still unknown, these are benign tumors, made up of smooth muscle cells and represent hormonal interactions (estrogen/progesterone). Most often these tumors are asymptomatic and undiagnosed. These neoplasms frequently cause abnormal period, pelvic pain, and pressure symptoms of surrounding organ. Large leiomyoma may compress the bladder and /or uterus, with potential for renal damage if not correlated. Transvaginal ultrasonography, magnetic resonance imaging, sonohysterography, and hysteroscopy are available to evaluate the size and position of tumor. Ultrasonography should be used initially because it is the least invasive and most effective investigation.

Treatment must be individualized based on such consideration as the presence and severity of symptoms, the patient's desire for definitive treatment, the desire

to preserve childbearing capacity, the importance of uter-

ine preservation, infertility related to uterine cavity distortion, and previous pregnancy complication related to fibroid tumor. (7)

REFERENCES :

1. Atombosoba. A. Ekine, Lucky O. Lawani. Review of the Clinical Presentation of Uterine Fibroid and the Effect of Therapeutic Intervention on Fertility. *American Journal of Clinical Medicine Research*, 2015, Vol. 3, No. 1, 9-13.
2. Ezeama C, Ikechebelu J, Obiechina N, Ezeama N: Clinical Presentation of Uterine Fibroids in Nnewi, Nigeria: A 5-year Review. *Ann Med Health Sci Res* 2012, 2: 114-118.
3. Elizabeth A Stewart , Robert L Barbieri. Differentiating uterine leiomyomas (fibroids) from uterine sarcomas. UpToDate 2016.
4. Buttram VC Jr, Reiter RC. Uterine leiomyomata: etiology, symptomatology, and management. *Fertil Steril* 1981; 36:433.
5. Van Voorhis BJ, Romitti PA, Jones MP. Family history as a risk factor for development of uterine leiomyomas: result of a pilot study. *J Reprod Med*.2002;47:663-69.
6. Lumsden MA, Wallace EM. Clinical presentation of uterine fibroids. *Baillieres Clin Obstet Gynaecol* 1998;12:177-95.
7. Safa M.Al-Obaidi , Mohammed Abd-Zaid Akool. A case of Giant Uterine Fibroid in a Young Woman. *THE IRAQI POSTGRADUATE MEDICAL JOURNAL VOL.11, NO.4, 2012.*