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ACUTE INTESTINAL OBSTRUCTION: AN UNUSUAL PRESENTATION OF BENIGN UTERINE LEIOMYOMA

KEYWORDS: uterine leiomyoma, intestinal obstruction

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ABSTRACT *Uterine fibroids present with a wide range of symptoms with abnormal uterine bleeding and dymenonrrhea being the most common ones. Our patient presented with features suggestive of acute intestinal obstruction- abdominal pain, vomting, constipation and absent bowel sounds. CT Abdomen showed large uterine fibroid causing mechanical compression on the large bowels leading to acute large intestine obstruction. She underwent emergency laprotomy and intraoperatvely was found to have early bowel gangrene , multiple fibroids adherent to bowel loops and constricting band at the sigmoid colon. Adhesion release, sigmoid colon resection and diversion colostomy was done, followed by subtotal hysterectomy.*

This case report highlights that acute intestinal obstruction is a rare complication of benign uterine fibroid and should be considered when patients present with the above clinical scenario.

INTRODUCTION

Uterine leiomyomas are the most common tumours in women of reproductive age. They are benign tumours arising from the smooth muscle and are often multiple.

Myomas can give rise to variety of symptoms depending on the location, size and number. Nearly 40 to 50% remain asymptomatic and 30-40% present with abnormal uterine bleeding. Other common presentations include secondary dysmenorrhea of congestive type, pelvic pain or discomfort, feeling of abdominal mass, pressure symptoms on bladder and subfertility. Less frequent presentations include rectal compression by large posterior or cervical myomas leading to incomplete bowel evacuation, uterine inversion, sarcomatous change and bowel obstruction(1). Here we present a rare case of acute large bowel obstruction with impending perforation secondary to large uterine fibroids impacted in the pelvis.

CASE REPORT

37 year old nulliparous lady, presented with complaints of abdominal pain and vomiting for 5 days, and constipation for 3 days duration. She had been married for 18 years and had undergone myomectomy in 2003 and 2006 respectively- the details of which was not available. She had regular menstrual cycles with normal flow; she had no other co morbid illnesses.

At admission, she was afebrile and was hemodynamically stable. On examination, her abdomen was distended with mild diffuse tenderness and a 24 weeks mass was palpable.Her upper abdomen was noted to be markedly distended with sluggish bowel sounds. Her per vaginal examination revealed pulled up cervix, irregular uterus enlarged to 22 weeks size, filling the pelvis with restricted mobility; suggestive of a large uterine fibroid

She was managed conservatively for 2 days with fluids, antiemetics and antispasmodics but she continued to be symptomatic. She was simultaneously evaluated for further complications or alternate etiology. USG abdomen showed a large heterogenous, hyperechoic lesion in the pelvis measuring 12*13*15cm with minimal peripheral and internal vascularity. Bilateral ovaries were not visualised separately; CA 125 was 269. Plain X Ray of Abdomen showed multiple air fluid levels suggestive of large bowel obstruction. Subsequently, CECT abdomen was done which showed a large uterine mass- probable fibroid/sarcoma. The rectally administered contrast was not seen proximal to a certain point of the sigmoid colon, which was in close contact with the uterine mass; suggestive of mechanical compression/ infiltration by the sarcomatous mass. The large bowel was grossly dilated(colon- 6.9cm, transverse colon- 6.4cm and caecum- 5.4cm); small bowel loops were not dilated suggestive competent ileocaecal valve.

Thus a diagnosis of large uterine fibroid causing large bowel obstruction was made. She was taken up for emergency laprotomy, with intra operative help from the General Surgery team. Intraoperatively, bowel loops were found to be distended with areas of early gangrene and one area with breach in the serosal layer suggestive of impending large bowel perforation. Uterus was enlarged to 24 weeks, with multiple fibroids densely adherent to the pelvis and bowel loops. Both cornual region were sealed off with adherent bowel loops- ceacum on the right side and sigmoid on the left side. Urinary bladder was also pulled up and adherent anteriorly.

The bowel adhesions were released; as the uterus could not be lifted due to adhesions, morcellation of fibroids was done. 10 to 15 myomas of 2-6cm size were removed and then proceeded with subtotal hysterectomy. Cervical stump could not be removed due to dense pelvic adhesions. As the adhesions between bowel and uterine mass were released, the adhesion was also noted to form a band around the sigmoid colon leading to luminal narrowing and proximal dilatation. The adhesion was released and the constricting band along with a segment of the sigmoid colon was resected and a diversion colostomy was done. Abdomen was closed after keeping an intraperitoneal drain.

Histopathology of the surgical specimen was reported as benign uterine leiomyomata. Post operatively, patient was put on iv antibiotics and other supportive measures. She was discharged on Day 12 and advised follow up under Surgery for colostomy closure.

DISCUSSION

Uterine fibroids are the most common benign uterine tumours in women, most of which are asymptomatic.

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Intestinal obstruction is a rare complication of large fibroids with few case reports in literature. The clinical presentation in these cases were abdominal pain and distension, vomiting and constipation which was similar to our patient. Fontana R et al described a case of a 38 yr old presenting with small bowel obstruction; the possible pathophyiologies postulated are mechanical compression of the bowel by the fibroid, adhesions between intestine and infarcted mass and serosal pedunculated fibroid entrapping the bowel. Intraluminal obstruction can also occur rarely with fibroid as reported by Jacobs et al in which a pedunculated fibroid formed adhesion with the intestinal wall followed by erosion of the wall and formation of intraluminal calcified mass leading to obstruction. Aggressive leiomyosarcomas infiltrating the bowel wall can also lead to this clinical picture though there are no cases documented of the same; metastatic uterine leiomyosarcoma to the jejunum causing obstruction has been reported. In our case, there was mechanical compression and also adhesion band around the sigmoid colon leading to large bowel obstruction and early features of gangrene with impending perforation. Management was surgical with adhesion release, bowel resection and hysterectomy.

This case highlights that intestinal obstruction should also be considered as a differential in a patient known to have uterine fibroid, presenting with abdominal pain and vomiting. High degree of suspicion is required for early diagnosis and prompt intervention to prevent further complications such as perforation, sepsis etc. Multidisciplinary approach along with the General Surgery team should be undertaken for relieving the obstruction and adhesions, followed by hysterectomy/myomectomy.

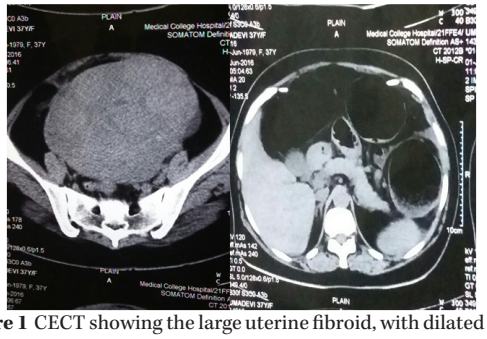

Figure 1 CECT showing the large uterine fibroid, with dilated bowel loops

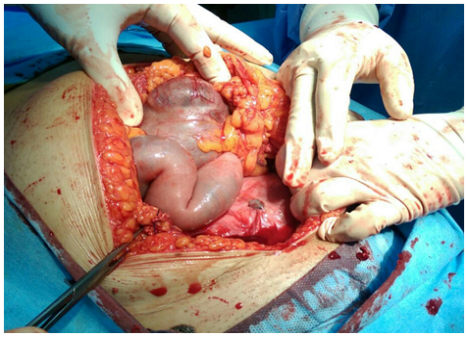

Figure 2 Intra op view showing dilated large bowel loops with features of early gangrene and one site of impending perforation.

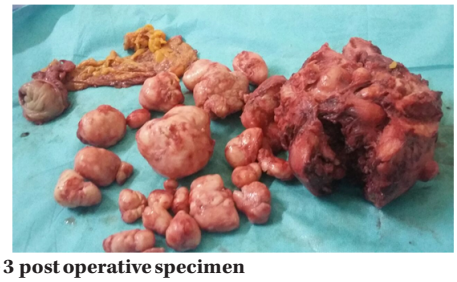

Figure 3 post operative specimen

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