Original Research Paper

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Gynaecology

A CASE REPORT ON ANTERIOR VAGINAL WALL LEIOMYOMA: A RARE ENTITY

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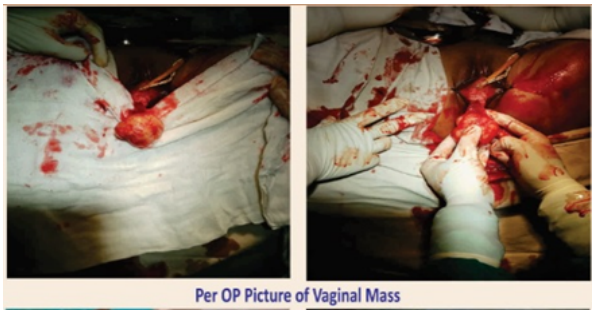
ABSTRACT LEIOMYOMAS are common benign tumours of uterus, incidence being 20-40% in women of reproductive age and it increases with age .However, vaginal leiomyomas remain an uncommon entity with only 330 cases reported in literature till now. Vaginal leiomyomas are most commonly located in anterior vaginal wall .They present with varied clinical features .Sometimes they are associated with leiomyomas elsewhere in the body. We report a case of primary leiomyoma of vagina arising from anterior wall and presenting with primary infertility.

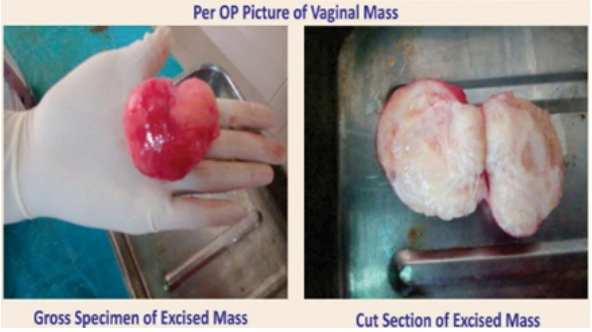
KEYWORDS : Leiomyoma, Vagina

CASE REPORT

A 21 year old nulliparous patient came in OPD in Civil Hospital Ahmedabad with H/O primary infertility since 4 years with usg pelvis report S/O Approx 5x4.8cm sized heterogenous echotexture lesion with raised vascularity in vagina extending from cervix findings S/O prolapsed submucosal fibroid more likely over cervical polyp. Her LMP was 8/12/2017. Her menses were regular. Patient was taking treatment for infertility in a private hospital. Patient admitted in gynaec ward for further management. Her general condition was fair, vitals were normal. On systemic examination, respiratory and cardiovascular systems were clear. On her Per Abdomen examination: Abdomen was soft. On Per Speculum examination: Cervix was taken up. On Per Vaginum examination: Approximately 5x5 cm mass felt in anterior vaginal wall. Non tender. Uterus was anteverted, normal in size with bilateral adnexa clear. On lab investigations, her Hb was 10.5 g/dl, wbc 7x10^3, platelets 155x10^3. Her RFT, LFT, Urine RM were within normal limits. Her Urologist reference was done for preop assistance and prophylactic ureteric stenting was done by them. The patient was taken for elective OT for removal of mass on 20/12/17. Under spinal anaesthesia, small vertical incision was given over the mass in the anterior vagina. Mass separated from the capsule by blunt dissection, taken out sent for HPE. Few hemostatic sutures were taken at the base of the cavity. Cavity closed with purse string suture with chromic catgut no 1-0. V aginal mucosa sutured with vicryl no 1 in a continuos interlocking manner. Patient was given injectable antibiotics for 3 days and discharged on post op day 4 on oral antibiotics, folic acid and multivitamins. Patient was advised to visit gynaec OPD for further infertility work up after next menses.



Per OP Picture of Vaginal Mass



Gross Specimen of Excised Mass

Cut Section of Excised Mass

DISCUSSION

Vaginal tumours are rare and include papilloma, hemangioma, mucus polyp and rarely leiomyoma. Leiomyoma in the female genital tract are common in the uterus and to some extent in the cervix followed by the round ligament, utero-sacral ligament, ovary and inguinal canal[1]. Vaginal leiomyomas are commonly seen in the age group ranging from 35 to 50 years and are reported to be more common among Caucasian women [2]. They usually occur as single, well-circumscribed mass arising from the midline anterior wall [1,3] and less commonly, from the posterior and lateral walls. They may be asymptomatic but depending on the site of occurrence, they can give rise to varying symptoms including lower abdominal pain, low back pain, vaginal bleeding, dyspareunia, frequency of micturition, dysuria, or other features of urinary obstruction these tumours can be intramural or pedunculated and solid as well as cystic. Usually these tumours are single, benign, and slow growing but sarcomatous transformation has been reported[5]. Diagnosis is usually difficult preoperatively as the condition mimics cystocele or cervical fibroid, but magnetic resonance imaging usually clinches the diagnosis. In magnetic resonance imaging, they appear as well-demarcated solid masses of low signal intensity in T1- and T2-weighted images, with homogenous contrast enhancement, while leiomyosarcomas and other vaginal malignancies show characteristic high T2 signal intensity with irregular and heterogeneous areas of necrosis or haemorrhage [6,7]. However, histopathological confirmation is the gold standard of diagnosis and also beneficial to rule out any focus of malignancy.

Surgical removal of the tumour through vaginal route, preferably with urethral catheterization to protect the urethra during surgery, is usually the treatment of choice as the approach is easy and there is availability of good surgical plane. When the tumour is large, an abdomino-perineal approach is preferred. In perimenopausal women treatment of choice is total abdominal hysterectomy .In large leiomyomas, if diagnosed preoperatively, GnRH anologues can be tried to reduce the size. The patient needs to be followed up for chance of recurrence. Our patient was symptom-free at 1 year follow-up. Though vaginal leiomyoma is rare, but its diagnosis should be kept in mind whenever examining a vaginal swelling

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