



CERVICAL LEIOMYOMA-A RARE INCIDENTAL CASE

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ABSTRACT Leiomyoma is a benign and nonepithelial tumor that commonly arises from uterus, esophagus and skin. Fibroids arising from cervix are rare tumors accounting for 2% of all fibroids¹. It affects women in their 4th and 5th decade. We received formalin fixed cervical tissue of a 44-year female who presented with bleeding and discharge per vaginam for 3 days. Grossly it looked like polyp and microscopically as leiomyoma.

KEYWORDS : LEIOMYOMA, CERVIX

INTRODUCTION

Leiomyomas are the most common benign tumors of the uterus and pelvic area. It is found in 20% of women in reproductive age group². Variant forms account for 10% of cases³. Incidence is 4% in below 30 year age group and very rare to be seen below the age of 18 and tend to regress after menopause⁴. Cervical leiomyoma are uncommon as compared to uterus. Cervical leiomyomas constitute 1-2% of the total leiomyomas cases¹. A cervical leiomyoma is single and is either interstitial or subserosal, rarely it becomes submucous and polypoidal. Depending on their site of origin, they are classified as anterior, posterior, lateral and central. Each fibroid presents with varying symptoms like menstrual abnormalities, acute urinary retention and frequency, constipation, dyspareunia and post coital bleeding or simply as abdominal mass⁵. Grossly they are well demarcated spheroidal masses with white/light pink/tan, whorled or trabecular incised surfaces, similar to uterine ones. Microscopically leiomyomas are composed of spindle shaped cells arranged in intersecting fascicles with well defined borders. Cells have eosinophilic fibrillary cytoplasm and cigar shaped nuclei with small nucleoli, infrequent mitosis and rare calcification and ossification.

CASE REPORT

A 44-year-old female came to gynaecology department with complaints of bleeding and discharge per vaginam associated with pain and clots for three days. Her last cycle was regular with average flow of 4-5 days and had history of tubal ligation. No history of post-coital bleeding or drug intake or any other chronic illness. P/S examination revealed polypoidal growth coming from external os which bleeds on touch and was suggestive of cervical polyp. P/V examination showed anteverted, firm, mobile, non-tender uterus, bilateral adnexa clear and non-tender with ?cervical polyp measuring approx. 5-6 cm. On USG an echogenic lesion of 3.2x1.9 cm suggestive of cervical polyp and intramural fibroid measuring 2.7x2.2 cm was diagnosed. D&C was done and endometrial curettage with ?cervical polyp was sent for HPE.

Formalin fixed labelled container as cervical polyp was received which contained grey-brown polypoidal tissue piece measuring approx. 3x3x1 cm. Outer surface is irregular and on cut solid whorling pattern was noted.



Fig1: Resected Tissue Measuring 3x3x1 cm.



Fig2: Cut surface shows whorling like pattern in cervical growth

Microscopically polypoidal tissue section shows mucosa with partially denuded lining epithelium and partially lined by metaplastic squamous epithelium. Subepithelial stroma is infiltrated with lymphoplasmacytic infiltrate with few neutrophils and congested vessels. Endocervical glands are dilated. Deeper part shows proliferation of spindle shaped smooth muscle cells arranged in fascicles transverse in irregular fashion, at places whorling is seen. The muscle fibres along with fascicles of fibroblast are also seen. Histopathologically diagnosed as cervical leiomyoma.

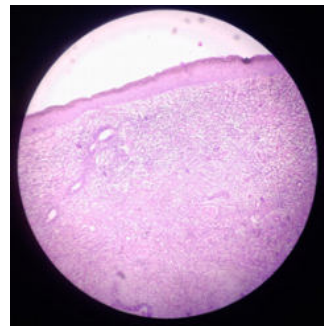
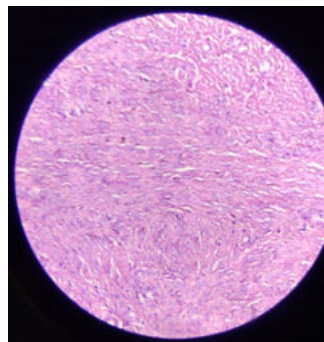


Fig3,4: Showing interlacing bundles of spindle cells arranged in fasciculation.



DISCUSSION

Leiomyomas are the most common benign tumors of the uterus showing smooth muscle differentiation and containing a variable amount of collagen rich extracellular matrix³. They are commonly seen in uterus and also rarely seen in cervix, round ligament, uterosacral ligament, ovary and inguinal canal. Pedunculaed fibroids arise from endocervical canal or from uterine cavity and protrude through the cervix. They may arise either from supravaginal or vaginal portion of cervix. Anterior fibroids may present with urinary symptoms, posterior may present with difficulty passing stools, lateral would extend to broad ligament and central one pushes uterus upwards. Upon opening abdominal cavity, central cervical fibroid can be recognized at once because of its characteristic “the lantern on the dome of St. Pauls” appearance⁶. Symptoms depend on type and position of mass.

The proposed mechanism for the development of leiomyoma include a congenital origin, blood flow disturbance, infection and involvement of estrogen but no consensus has been reached. Cervical fibroids generally don't affect reproducibility of women and are rare during pregnancy⁷. Grossly and histopathologically they are similar to uterine fibroids and shows various degeneration like hyaline, myxoid and cystic degeneration⁴. Immunohistochemically alpha-SMA, h-caldesmon show positivity⁸. Treatment of cervical fibroid is either myomectomy or hysterectomy⁹. They give rise to greater surgical difficulty as relatively inaccessible and close proximity to bladder and ureter¹⁰. Preop GnRH analogue administration for 3mo reduces intraop blood loss and facilitates surgery.

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