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GIANT EXTRA-UTERINE LEIOMYOMA : AN UNUSUAL CASE REPORT

General Surgery

Dr. Karan Ratnam Rawat Department of General Surgery , Mahatma Gandhi University Of Medical Sciences And Technology, Jaipur (Rajasthan)

Dr.Ritik Hooda Department of General Surgery , Mahatma Gandhi University Of Medical Sciences And Technology, Jaipur (Rajasthan)

Dr.Sahil Punia Department of General Surgery , Mahatma Gandhi University Of Medical Sciences And Technology, Jaipur (Rajasthan)

Dr. k.k.dangayach Department of General Surgery , Mahatma Gandhi University Of Medical Sciences And Technology, Jaipur (Rajasthan)

ABSTRACT

20 % - 30% uterine tumours are leomyomas and broad ligament leomyoma are a rare variant. Presenting an interesting case of a huge Abdominal lump extending from symphysis pubis upto xiphisternum in a young female which is presenting with only features of constipation and increase in urinary frequency and features of anaemia and no history of abnormal bleeding per vaginum ,on CT being queried upon as ovarian tumour (malignancy) while CA -125 being under normal range was operated and found out to be a one of the heaviest leiomyoma (benign extra uterine tumour) with cystic degeneration on enucleation in india weighing 11.75 kg .

KEYWORDS:

Benign Uterine Tumor, Cystic Degeneration, Leiomyoma

INTRODUCTION

Leiomyomas are commonly found in 20 – 30% of uterine tumors with typical sonological appearance.[1] The diagnostic dilemma arises when leiomyomas undergo degenerative changes. This is a case report of huge leiomyoma with massive cystic degeneration resulting in diagnostic confusion with ovarian malignancy on clinical evaluation and radiological findings.[4]

Uterine leiomyoma can undergo cystic degeneration and is said to be found in 4% of all types of degenerations.[2] The commonest type of degeneration is hyaline seen in 60% of patients.[3]. However, when fibroids undergo massive cystic degeneration they may present clinical and sonologic diagnostic difficulties.

Huge broad ligament leiomyoma with cystic degeneration may present diagnostic difficulties in differentiating ovarian malignancies even on ultrasound and MRI. This differential diagnosis must be considered prior to surgical management.

CASE REPORT

Case of a 28 year old unmarried ,nulliparous female came to surgery OPD with chief complaints of abdominal mass followed by distension since 6 months. She noticed a lemon sized swelling in the right lower abdomen which was non tender and progressively increased in size to whole abdominal mass associated with increase in the frequency of micturition and defecation .No h/o nausea and vomiting or bleeding per vagina. patient has regular menstrual cycles with her last menstrual period ten days back. she has no family history of any cancer ,pocd,fibroid , tuberculosis or any drug /radiation exposure or any chronic metabolic diseases.

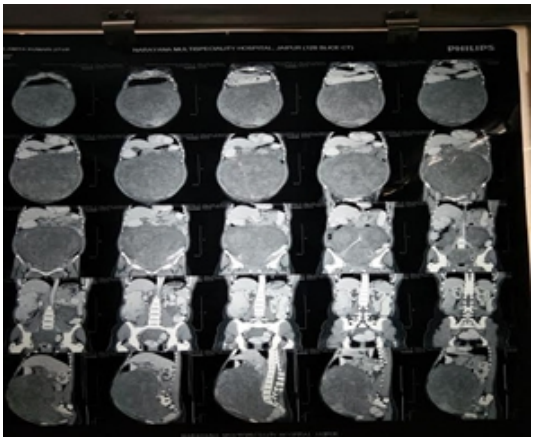
On examination her general condition is fair with BMI - 23.5 ,vitals were stable, moderate palor present , no lymphadenopathy and no pedal odema. While performing per abdomen examination , on inspection there was uniform abdominal distension uptil xiphisternum with central overstretched umbilicus. no abnormal vascularisation was seen. On palpation the mass was single ,smooth contour , firm in consistency and non tender with restricted mobility.no hepato-spleenomegaly was there.no features of ascitis were present. On auscultation normal bowel sounds were present. On per rectal examination nulliparous anteverted uterus was felt with free mobility and no adhesions or fibrous bands were present.

The hemogram was suggestive of **hb**-8.00 gm/dl **,WbC**- 15000 **,plt** - 340000 .Biochemical investigations Liver function test and Renal function test were in normal limit.Urine Pregnancy Test was negative .**CA-125** -15.62 U/ml

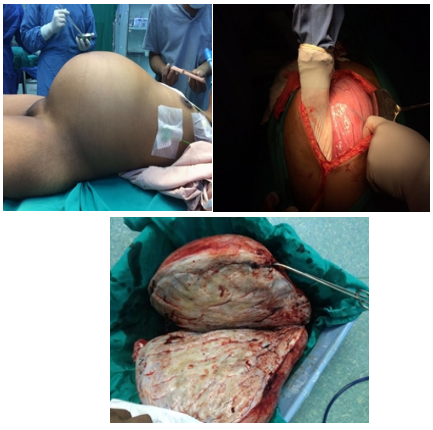
FNAC -very low content of epithelial cell repeat biopsy advised to rule out malignancy

Tru-cut biopsy -linear fragments of tissue made up of spindle round cells with ill defined cytoplasm .marked oedema ?benign mesenchymal tumour

CT findings -large well defined hypodense lesion in the adominal cavity extending from pelvis to epigastric region with heterogenous contras enhancement ,multiple intralesional and perilesional collaterals ,non - visualization of both ovaries separately .Abutment and mild compression over lower ureters resulting mild bilaeral hydronephrosis was seen.Abutment of aorta and illiac vessels posteriorly and also superior and inferior mesenteric artery .uterus is compressed anteriorly by the lesion ?ovarian neoplasm /broad ligament fibroid



Intraoperative finding - lower midline incision was given .lump occupying whole of the peritoneal cavity and pelvis ,excision done after manipulation,b/l ovaries and uterus spared.
weight of the excised mass - **11.75 kg**



HPE findings - in favour of **leiomyoma showing degenerative changes**

DISCUSSION

Knowledge of unusual presentation of the benign degenerated fibroids is essential to the clinicians; to help differentiate benign from malignant tumor entities.[8]

The location of fibroid often determines the various clinical symptoms [6]. Extra uterine leiomyoma which commonly occurs in the broad ligament are usually asymptomatic. Broad ligament fibroid have the potential to grow to a very large size [7]. If allowed to reach an enormous size, it can present with pressure symptoms of pelvic pain and bladder and bowel dysfunction. Intra uterine fibroid on the other hand in addition to pressure symptoms often presents with menstrual abnormalities and dysmenorrhoea.

Preoperative identification of feeding or draining vessels arising from the myometrium could be helpful in distinguishing an intraligamentary leiomyoma from a retroperitoneal tumor.[5]

Intraoperatively the irregular shape, solid cum cystic appearance and the left lateral extension of the mass caused difficulty in distinguishing from retroperitoneal malignant encroachment of tumour. Intraoperative finding of ascites with the huge tumour mimicked ovarian malignancy. However, the attachment of the tumour to the lateral border of uterus along with bridging vessel sign (vessels bridging the mass and myometrial tissue can provide a clue to the diagnosis of degenerated broad ligament fibroid. Intraop erative high index of suspicion and careful search for the above mentioned signs can salvage ovaries and uterus in younger patients.

CONCLUSION

Huge broad ligament leiomyoma with cystic degeneration may present diagnostic difficulties in differentiating ovarian malignancies even on ultrasound and MRI. This differential diagnosis must be considered prior to surgical management.

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