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INTERESTING CASE: IS A CLINICAL DIAGNOSIS BETTER THAN IMAGING SCIENCES?

KEY WORDS:

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INTRODUCTION

Uterine fibroids are the most common benign tumors of the uterus, with prevalence reported as high as 70–80% in women by the age of 50 years (Stewart et al., 2015). They can present with varied clinical symptoms ranging from heavy menstrual bleeding and infertility to mass effect symptoms such as constipation, urinary frequency, and abdominal distension (Bulun, 2013). While many cases are straightforward, atypical presentations with associated adhesions, infection, or degeneration make diagnosis and management complex. We present here an interesting case of a 40-year-old woman with multiple large fibroids and dense pelvic adhesions, requiring a multidisciplinary surgical approach. While imaging provided useful structural details, clinical examination proved crucial in assessing mobility, tenderness, and relation to surrounding structures, emphasizing that bedside findings remain indispensable. Furthermore, intraoperative assessment often reveals variations from radiological interpretations, underscoring the importance of clinical judgment in guiding management. In this case, given the symptomatic burden, uterine size, and completed parity, definitive surgical management with total abdominal hysterectomy was deemed appropriate. This case highlights the essential role of integrating history, examination, imaging, and intraoperative findings, reinforcing that radiodiagnostic tools are adjuncts rather than replacements for clinical acumen in gynecology.

Case Presentation

A 40-year-old woman, P1L1A1, with a history of LSCS 12 years prior, presented with acute abdominal pain of 2 days' duration, generalized and non-radiating, associated with low-grade fever and constipation for 3 days. She denied nausea, vomiting, diarrhea, urinary complaints, or menstrual irregularities. There was no significant medical history.

On admission, she was conscious, oriented, and vitally stable except for tachycardia (P: 102/min, BP: 130/80 mmHg).

Abdominal examination revealed distension with a generalized tender lump measuring approximately 15×10 cm in the umbilical, right lumbar, and hypochondrial regions. Per-vaginal examination suggested a uterus enlarged to 28–30 weeks size.

Imaging Finding:

- **USG:** Multiple fibroids (FIGO 5–6), the largest 11.7×10.3 cm in the posterior wall, others in anterior wall and endocervical region. Degeneration not mentioned.
- **CT Scan:** Lobulated pelvic soft tissue mass (10×11×12 cm) with necrotic changes, suggestive of uterine fibroid.
- **IVP:** Showed medial deviation of ureters.

The patient was newly diagnosed with hypertension and type 2 diabetes mellitus during admission and was started on amlodipine and oral hypoglycemics with insulin as per sliding scale.

Intraoperative Findings:

On laparotomy, multiple dense adhesions were encountered between the uterus, omentum, bowel, and posterior pelvic wall including transverse colon, sigmoid colon, and terminal ileum. Uterus was enlarged to 28 weeks' size with multiple fibroids including a large cervical fibroid. Fallopian tubes and ovaries were adherent to omentum and bowel loops. Thick pus was noted above the right uterosacral ligament, sent for culture and AFB studies. A total abdominal hysterectomy with left salpingectomy was performed. The right tube, densely adherent to bowel, was divided at uterine end. Surgical colleagues assisted in separating extensive adhesions involving ileum, sigmoid colon, and omentum. Appendix could not be visualized. Gross specimen revealed multiple fibroids without evidence of degeneration.

DISCUSSION:

The presented case highlights the importance of integrating clinical assessment with radiological findings in gynecology. A 40-year-old woman with abdominal pain, constipation, and fever was found to have a markedly enlarged uterus due to multiple fibroids, the largest exceeding 11 cm (Stewart et al., 2017). Fibroids of this size are known to cause pressure symptoms, bowel dysfunction, and acute pain due to degeneration or torsion (Bulun, 2013).

While imaging modalities such as ultrasound, CT, and MRI provide accurate information on the size, number, and location of fibroids (Dueholm, 2017), they should not substitute for thorough clinical examination. In this case, the uterus was clinically assessed as 28–30 weeks in size, palpable up to the umbilicus and lumbar regions with associated tenderness. Clinical examination remains indispensable because it helps identify mass mobility, tenderness, relation to surrounding structures, and associated complications that static imaging cannot always capture (Gupta et al., 2020).

It is equally important to acknowledge that radiological findings can differ from intraoperative findings. Fibroids classified as intramural radiologically may be discovered intraoperatively to have subserosal or pedunculated components (Sowter & Lethaby, 2015). Similarly, adnexal masses seen on imaging can turn out intraoperatively to be pedunculated or parasitic fibroids (Cramer & Patel, 1990). Thus, reliance solely on imaging may mislead management strategies, while intraoperative assessment provides the definitive characterization of pathology (Marret et al., 2012).

For gynecologists, clinical judgment remains the cornerstone of patient care. Overreliance on imaging carries the risk of diagnostic complacency, whereas bedside examination adds essential dynamic information—mobility, consistency, tenderness—that radiology cannot replace (ACOG, 2021). Furthermore, intraoperative findings demand flexibility in surgical planning, reinforcing the clinician's role in synthesizing information from history, examination, radiology, and operative findings (Munro et al., 2011).

In the present case, the symptomatic burden, pressure effects,

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and uterine size favor definitive surgical management. Total abdominal hysterectomy is the most appropriate option given the patient's age, parity, and completed family, providing both symptomatic relief and prevention of recurrence (Baird et al., 2003).

Thus, this case emphasizes that radiodiagnostic modalities are powerful adjuncts, but not replacements, for clinical acumen. The clinician's ability to correlate history, examination, imaging, and intraoperative findings ensures safe, individualized, and effective patient care (Stewart et al., 2017).

CONCLUSION:

This case illustrates a rare presentation of giant multiple fibroids complicated by dense pelvic adhesions, infection, and ureteric displacement. It underlines the importance of thorough preoperative evaluation, interdisciplinary surgical collaboration, and optimization of comorbid conditions in complex gynecological surgeries. The findings also reinforce the variability of fibroid presentations and the necessity for vigilance in atypical cases.

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