Case Report

Unusual presentation of cervical fibroids: Case report of two cases

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Abstract

Leiomyoma of uterus are the most common benign tumours of the female pelvis but cervical fibroids are rare. The incidence of cervical fibroids is around 0.5-1%. Usually cervical fibroids cause infertility, difficulty in labour, infections, metrorrhagia, menorrhagia, constipation; retention of urine and dyspareunia, sometimes the presentation may be unusual. We present two cases of cervical fibroid, first one being a huge cervical fibroid mimicking an ovarian tumour and the second being a prolapsed fibroid polyp. Even though we have modern diagnostic techniques like CT scan and MRI, sometimes diagnosis is only confirmed on laparotomy.

Keywords: cervical fibroids.

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INTRODUCTION

Uterine fibroids are benign smooth muscle tumours of the uterus[1]. Incidence of uterine fibroid is ~ 20% while that of cervical fibroid is 0.5 – 1% of all fibroids[2]. It may arise either from supravaginal part of cervix or vaginal part of cervix. Uterine fibroids are known to assume various locations in relation to the uterus and by which they are often classified. They may be submucous, intramural, subserous, pedunculated, interligamentary or parasitic. Growth of fibroid is oestrogen dependant. After menopause, with regression of ovarian oestrogen secretion, growth of leiomyoma usually ceases. Cervical fibroids may also present as introital polypoidal masses[3]. They can change the shape of the cervix or may lengthen it. If cervical fibroid grows rapidly, it may push the uterus upwards or obstruct the cervical canal .Large cervical fibroids are difficult to handle and need an expert hand to operate these cases[4].

CASE 1

A 40 year patient came to our OPD at Krishna hospital, Karad with complaints of lump in abdomen since 7 months. She had noticed a gradual increase in the size of the lump to its current size. She had no other symptomatic complaints. Her menstrual cycles were regular, with moderate flow. She is married since 17 years, having two living issues and is tubectomized. Patient gave history of 4 units of blood transfusion over the last week. On examination, patient was comfortable in bed. Vitals were within normal range and respiratory and cardiovascular systems were all within normal range. Per abdomen examination revealed a large pelvic mass of approximately 30 weeks size with irregular borders, fixed and firm in consistency. Cervix was not visualized on per speculum examination and per vaginal examination confirmed a 30 weeks pelvic mass.USG report showed a large exophytic myoma measuring 18×13×15 cm in relation to cervix extending from pelvis to epigastrium. 2 to 3 small intramural fibroids were also noted. CT scan suggested a well-defined homogenously enhancing solid lesion in pelvis and lower abdomen, possibly fibroid or ovarian neoplasm. After getting her preoperative evaluation done, patient was posted for exploratory laparotomy under epidural anaesthesia. Intra-operative findings were – cervical fibroid of 30×18 cm size, well encapsulated. Uterus was deviated to left side and was normal in size. Right fallopian tube and broad ligament were oedematous because of pressure effects.

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Considering the age and other parameters, laparotomy was preceded by abdominal Pan-hysterectomy. Histopathology report confirmed leiomyoma of cervix. Patient was discharged in good health after 7 days.

Figure 1: Cervical `fibroid along with uterus and congested tubes

CASE 2

48 year patient was referred to Krishna hospital, Karad with history of something coming out of vagina and p/v bleeding since 6 hours. Patient presented in the OPD with complaints of sudden uterine prolapse and per vaginal bleeding associated with pain in abdomen. She had attained menopause 1 year back. She had two living issues, both vaginal deliveries and was tubectomized. On examination, patient was pale, pulse-100/min, B.P-130/80 mmhg, cardiovascular and respiratory systems were within normal limits. No mass was felt on palpation of abdomen. Local examination revealed a bosselated mass approx. 10×5 cm size coming out of vagina, bleeding present. Above findings were confirmed on per vaginal examination and pedicle was felt inside the os. Uterus was appox. 10 weeks in size. A provisional diagnosis of prolapsed fibroid or chronic inversion was made. Patient's haemoglobin was 8 gm%. Rest haematological and biochemical investigations were within normal range. USG impression was e/o normal size uterus with descent and an exophytic, solid superior fundal wall lesion likely to be fibroid.

Figure 2: Preoperative impression of mass

Patient was transfused two units of packed cells and posted for hysterectomy. Intraoperative findings were-pedunculated fibroid polyp seen coming out of vagina with bosselated surface of size approx. 7×8 cm which removed vaginaly proceeded by abdominal Pan-hysterectomy. Uterus was atrophied as were the ovaries. Rudimentary horn connected to uterus with bosselated surface with multiple small intramural fibroids. Rudimentary horn did not have cavity. Patient was stable postoperatively. Patient had no further complications and was discharged. Histopathology report confirmed diagnosis of cervical fibroid polyp with secondary changes of edema and ischemic changes. Another leiomyoma of uterus also was confirmed.

Figure 3: Intra-operative photo of uterus with cervical fibroid

Figure 4: Post-hysterectomy specimen of uterus with rudimentary horn

DISCUSSION

Leiomyoma are benign smooth muscle tumours of uterus. Although cervical polyps can be seen at any age, they occur most frequently in multiparous women in their fifth decade of life. These are considered to be oestrogen and progesterone dependent. They can distort the uterine cavity. Anterior fibroids may present with urinary symptoms, posterior may present with difficulty passing stools, lateral would extend to broad ligament and central fibroid pushes the uterus upwards[5]. These fibroids push the bladder up, ureters are pushed laterally and uterine vessels are also pushed up and laterally, making these structures more prone to injury during surgery[4]. Cervical polyp can be confused with chronic inversion of uterus, 3rd degree uterovaginal prolapse with ulceration, cervical malignancy, or uterine rhabdomyosarcoma[6]. USG is the

initial investigation done for the diagnosis of fibroid. Both transvaginal and transabdominal USG can be done. Fibroids appear as well-defined, solid masses with a whorled appearance. These are usually of similar echogenicity to the myometrium, but sometimes may be hypoechoic. MRI is the preferred method for accurately characterizing pelvic masses. It has been shown to be more sensitive in identifying uterine fibroids than USG[7]. Submucosal, intramural and subserosal fibroids are usually easily differentiated with MRI and fibroids as small as 5 mm in diameter can be demonstrated. Fibroids in relatively unusual locations, such as within the cervix, can also be identified. Treatment of cervical fibroid is either hysterectomy or myomectomy [8]. They may give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter[4]. Preoperative evaluation helps in deciding the route and procedure of choice. Cervical fibroid inside the cervical canal and with major part towards the body of uterus can be approached abdominally, and the one growing outside the cervical canal can be operated vaginally[8]. Recently uterine artery embolization is done to treat myomas[9].

CONCLUSION

We conclude that cervical fibroids may have unusual presentations; they may grow into the body of the uterus and present as abdominal mass or may present as a pelvic mass or they may grow outside the cervical canal and present as prolapsed pedunculated fibroid. Hospitalization, clinical evaluation, and clear definition of pathology coupled with meticulous surgery by an expert remain the mainstay of successful management especially in cases where modern diagnostic tools are not able give to accurate diagnosis.

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