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Case Report

A case of degenerated cervical fibroid polyp

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ABSTRACT

Cervical fibroids are often solitary. It may be either interstitial, subserous, submucous or polypoidal. Cervical fibroid usually develops in the wall of the cervix, supravaginal portion. They can change the shape of the cervix or lengthen it, grow rapidly and obstruct the cervix. As fibroids enlarge they may outgrow their own blood supply leading to various types of degeneration. Cystic degeneration is observed in 4% is considered an extreme sequelae of oedema. However atypical appearances that follow degenerative changes can cause diagnostic confusion. Hence misdiagnosis of adenomyoma, hematometra, pyometra, uterine sarcoma and ovarian masses is common.

Keywords: Cervical fibroid, Polyp, Myoma

INTRODUCTION

Leiomyoma is the most common gynaecological tumor in women with estimated incidence of 25-30% at reproductive age.[1] Although it is a benign entity that is commonly asymptomatic, its potential to reach a remarkable size can result in bleeding, mass effect, pain, dyspareunia and/or infertility.

Leiomyomas are usually uncomplicated presumed diagnosis, recognized by pelvic imaging modalities with a characteristic whorled appearance on ultrasonography and superior detection with magnetic resonance imaging with sensitivity and specificity both near 90%. However, leiomyomas can demonstrate unique qualities that can distort normal pelvic tissue architecture, mimic clinical features of carcinoma, and challenge the diagnosis.[2]

Pathological evaluation is required for the characteristics of malignant tumor as they are the only reliable way to distinguish between benign and malignant etiology of uterine tumors. Cervical myomas are rare and account for less than 1% of uterine leiomyomas.[3] Bleeding is a typical sign of myoma.

CASE REPORT

A 47-year-old woman para 4, living 4 presented to the emergency room with the complaint of sudden huge irreducible mass protruding out of vagina which is foul smelling. It was associated with heavy menstural bleeding since 3 cycles. Her previous cycles were regular, with an average flow of 4-5 days. Past history was unremarkable. General physical examination- she was pallid, systemic examination and per abdomen examination was unremarkable.

On local examination, a large gummy fragile mass of about 10×10 cm was seen dangling from the vaginal introitus. The surface was irregular, friable and necrotic. It had a rancid odour inferable from enormous epithelial tissue quagmire. The encompassing vaginal walls were hypertrophied and inflamed. However, the mass was felt like emerging from anterior lip of cervix and didn't

transmit cough impulse. On bimanual examination, the normal- size uterus was felt separately from the mass.

On further examination, no cystocele/rectocele/utero-cervical descent were found. Relevant investigations done and haemoglobin was reported to be 2.9 g/dl. Ultrasound examination revealed bulky uterus with echogenic stalk arising from lower part of uterus with endometrial thickness of 6 mm and cystitis. Magnetic resonance imaging (MRI) of pelvis showed a fairly well defined T2 hyperintense prolapsed mass, measuring 11.0×8.0×5.6 cm notes arising from cervix. Anteriorly the lesion is displacing the uterus, posteriorly it is abutting rectum, inferiorly the mass is seen hanging outside vagina with features suggestive of cervical fibroid**.** Thorough work up was done and patient was transfused with 4 units of packed red cells preoperatively. She underwent polypectomy with total abdominal hysterectomy with bilateral salphingo ooperectomy with 1 pint packed red cells transfusion done intraoperatively. Post-operative period was uneventful. Repeat haemoglobin was reported to be 9.7 g%. Histopathological examination was suggestive of benign leiomyoma. Patient was discharged on post-operative day 8.

Figure 1: Degenerated cervical fibroid polyp.

Figure 2: Specimen of uterus.

DISCUSSION

Fibroid is the most common benign solid tumor of the uterus arising from the neoplastic single smooth muscle cell of the myometrium. Cervical fibroids can arise from the supravaginal or vaginal portion of the cervix. Supravaginal cervical fibroids can be of interstitial or subserosal and rarely polypoidal type.

Depending on the position, they may be anterior, posterior, lateral, and central. Interstitial growth can displace the cervix or expand it so much that the external os can be sometimes difficult to recognize. Excessive growth of cervical fibroid can disturb the anatomy of the pelvis and the ureter.[4,5] Anterior fibroid bulges forward and undermines the bladder, leading to urinary frequency or retention.[6,7]

Posterior fibroid flattens the pouch of Douglas and compresses rectum against sacrum causing constipation. Central cervical fibroid expands the cervix equally in all directions, pushing the uterus upwards to give the typical 'Lantern of St. Paul's dome' appearance.[7] Huge cervical fibroid might present as a polypoidal vaginal mass, can even mimic incarcerated procidentia or can masquerade as chronic uterine inversion. It can also cause uterocervical descent as a result of traction. Ultrasound and magnetic resonance imaging (MRI) play an important role in the management of patients with cervical fibroid. MRI is very accurate imaging modality to assess leiomyomas in order to detect their number, size, and location.[8-14]

The relative echogenicity of leiomyomas depends on the ratio of fibrous tissue to smooth muscle, the extent of degeneration and presence of dystrophic calcification.[15,16] Computed tomography (CT) is useful for leiomyomas that are calcified or necrotic. MRI has limitations of cost and availability. Ultrasound being least invasive and most cost effective, becomes the modality of choice. Fibroids are generally iso- or hypoechoic to the myometrium and rarely hyperechoic (due to calcification).

Depending on the patient's characteristics, myomectomy or hysterectomy are used to treat cervical fibroid. These end up being a test to the specialist considering their nearness to the indispensable pelvic structures and probability to cause surgical difficulties.

CONCLUSION

Pre-operative clinical evaluation, radiological imaging, and proper intra-operative delineation of pelvic anatomy can help in their fruitful management. One should be aware of the uncommon presentations of cervical fibroid and ought to think about it in the differential diagnosis of any pelvic mass.

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