International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Jaya Rakini K et al. Int J Reprod Contracept Obstet Gynecol. 2024 Oct;13(10):2952-2954
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20242840

Case Report

Giant cervical fibroid in a perimenopausal women: a rare case report

Jaya Rakini K., Vidhya Ravichandran*

Department of Obstetrics and Gynaecology, Southern Railway Headquarters Hospital, Chennai, Tamil Nadu, India

Received: 03 August 2024
Accepted: 03 September 2024

***Correspondence:**
Dr. Vidhya Ravichandran,
E-mail: vidhya281994@gmail.com

ABSTRACT

Uterine leiomyomas, are smooth muscle neoplasms and the most common benign gynaecological tumour prevailing in 70-80% of women reaching 50 years. Fibroids contribute to 40-60% of hysterectomies performed all over the world. Most of the fibroids are situated in the body of the uterus, but only 1 to 2% of cases, they are confined to cervix. Most of the patients remain asymptomatic but in patients with large fibroids mostly present with pressure symptoms depends upon location of fibroid. Cervical leiomyoma is mostly single and are subserous or interstitial in origin. They arise either from vaginal or supra-vaginal portion of cervix. We report a case of cervical fibroid in perimenopausal parous women with anaemia proceeded with laparotomy after anaemia correction. It showed a huge fibroid arising from the posterior cervix with uterus pushed anteriorly. Enucleation followed by abdominal hysterectomy was done. Large cervical fibroids are rare, presenting with surgical difficulties. Careful dissection by expert hands is needed in the management of such cases. Patient had an uneventful post-operative recovery.

Keywords: Cervical fibroid, Enucleation, Hysterectomy, Peri-menopausal

INTRODUCTION

Leiomyoma is the most common of all uterine and pelvic tumours. The usual anatomical location is the uterus. Cervical leiomyomas are uncommon (1-2%).[1] The incidence of leiomyoma in the reproductive period is 20%. Cervical fibroids are classified depending on their location as anterior, posterior, lateral, and central. They can be further classified as interstitial, subserosa and submucosal polypoid.[2] Cervical fibroid develop in the wall of cervix, usually in its supra-vaginal portion. Mostly cervical fibroid is single.[3] Large cervical fibroids generally present with pressure symptoms like retention of urine or constipation or sometimes as abdominal mass mimicking ovarian mass. Due to their proximity, there is increased risk of bladder and bowel injuries along with risk of intra-operative bleeding. Laparotomy is the most common mode as these are difficult to handle and meticulous surgical dissection is important.[2] Here we conclude that cervical fibroids are a challenge to the gynaecologist due to close proximity to the ureter and bladder. Careful dissection is needed in the management of such cases. With proper pre-operative evaluation and knowledge of anatomical structures is essential to perform myomectomy or hysterectomy for cervical fibroid.[4] Here we are presenting a rare case of huge cervical fibroid which occurred in a peri-menopausal women where total abdominal hysterectomy and bilateral salpingectomy was done to manage this case.

CASE REPORT

A 52 years old parous (P1L2) sterilised female came to gynaecology OPD with heavy menstrual bleeding for 4months, abdominal distension for 2 months, abdominal pain for 10 days, breathlessness for 7 days. Menstrual history-7/20-22 days cycle, changed 7-8 clothes/day, no dysmenorrhea, with passage of clots. Her previous cycles were regular with average flow of 3-4 days. History of loss of weight and appetite present. She had a lower segment caesarean section 16 years back. She had no bladder/bowel disturbances or mass per vagina. There was no post-coital or inter-menstrual bleeding. Her previous medical and

family histories were unremarkable. General and systemic examination was normal expect moderate pallor. On per abdomen examination, a solid irregular mass of 28-30 weeks size gravid uterus, occupies suprapubic, both iliac, both lumbar and umbilical region, firm in consistency, non-tender with restricted mobility noted. Lower margin could not be reached. SPT scar present and healthy. Per speculum examination-cervix could not be visualised. Bleeding noted. Bimanual pelvic examination showed a large solid mass filling the pelvic cavity extending up to the umbilicus, cervix was taken up, uterus could not be felt separate from the mass, fullness noted in the pouch of Douglas and left lateral fornix. On per rectal examination, rectal mucosa was found to be free (Figure 1).

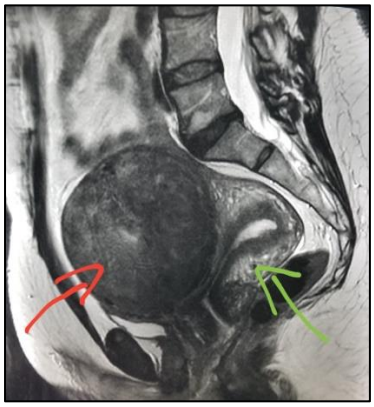

Figure 1: MRI image of cervical fibroid.

Figure 2: Intra-operative pictures of fibroid uterus.

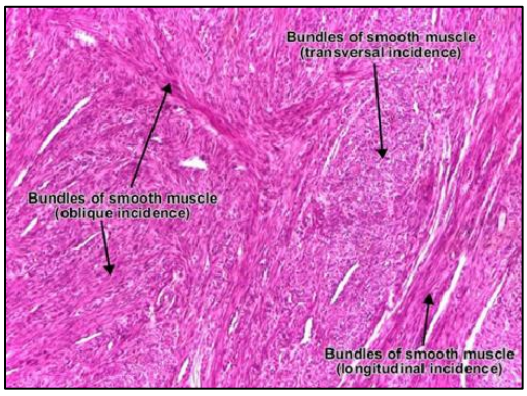

Figure 3: Post-operative histopathology.

Investigations showed moderate anaemia with haemoglobin of 6 gm and peripheral smear shows microcytic hypochromic picture with no abnormal cells. Tumour markers and other blood investigations found to be normal. Ultrasound report showed a bulky uterus measuring 13×8.6×7.6 cm and a solid lesion of 24×20×14 cm in the cervix arising from the posterior wall suggestive of a cervical fibroid. MRI was done which showed large uterine wall myoma involving posterior wall of lower uterine segment with mass effect displacing the bladder and rectum without any invasion. Mild bilateral hydroureteronephrosis was seen. There was no evidence of degeneration, calcifications, or haemorrhage. After stabilization and blood transfusion patient was taken up for surgery. Bilateral Double J stenting done in view of ureteric compression. Decision for exploratory laparotomy was taken (Figure 2).

Under GA surgery proceeded to total abdominal hysterectomy with bilateral salpingectomy. Intra-operatively uterus of size was around 30 weeks (30×30 cm) seen with bosselated appearance with bilateral adnexa clear. The mass was huge and occupying whole of the lower abdomen extending from pelvis to epigastrium. Bilateral ureters traced out. Omental and bowel adhesions were present and the same released. Surgery proceeded to enucleation of fibroid followed by total abdominal hysterectomy. Patient received two units of blood intra-operatively (Figure 3). Her post-operative period was uneventful. Histopathology confirmed the diagnosis of leiomyoma with non-specific cervicitis and proliferative endometrium. Patient discharged in stable condition. At the post-operative visit the patient was clinically well and had no major changes to the objective and gynaecological examination.

DISCUSSION

Uterine leiomyomas are noted to be more than 30-40% in women of 40-60% years of age compared to 4-18% in women of reproductive age group (20 to 40 years).[5] There are very few cases of large cervical fibroid reported in literature. The main component of these tumours is smooth muscle along with varying amounts of fibrous connective tissue. Most of the fibroids usually regress after menopause, there are a few cases that have reported growth of fibroid after menopause.[6] Most of them asymptomatic but few have symptoms like such as heavy menstrual bleeding, dysmenorrhea, pelvic pressure, infertility and early miscarriage.

The development of uterine myomas with menarche and pregnancy and its suppression with menopause validates the oestrogen dependant nature of these tumours.[3] Some studies have demonstrated expression of oestrogen synthetase and aromatase by myoma cells, producing a local oestrogen environment to support its own growth.[5] Understanding these pathophysiology, medical management of uterine leiomyomas have been used extensively by gynaecologists. The initial step of diagnosis

is the imaging of myomas by ultrasonography. The trans-vaginal ultrasound is the technique of choice for the diagnosis because it is the most cost-effective approach with perfect display. Magnetic resonance imaging is preferred for precise myoma mapping. If the fibroid exceeds the pelvis, abdominal ultrasound is required to view the complete mass. As leiomyomas enlarge, they may outgrow their blood supply resulting in various degenerations like hyaline, cystic, myxomatous, calcific and red degeneration. Radiological investigations can be of help, but intra-operative surprises are not uncommon. Studies have shown that round ligament is the guiding factor to go in the anatomical plane in cases of huge fibroids and guides us further surgeries.[7]

In India, one of the commonest causes of hysterectomy in reproductive age group is uterine leiomyoma.[8] Treatment of cervical fibroid is myomectomy or hysterectomy. Myomectomy in such cases is technically difficult as there is increased risk of injury to the ureters because of distorted pelvic anatomy and hence it is always better to trace the course of ureter, retroperitoneal space before removing such huge fibroids or applying clamps while doing hysterectomy.[4] Abdominal hysterectomy is however, the most beneficial surgical procedure for huge uterine fibroids, but when huge pedunculated fibroid or when fertility an issue uterine sparing surgical intervention should be considered.[8] However in this case, elective laparotomy revealed the giant fibroid tumour, considering age and parity of patient we performed total abdominal hysterectomy and bilateral salpingectomy.

CONCLUSION

We conclude that proper pre-operative evaluation and knowledge of altered anatomical structures is essential to perform myomectomy or hysterectomy for cervical fibroid. Treatment of huge cervical fibroid is either by myomectomy or hysterectomy. Myomectomy can be tried in young patients. Pre-operative treatment with GnRH analogues for 3 months can be tried. During surgery, due to proximity of ureters, careful nucleation followed by dissection should be done. During enucleation, limiting dissection to within the capsule is the key to preventing ureteric injury. Here, a case of peri-menopausal huge cervical fibroid managed by total abdominal hysterectomy with bilateral salpingectomy.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Kiran U, Katke RD, Pimple P. Large cervical fibroid. J Case Reports. 2016;6(3):391-3.
2. Sunanda N. Large cervical fibroid: a rare case report. Int J Reprod Contracept Obstet Gynecol. 2019;(8):3414-6.
3. Sharma G, Yadav M, Sharma S, Maheswari M. Cervical Fibroid: A rare case report. Medical Science.2016;5:6.
4. Vidhya R, Pavitthra ND, Cervical Fibroid: A Case Report, J Res Med Dent Sci. 2021;9(9):60-1.
5. Annal A, Sagili H. Symptomatic fibroids in a perimenopausal women with previous two caesarean sections and incisional hernia repair. Can surgery be avoided? Indian J Obstet Gynecol Res. 2021;8(2):282-4.
6. Ananthula S, Gopalan U. Wombstone-massive calcified fibroid: a case report. Int J. Reprod Contracept Obstet Gynecol 2021;10:1701-3.
7. Katke RD, Pushpa C, Asrani S. Giant uterine leiomyoma (5 kg) with bunch of 45 fibroids: a challenging case during covid-19 pandemic. Obstet Gynecol Int J. 2021;12(4):199-201.
8. Singh V, Shinde S, Shinde N. Dilemma in diagnosis of giant uterine fibroid: Case Report. IJMSCR. 2021;4(2):633-6.

Cite this article as: Jaya Rakini K., Ravichandran V Giant cervical fibroid in a perimenopausal women: a rare case report. Int J Reprod Contracept Obstet Gynecol 2024;13:2952-4.