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Case Report

The wandering fibroid: a case report and an approach in reducing its incidence of future cases

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ABSTRACT

Uterine fibroids are one of the most common tumours found in women of reproductive age group. parasitic or wondering fibroid are rare extra uterine benign tumours. Due to its atypical presentations and locations, these tumours cause dilemma to reach to a correct diagnosis pre operatively. Here is a case report where a 44-year-old female presenting with lower abdominal pain with a prior history of laparoscopic myomectomy with a diagnosis of leiomyoma on MRI turned out to be parasitic fibroid intra operatively.

Keywords: Parasitic fibroid, Morcellation, Case Report

INTRODUCTION

Uterine fibroids are the commonest benign tumour of women in the reproductive age group. These are benign tumour originating from the smooth muscles of the uterus are hormone dependent. Under the FIGO classification uterine fibroids are classified on the basis of their location.

Wandering fibroids or parasitic fibroids represent a rare subtype of leiomyomas categorized under type 8 of FIGO classification.[1] The reported incidence of iatrogenic parasitic leiomyomas after laparoscopic morcellation is 0.07-1.25% while the prevalence of spontaneous parasitic leiomyomas has been estimated at 0.21%.[2,3] Typically originating as pedunculated sub serosal fibroids, these lesions detach and subsequently re-attach to non-uterine sites, manifesting with vague symptoms such as abdominal pain, heaviness or palpable migratory lumps.[4] Increased laparoscopic myomectomy procedures particularly involving power morcellations have been associated with the rising incidence of secondary parasitic fibroids.[5]

Parasitic fibroids or leiomyomas are rare extrauterine benign tumours in women of reproductive age. They lack any myometrial connection and receive their nourishment from other abdominopelvic structures to which they are attached.[4] Clinicians often find it difficult to diagnose these fibroids preoperatively due to their atypical presentations and locations.

This case report discusses about the pre operative diagnostic dilemma of an abdominal mass in a reproductive age women who presented with abdominal discomfort. Here the patient also had a previous history of laparoscopic hernia repair. Patient was diagnosed intra operatively and was later confirmed by on histopathology.

CASE REPORT

A 44-year-old women was examined in the OPD for pain abdomen and irregular menstrual cycles with heavy bleeding lasting for 10-12 days associated with passage of clots. She was P1L1 with a married life of 17 years with 1 vaginal delivery non ligated and last child birth of 15 years back with a history of laparoscopic followed by open myomectomy and a history of mesh-plasty for hernia 6 years back. She was a known case of hypertension and had no family history of any malignancy. There was no history

of vaginal discharge or any bowel and bladder complaints.

On examination her vitals were stable. On per abdominal examination it revealed a mobile, non-tender abdomino-pelvic mass of approximately 20-22 weeks gravid uterus size. The mass had a smooth surface, mobile from side to side, non-tender. On per speculum examination the cervix and vagina were healthy. On per vaginal examination it revealed a mass corresponding to 24 weeks size uterus size with bilateral adnexa free and non-tender.

The hemogram, serum electrolytes, urea, creatinine, liver function tests, and urinalysis were all within normal limits.

Abdomino-pelvic ultra sound revealed a 12×8 cm posterior wall fibroid and bilateral ovaries could not be visualized.

MRI of the abdomen and pelvis (Figure 1) revealed multiple well defined mass lesions with internal cystic areas arising from fundus, posterior wall and right lateral wall pedunculated and sub-serosal, largest was intra mural in origin of size 11.5×12×11.8 cm.

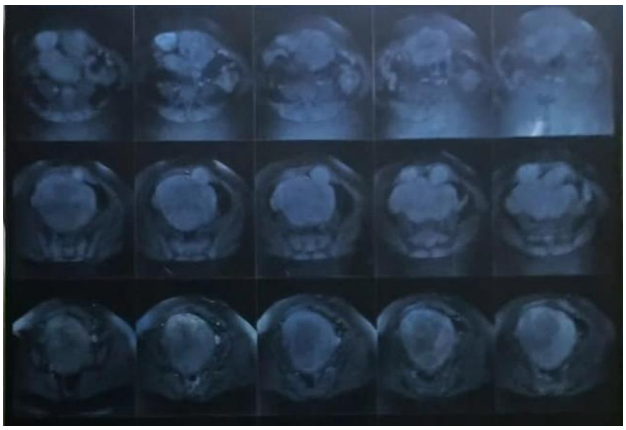


Figure 1: Well define mass lesions, sub serosal fibroid, pedunculated from fundus, right lateral wall of uterus.

Investigations supported a provisional diagnosis of type 3 and 4 fibroid, prompting surgical intervention.

The patient underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy with rectus muscle fibroid enucleation under combined spinal epidural anaesthesia.

Intra operatively while opening the abdomen in layers it revealed 4 extra peritoneal fibroids completely detached from uterus measuring 5×4 cm, 3×2 cm, 4×3 cm in the rectus muscle (Figure 3). Fibroid enucleation was done. The Uterus was approximately 22-24 weeks (Figure 4). Adhered to the momentum, with bilateral unhealthy ovaries. Total abdominal hysterectomy with bilateral salpingo-oopherectomy with fibroid from rectus muscle enucleation was done (Figure 2). The histopathology showed spindle shaped cells with no pleomorphism and confirmed the diagnosis of leiomyoma. The patient stood the procedure well.



Figure 2: Extra peritoneal fibroids in recuts sheath detached from uterus.



Figure 3: Dissection done to separate the fibroids.

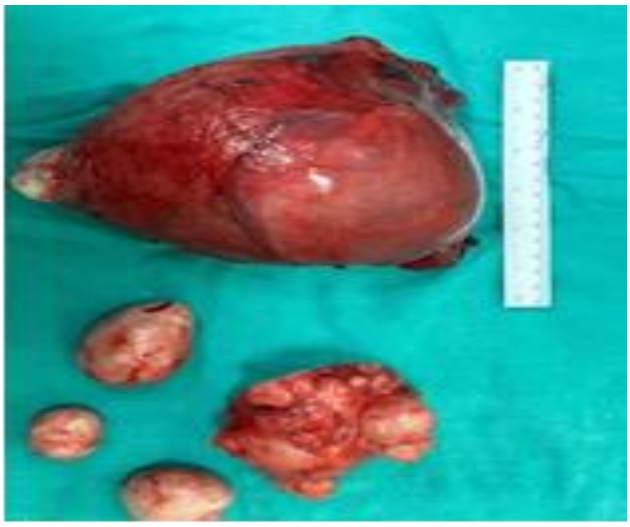


Figure 4: Uterus of around 24 weeks with 4 extraperitoneal fibroids.

The patient had an uneventful postoperative course.

Her post operative recovery was un-eventful with appropriate transfusion and patient was discharged on post operative day 10.

DISCUSSION

This case report of parasitic leiomyomas are an unusual variant of uterine fibroids that have detached from the uterus and re implanted onto extra uterine sites, where they derive their blood supply from adjacent tissues.[4] Classified as type 8 in the FIGO system these fibroids are classified as primary spontaneously or secondary parasitic leiomyomas-most commonly following surgical interventions such as laparoscopic myomectomy involving morcellation.[2]

The rise in minimally invasive gynaecological procedures particularly those using power morcellators has led to increased reports of iatrogenic parasitic fibroids.[5] Fragments of leiomyoma tissue inadvertently left behind during morcellation can implant on peritoneal surfaces and grow independently.[6] Although morcellation offers significant benefits like reduced postoperative pain and quicker recovery, it carries risk of tissue dissemination and even malignant spread in rare cases.[7]

The common sites for these fibroids are the pelvic cavity, small intestines, rectum, cecum, vaginal/cervical stump, and laparoscopic port site

Clinically, parasitic fibroids often present with vague, nonspecific symptoms such as abdominal discomfort, bloating and heavy menstrual bleeding making early diagnosis difficult.[4] In this case the patient's history of a previous myomectomy and subsequent hernia repair possibly contributed to altered anatomy and fibroid migration. The identification of multiple fibroids within the rectus muscle, detached from the uterus strongly supports the diagnosis of parasitic fibroids.

Theories of de novo development of fibroids have also been described in some rare variants of extra uterine firboids such as in leiomyomatosis peritonealis disseminata and benign metastasizing leiomyomatosis.

LPD is a benign condition characterized by the development of multiple fibroid nodules on peritoneal surfaces. There are multiple theories behind pathogenesis of LPD. One of them is estrogen induced metaplasia and differentiation of sub peritoneal mesenchymal stem cells to smooth muscle cells.

Similarly in case of metastasis in leiomyomata's embolization of fibroid tissue from the uterus is implicated as one of the etiopathogenesis.

Imaging modalities such as ultra sound and MRI are valuable in assessing the origin, vascular supply and extent of these masses, although definitive diagnosis often requires intra operative visualization and histo-pathology.[8]

Morcellation should be avoided in the cases where malignancy is suspected. Surgical excision remains the main stay of treatment and careful intra operative inspection for additional fibroid implants is critical.[5]

CONCLUSION

Parasitic fibroids though rare, but should be considered as an important differential diagnosis of extra uterine or abdominal pelvic masses. This case underscores the importance of maintaining a high index of suspicion for parasitic fibroids, particularly in patients with a history of uterine surgery such as laparoscopic myomectomy or morcellations. A thorough inspection along with abundant and repeated washings and aspiration in the abdomino-pelvic cavity at the end of surgery is important to remove all the fragments. This case also emphasizes the importance of cautious surgical techniques, such as avoiding uncontained morcellation and the need for thorough post operative follow up in patients undergoing fibroid removal.

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REFERENCES

1. Bajaj S, Gopal N, Clingan MJ, Bhatt S. A Pictorial Review of Ultrasonography of the Figo Classification For Uterine Leiomyomas. Abdom Radiol (Ny). 2022;47(1):341-51.
2. Van Der Meulen JF, Pijnenborg JM, Boomsma CM, Verberg MF, Geomini PM, Bongers My. Parasitic Myoma After Laparoscopic Morcellation: A Systematic Review of the Literature. BJOG. 2016;123(1):69-75.
3. Lete I, González J, Ugarte L, Barbadillo N, Lapuente O, Álvarez-Sala J. Parasitic Leiomyomas: A Systematic Review. Eur J Obstet Gynecol Reprod Biol. 2016;203:250-9.
4. Fasih N, Prasad Shanbhogue AK, Macdonald DB, Fraser-Hill MA, Papadatos D, Kielar AZ, et al. Leiomyomas Beyond the Uterus: Unusual Locations, Rare Manifestations. Radiographics. 2008;28(7):1931-48.
5. Nezhat C, Kho K. Iatrogenic Myomas: New Class of Myomas? J Minim Invasive Gynecol. 2010;17(5):544-50.
6. Erenel H, Temizkan O, Mathyk Ba, Karataş S. Parasitic Myoma After Laparoscopic Surgery: A Mini-Review. J Turk Ger Gynecol Assoc. 2015;16(3):181-6.
7. FDA Safety Communication. Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Recommends. 2014.

8. Khan A, Shawl A, Leung Ps. Parasitic Leiomyoma of the Greater Omentum Presenting as Small Bowel Obstruction. J Surg Case Rep. 2018;2018(7):Rjy164.
9. Salih AM, Kakamad FH, Dahat AH, Habibullah IJ, Rauf MG, Najar KA. Parasitic Leiomyoma: A Case Report with Literature Review. Int J Surg Case Rep. 2017;41:33-5.

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