International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Ozori ES et al. Int J Reprod Contracept Obstet Gynecol. 2026 Jan;15(1):367-369
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20254316

Case Report

A rare occurrence of multiple vaginal fibroids: a case report from Yenagoa, Bayelsa, Nigeria

Ebiogbo S. Ozori*, Nuvie Oyeyemi, Lukman Obagah, Ariwelo S. Warisuo, Oghenetega Onojoserio, Miracle C. Amadi-Oyioma, Oghenetega J. Agbagoro

Department of Obstetrics and Gynaecology, Federal Medical Centre, Yenagoa, Bayelsa, Nigeria

Received: 28 October 2025
Revised: 02 December 2025
Accepted: 04 December 2025

***Correspondence:**
Dr. Ebiogbo S. Ozori,
E-mail: ozoriniseod@yahoo.com

ABSTRACT

Vaginal leiomyomata are an unheard-of diagnosis in many climes. When a case is seen, especially if there are multiple vaginal fibroids, it becomes a reportable event. This case highlights the possibility of finding multiple leiomyoma at a very unusual site in the genital tract and its treatment. A 36-year-old patient with asymptomatic, multiple, lateral and posterior vaginal walls nodules, presented on self-referral to the gynaecology clinic for evaluation, diagnosis and treatment. Preoperative assessment was done with physical examination and investigations. Following surgical excision of the vaginal nodules, histological assessment revealed a differentiation of the mesenchyme of the tissues toward leiomyoma. Vaginal fibroid is a rarity. Multiple vaginal fibroids is a distant rarity. Thus, a high index of suspicion is necessary when examining women presenting with nodule(s) in the vagina. Such swellings or nodules should be subjected to histological assessment to clinch the diagnosis of vaginal leiomyomata.

Keywords: Vagina, Fibroid locations, Vaginal leiomyomata

INTRODUCTION

Fibroids are non-cancerous tumour commonly seen in the uterus.[1] It can be found occasionally on the cervix, broad ligament, round ligament, uterosacral ligament, and ovaries.[2] It is rarely seen in the vagina.[2] To the best of our knowledge this is the first recorded case in Southern Nigeria. The incidence is a few hundreds of cases in the world.[2] In Africa there is very scanty documentation of this condition. This may be due to failure to report, under-reporting, poor health seeking behaviour or shame on the part of the patient.[3]

It is found in women aged 35- 50 years.[4,5] Patient do not have usually have symptoms. For symptomatic patient, the symptom is related to the location of the fibroid. The condition has a propensity to occur on the anterior vaginal wall.[2-5]

It exhibits mimicry with many benign vaginal conditions. Hence, spot diagnosis can be difficult. Preoperative investigations to make a diagnosis is difficult, especially for small sized vaginal fibroids.[6] Thus, histopathological examination is key to diagnosis. Surgical excision is curative in all cases recorded.

CASE REPORT

Patient's history

Mrs. OTI, was a 36 year old para 2^{+2} who presented with multiple vaginal swellings of 14 months duration. Vaginal swelling was of insidious onset, gradually increasing in size especially at her last confinement. It was not painful but was firm in consistency. It was noticed during douching. No other swelling in any other parts. There was bleeding per vaginam, abnormal vaginal discharge, urinary

symptoms or coital difficulties. There was no family or personal history of gynaecological cancers. She has a family history of uterine fibroids. Mrs. OTI had two complete miscarriages in 2019 and 2020, both followed eight weeks history of amenorrhoea. She did a Papanicolaou smear in 2020 which was normal. She had a spontaneous vaginal delivery in 2018. She had a caesarean section, twenty-two months ago prior to presentation, where endometriotic deposits noticed in intraperitoneal cavity and on the pelvic organs. She does not take tobacco products or alcoholic beverages.

Clinical examination

General and systemic examinations were essentially normal. Vaginal examination revealed two clumped together, pale, non-tender, rubbery nodules at the middle third of the left lateral vaginal wall. They measured 0.5 cm × 1 cm, and 1 cm × 1 cm, respectively. There was also a solitary non-tender, firm, 1 cm × 1 cm nodule at the distal one third of the posterior vaginal wall.

Management

Mrs. OTI preoperative investigations (full blood count, electrolyte urea and creatinine assay, and urinalysis) were normal. She was counselled on the need for surgical excision of the masses and its subsequent histological analysis. She was admitted on the day of surgery as a day case. Surgical excision was done under saddle block, routine cleaning and draping was done. The bladder was emptied with a metal catheter. Specula were introduced into the vagina to expose the vaginal masses. The excision procedure entailed clamping the vaginal nodules with artery forceps, and making an incision at the base of each nodule; followed by enucleation of the masses. The vaginal walls were repaired with continuous vicryl 2/0 sutures. The vagina was packed with povidone iodine-soaked gauze, which was removed after 12-hours. Figure 1 shows the fibroid nodules enucleated from the vagina.

Her postoperative recovery was satisfactory. She was discharged home in the evening of the day of surgery, on broad spectrum antibiotics and analgesics. She was a two-week gynaecological clinic appointment. At the gynaecology clinic visit, she had no complaints. She presented with her histopathological report.

RESULTS

Histopathological findings

Three vaginal nodules were received on 11th March 2024. Date reported was on 10th April 2024. Gross findings demonstrated specimens consisting of fragments of greyish white tissue each measuring 0.7 cm × 0.7 cm × 0.5 cm. Microscopic findings showed a benign mesenchymal lesion with differentiation towards leiomyoma. There was no atypia seen. A histologic diagnosis of vaginal leiomyoma. Figure 2 demonstrates the microscopic view of a section of the vaginal nodule.

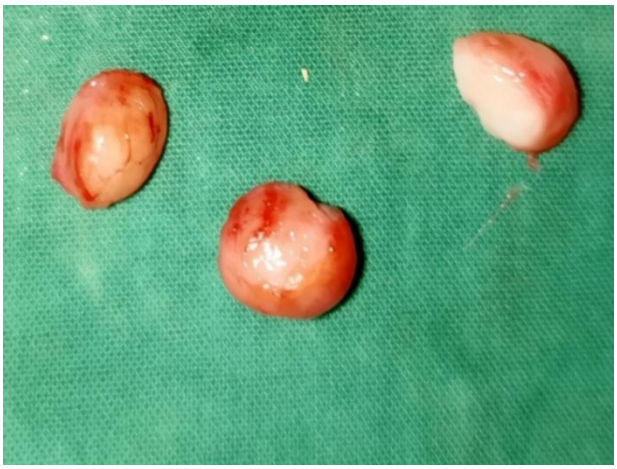

Figure 1: The fibroid nodules enucleated from the vagina.

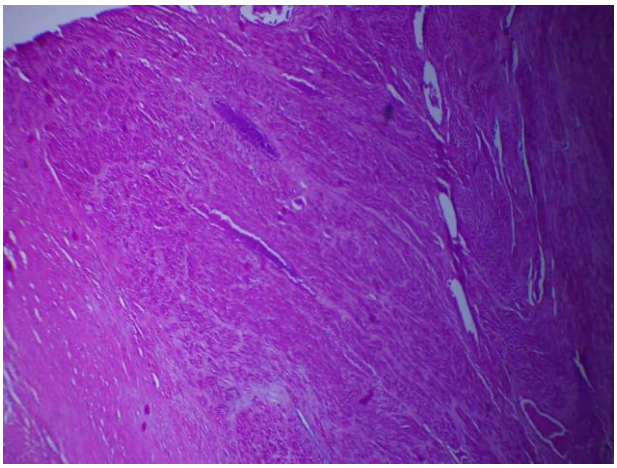

Figure 2: The microscopic view of a section of the vaginal nodule.

DISCUSSION

Leiomyomata of the vagina is rare. There is a preponderance for white women than blacks.[5] This is surprising as uterine fibroids is usually seen in black women than Caucasians.[1] Vaginal leiomyoma is commonly located on the anterior vaginal wall (69%), posterior vaginal wall (17%) and lateral vaginal wall (13%).[5-7] Vaginal fibroids are usually solitary.[5] Multiple vaginal fibroids are a rarity. Mrs. OTI had fibroid nodules at the lateral and posterior vaginal walls.

Vaginal leiomyoma grows slowly and are usually small (3-4 cm).[5] They may grow to gigantic sizes in long standing cases.[8] This condition has been diagnosed in pregnancy.[8] These fibroids are hormone sensitive and their growth is influenced my oestrogen and progesterone.[3-8] Mrs. OTI noticed that the fibroid nodules became more prominent in size during her second pregnancy.

Malignant change of this fibroid is a rarity.[9-11] It is usually associated with posterior wall vaginal fibroids.[5] Although Mrs. OTI had a solitary posterior vaginal fibroid nodule, its histologic analysis did not show any malignant change.

Patients with this condition are usually symptomatic. The mass is usually an incidental finding by individuals who douche, as was the case with Mrs. OTI, or on vaginal examination by a clinician. Symptoms can develop, depending on the site and size of the vaginal fibroid. The symptoms are vaginal fullness, dyspareunia, abnormal vaginal discharge, spotting bleeding per vaginam, dysuria, urinary retention, discomfort, and anxiety.[12]

If the fibroid is on the anterior vaginal wall fibroid, a close differential would be a cystocele urethral diverticulum and sub-urethral nodule/ cyst.[5,12] If the lesion is located on the lateral wall it may imitate a cyst of the duct of Gartner.[12] Other differential diagnosis are genital wart, vaginal cyst, vaginal cancer and vaginal endometrioma.[12]

Vaginal endometrioma was suspected in Mrs. OTI's case because she has a history of chronic lower back pains and an incidental finding of widespread endometriotic deposits in the peritoneal cavity noticed at a prior caesarean delivery. Vaginal fibroid has been found to also mimic pelvic organ prolapses prolapsed cervical fibroids and Bartholin's gland.[10-14]

Diagnosis is usually from histology as the condition is hardly ever diagnosed before surgery as was in this index case. Treatment is usually by resection or surgical excision under a saddle block.[10] There is a risk of reoccurrence especially if the resection/excision was incomplete.[2-6] Sexual intimacy may be suspended after surgical excision as was noted in this patient.[3]

CONCLUSION

Vaginal fibroid is a rarity. Multiple vaginal fibroids is a distant rarity. Thus, a high index of suspicion is necessary when examining women presenting with nodule(s) in the vagina. Such swellings or nodules should be subjected to histological assessment to clinch the diagnosis of vaginal leiomyomata.

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

REFERENCES

1. Awoyesuku PA, Mac-Pepple DA, Altraide BO, John DH. Review of gynaecology diagnoses and surgeries performed at a tertiary health facility in Niger-Delta of Nigeria from 2012 – 2017: Implication for healthcare planning and budgeting. JAMMR. 2020;32(2):1-10.
2. Rahul RP, Nikita RV, Sulbha J. An Usual Presentation of Vaginal Leiomyoma. J Midlife Health. 2019;10(4):204-20.
3. Egbe TO, Kobenge FM, Metogo JAM, Manka'a Wankie E, Tolefac PN, Belley-Priso E. Vaginal Leiomyoma: Medical imaging and diagnosis in a resource low tertiary hospital: BMC Women's Health. 2020;20(1):12.
4. Chakrabarti I, De A, Pati S. Vaginal leiomyoma. J Midlife Health. 2011;2(1):42-3.
5. Benjelloun AT, Ziad I, Elkaroini D, Boufettal H, Mahdaouni S, Samouh N. Vaginal leiomyoma mimicking a cystocele (report case). Int J Surg Case Rep. 2022;93:106955.
6. Bae JH, Choi SK, Kim JW. Vaginal leiomyoma: a case report and review of literature. J Wom Med. 2008;1(2):92-4.
7. Braga A, Soave I, Caccia G, Regusci L, Ruggeri G, Pitaku I, et al. What is this vaginal bulge? An atypical case of vagibnal paraurethral leiomyoma. A case report and literature systematic review. J Gynecol Obstet Hum Reprod. 2021;50(6):101822.
8. Lugata J, Makower L, Ashley R, Ibrahim S, Tecla L, Raziya G, et al. Unusual presentation of recurrent vaginal leiomyoma in pregnancy. A rare case report and review of current literature. Clin Case Rep. 2025;13(4):e70344.
9. Cobanoglu O, Gurkan Zorlu C, Ergun Y, Kutlay L. Leiomyosarcoma of the vagina. Eur J Obstet Gynecol Report Biol. 1996;70(2):205–7.
10. Leron E, Stanton SL. Vaginal leiomyoma an imitator of prolapse. Int Urogynaecol J. 2000;11(3):196-8.
11. Sim CH, Lee JH, Kwak JS, Song SH. Necrotizing ruptured vaginal leiomyoma mimicking a malignant neoplasm. Obstet Gynecol Sci. 2014;57(6):560-3.
12. Gao Y, Qin Y, Li J, Qian J, Yao J. Vaginal leiomyoma: a case report. Exp Ther Med. 2022;24(5):661.
13. Abrar S, Mohsin R. Vaginal leiomyoma presenting as pelvic organ prolapse in pregnancy. JCPSP. 2022;32(12):SS143-5.
14. Tarrab A, Sabbagh AI, Adwan D. Vaginal leiomyoma misdiagnosed as Bartholin's Abscess. A case report from Damascus, Syria. SAGE Open Med. Case Rep. 2022;10:2050313x221124072.

Cite this article as: Ozori ES, Oyeyemi N, Obagah L, Warisuo AS, Onojoserio O, Amadi-Oyioma MC, et al. A rare occurrence of multiple vaginal fibroids: a case report from Yenagoa, Bayelsa, Nigeria. Int J Reprod Contracept Obstet Gynecol 2026;15:367-9.