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Case Report

Large pelvic mass - careful planning - can decrease the morbidity

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ABSTRACT

We report a case of a 43-year old woman with a 24-26 weeks size pelvic mass, inspite of CT contrast pelvis the exact location of mass remained unclear. At laparotomy, it was found to be a broad ligament multilobulated leiomyoma measuring 20-24cm and weighing, approximately 1400gms. We are reporting this to emphasize the importance of planning a case and involving different team members in case of large mass with an anticipation of complications and also a pathologist a day prior about the need for frozen section.

Keywords: Broad ligament fibroid, Leiomyoma, Ureteric damage

INTRODUCTION

Leiomyoma is the most common pelvic tumor of the uterus. The broad ligament is the commonest extra uterine site for the occurrence of leiomyoma.¹ Extra uterine leiomyomas may develop in the broad ligament or at other sites where smooth muscle exists.^{1,2}

Common symptoms of leiomyomas include menstrual disturbances, dysmenorrhea, and symptoms related to pressure caused by the mass.³ Incidence of broad ligament fibroid is less than 1%.⁴

The broad ligaments are fusion of both müllerian ducts. This fusion brings together 2 peritoneal folds that become the broad ligament on each side of the fused müllerian ducts. Tumor can arise from any tissue that contains smooth muscle cells, but most commonly from the uterus. Broad ligament leiomyoma can originate from the uterus and invade the broad ligament or it can originate from the broad ligament itself. Broad ligament pathologies are rare, benign tumors and usually asymptomatic.

CASE REPORT

43 years old para 3 living 3, presented with complaints of feeling weak and body pains with loss of appetite since few days and a sense of fullness in the abdomen. No complaints of pain in abdomen, postcoital bleeding nor intermenstrual bleeding. No history of any bladder or bowel problems. Her menstrual cycles were usually regular. Noticed heavy periods 6 months ago but settled so didn't report to a doctor. This time with 2nd episode of heavy periods was evaluated thoroughly and hemoglobin was 4.4gms% with normal platelets.

Iron deficiency anaemia as a possibility due to heavy menstrual bleed was the working diagnosis, 2 units were transfused, later was referred to tertiary center for further management. She had all normal vaginal deliveries last child birth was 21yrs ago and was tubectomised for contraception.

Her medical, surgical and family history was not significant. Her general and systemic examination were normal. Abdominal examination revealed nontender mass

of 26 weeks size arising from the pelvis felt irregular on examination with more mass on the left side.

On speculum examination, the cervix was positioned high up, but looked normal. Fullness felt in the vagina more over the left part. Otherwise vulva vagina appeared normal. Abdominopelvic ultrasonography showed a large heterogeneous lesion, suggestive of a leiomyoma, endometrium seen separately normal looking and advised MRI pelvis for reevaluation.

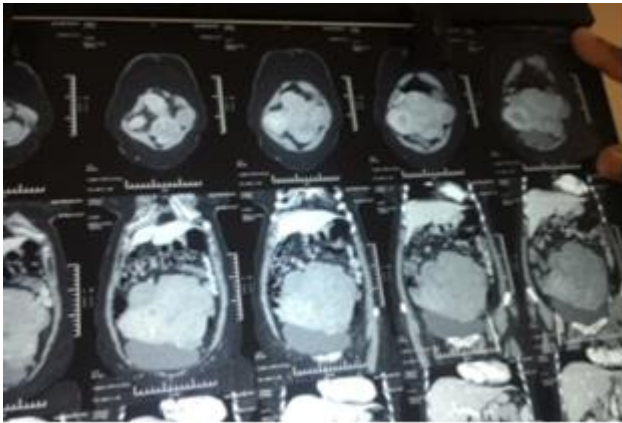


Figure 1: CT contrast.

Patient refused MRI for the fear of closed spaces and sounds, So Contrast Computed Tomography pelvis and KUB (Figure 1, Figure 2) showed the presence of multiple leiomyomas but couldn't comment origin, though endometrium lining looked normal. Lateral displacement of the left ureter and hydronephrosis and normal functioning kidneys. Incidental findings of Haemangioma was noticed accordingly a hepatobiliary expert had reviewed and advice follow up later.



Figure 2: CT contrast pelvis and KUB

Her hemogram showed hemoglobin to be 9.5 g/dl. Her urinalysis, Blood sugars, renal and liver function tests, chest radiograph and electrocardiogram showed no abnormality. CA 125 was normal. (as ovarian pathology should be in the background as well).

The patient opted for total abdominal hysterectomy with removal of ovaries because of fear of cancer and couldn't console enough to preserve ovaries. One unit of packed red cells was transfused. Patient was posted for surgery under combined epidural and spinal anaesthesia with all aseptic precautions and cefazolin as prophylaxis. Urologist had inserted bilateral ureteric stents under image guidance. Pfannestial incision given abdomen was stretched out due to the mass, on palpation a multilobulated mass measuring approximately 24cm extended laterally above the umbilicus though posteriorly it was free. The uterus was normal in size, elevated and felt displaced to the right side. The right tube and ovary were normal. So, felt it was probably a broad ligament fibroid (Figure 4) and few fibroids were removed without exteriorizing the specimen as it was difficult to exteriorize, left ovary and left in fundibulopelvic ligament were stretched over its upper surface.



Figure 3: Clear view of uterus separately.



Figure 4: Broad ligament fibroid.

The peritoneum was separated on the top of the myoma and using myoma screw through sharp and blunt dissection keeping traction on the myoma screw the myoma was lifted above the pelvis gradually and myoma resected after clamping the round ligament on either side and Infundibular ligament as well as the uterines were ligated and ureter was traced. Frozen histopathological examination of the resected specimen revealed a

leiomyoma with cystic changes. At the end, the urologist called in to trace the ureter to be doubly sure. The surgically resected mass weighed 1.4 kg. (Figure 3). The patient made an uneventful recovery. Followed up after 2 weeks for stent removal was on tablet ofloxacin 200mg daily once for 2 weeks.

DISCUSSION

Any large pelvic mass the aim should be to give less morbidity, less injury or no morbidity at all. With Such pelvic mass, the greatest fear is of bleeding and ureteric damage. So, steps should be to take to inform anaesthetist, blood bank, Pathologist, Oncologist (to be aware if it turns out to be cancerous) and urologist. If urologist they see imaging films a day prior and plan for stents that would really reassure the surgeon, as ureter remains a nightmare for gynaecologist.

Good Preoperative assessment of the possible location of the mass with contrast enhance computed tomography or MRI may be useful for this purpose.

Final Histology confirmed a large rent in the left side of uterus and a broad ligament leiomyoma and left tubal endometriosis, right tube and both ovaries being normal.

Magnetic resonance imaging (MRI), with its capabilities, may be more useful for differentiating broad ligament fibroids from masses of ovarian or tubal origin and from broad ligament but patient didn't wanted MRI for fear of closed spaces.^{5,6}

CONCLUSION

With any large pelvic mass, a complete biochemistry, high end imaging and multidisciplinary involvement

should be a must. So, think the worst and get the best might be the best rule of thumb for any challenging cases along with written informed consent.

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