

CASE REPORT

INTERESTING CASES OF DIFFERENT TYPES OF CERVICAL FIBROIDS

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ABSTRACT: The incidence of cervical fibroids is 0.5-1%. It is usually single; they are usually confined to supravaginal portion of the cervix. Rarely it becomes submucous and polypoidal. So it is usually subserous or interstitial. It can be anterior, posterior or central in position. We had different types of cervical fibroids of which we will describe a few. Usually cervical fibroids cause infertility, difficulty in labor, infections, metrorrhagia, menorrhagia, constipation, retention of urine and dyspareunia. The cervical fibroid distorts the shape of cervix and grows bigger. It pushes the uterus upward giving the appearance of lantern of Saint Paul's dome in a case of a central cervical fibroid. Most of the patients in the reproductive age get admitted for menorrhagia due to fibroid. Its growth is dependent on estrogen. It does not grow after menopause.

KEYWORDS: Cervical fibroid, fibroid polyp, hysterectomy.

CASE 1: A 52 year old housewife, completed the family, who had previous two LSCS section and sterilization done 20 years ago, got admitted with retention of urine for the past 12 hours. She gave history of burning micturition and frequent retention of urine for which catheterization was done a number of times outside.

She had lower abdominal pain and post coital bleeding. She had irregular menstrual history. Foley's catheter was introduced. Bimanual examination showed cervix was replaced by huge mass 8×11 cm occupying the whole cervix and vagina. This was a central cervical fibroid wherein the uterus was found sitting on top of it.

The uterus was palpable per abdomen as a soft globular mass 2×3 cm suggestive of a fundal fibroid. Patient was anemic and 2 units of blood transfusion were given. Routine investigations were normal. Ultrasound(USG) report showed a small fundal fibroid 2×2 cm and a huge central cervical fibroid of size 8.3×11.3 cm (figure 1). Patient was explained and consent for laparotomy was obtained.

Laparotomy showed plenty of adhesions due to previous surgeries which were released. The bladder was found plastered with the mass. So a transverse incision was made at the level of the UV fold to push the bladder up. Uterine vessels supplying the fibroid were engorged and tortuous were carefully cut and ligated (figure 2).

The uterus along with the central cervical fibroid shelled out without injuring the bladder, ureter and rectum. Pre-operative ureteric stenting could have helped in the surgery of shelling the cervical fibroid. Vault and abdomen closed after perfect hemostasis. The cut section of the specimen showed the uterus sitting on top of the cervical fibroid and had a small fundal fibroid of size 3×3cm.

The specimen was sent for histopathology, because of the increased cellularity and mitosis, leiomyosarcoma was thought of initially by the pathologist. Later on, they confirmed it as a feature of highly cellular leiomyoma with hyaline and cystic degeneration (figure 2) Post-operative period was uneventful. Patient passed urine freely. She came for follow up. She had no complaints.

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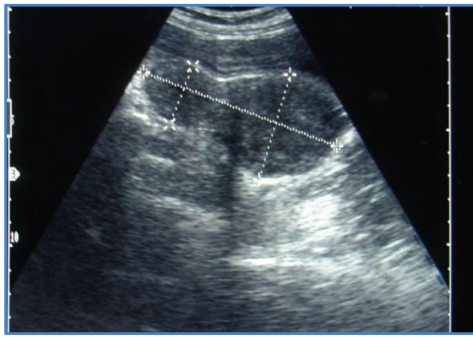


Figure 1: USG



Figure 2

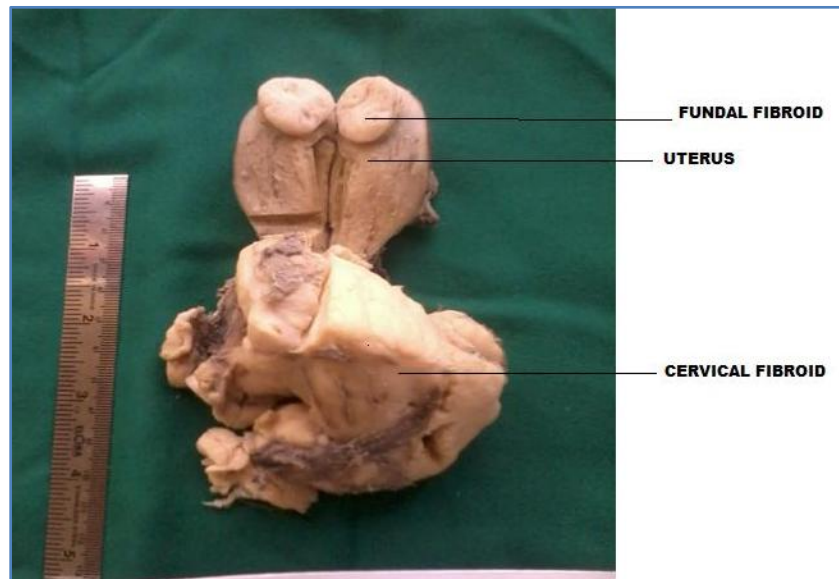


Figure 3

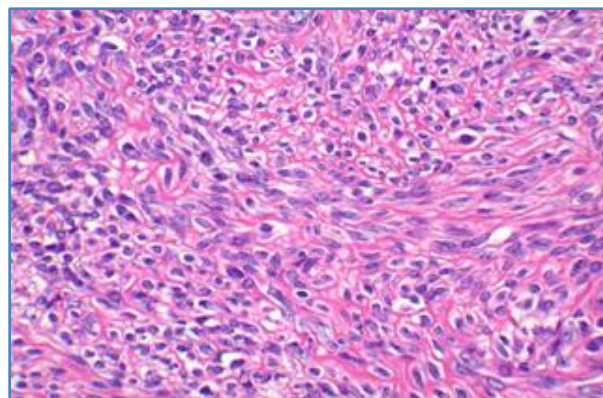


Figure 4: leiomyoma with hyaline degeneration

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CASE2: A 45 year old lady came with profuse, irregular intermenstrual and postcoital bleeding for the past 2 years. On examination she was anemic. Per abdomen uterus was not palpable. She had a scar due to sterilization done 20 years ago. Vaginal examination could not be done as there was a huge mass occupying the whole vagina.

We could not feel the cervix. Routine investigations were done, everything was normal but hemoglobin was 5.1gm%. Ultrasound showed large hypoechoic myoma of size 8.5×7.8cms in the cervical region occupying the whole vagina as a cervical fibroid. Urine culture showed pseudomonas growth and was treated with amikacin. Patient was given 3 units of blood.

Patient was taken up for laparotomy by pfannensteil incision. As usual after clamping, cutting and ligating the uterine arteries, the uterus was bisected (figure 5) upto the supravaginal portion of the cervix, after securing perfect hemostasis by ligating the vessels supplying the mass, the fibroid polyp was removed en mass. The cut section showed a typical fibroid (figure 6). The uterus also had multiple fibroids. She had a catheter for the bladder. Post-operative period was uneventful and she was discharged. She could pass urine freely. Histopathology revealed a leiomyoma (figure 7).

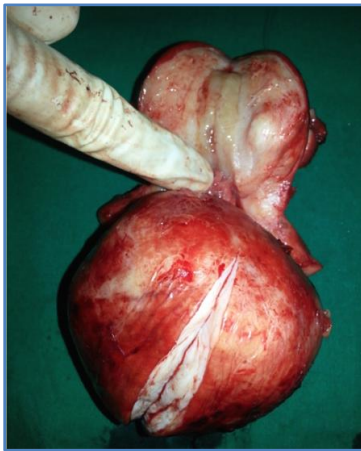


Figure 5



Figure 6

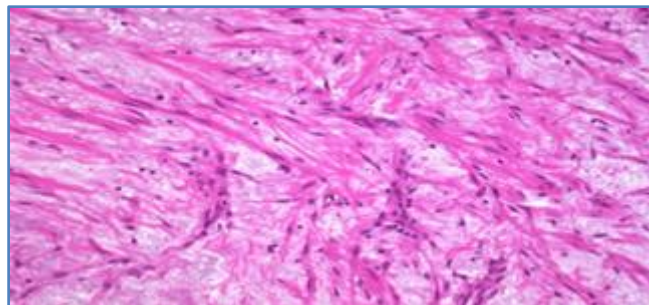


Figure 7

CASE 3: A 35 year old lady P2L2A2 had pain and swelling in the lower abdomen. Her menstrual cycles were regular. Per abdomen a mass of 16 weeks size was palpable. The cervix was pushed up and hitched onto the pubic symphysis. The mobility of the uterus was restricted. The movement of

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the cervix was transmitted to the mass. All fornices fullness was present because of the mass. All investigations were normal. Ultrasound showed a normal size uterus and a posterior cervical fibroid size 13×11 cm. IVP showed hydroureter and hydronephrosis on the left side (Figure 8).

Bilateral DJ stenting (BDJS) was done prior to surgery. A small uterus was found and the cervical fibroid of size 13×13 cm was found arising from the posterior side (Figure 9).

In this case laparotomy was done, as usual after clamping, ligating the uterine vessels, posteriorly a vertical incision was made to enucleate the cervical fibroid, without injury to the ureter thanks to BDJS. Cut section showed the cervical fibroid was arising from the posterior side (figure 10). The specimen was sent for histopathology, confirmed cervical leiomyoma.



Figure 8



Figure 9

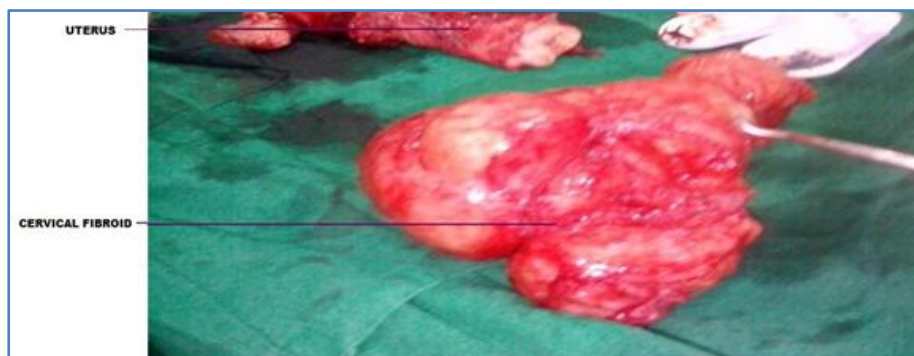


Figure 10

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DISCUSSION: Leiomyomas are the commonest benign swellings. The cervical fibroids incidence is 0.5-1%. Sometimes present as a cervical myomatous polyp also. These develop from the wall of the cervix.¹ Large fibroids are difficult to operate because of the close proximity to the vital organs like ureter, bladder needs experienced surgeons.² The treatment of cervical fibroid is hysterectomy or myomectomy. Myomectomy can be performed through abdominal route, if there is a good pedicle present, can be performed vaginally. Sometimes, a huge cervical fibroid may enlarge to occupy the abdomen and present as a mass.³

In younger patients if the cervical myoma has got a pedicle, can be removed easily by blunt dissection performed by vaginal route with low morbidity.⁴ Nowadays laparoscopic myomectomy and hysterectomy are performed.⁵ A vaginal myoma can be mistaken for a cervical myoma.⁶ Sometimes a cervical fibroid can mimic chronic inversion.⁷ Acute retention of urine is one of the complications in a cervical fibroid, which is managed with cystoscopy and transurethral endoscopic resection.⁸ Just as in the case of fibroid uterus the histopathology shows myxoid degeneration, the same thing can be noted in the cervical leiomyoma.⁹

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