

Large Cervical Fibroid – Endangering Life: A Case Report

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Most of the fibroid are situated in the body of the uterus, and causes menorrhagia, but a large cervical fibroid with severe per vaginal bleeding threatening life is uncommon. Our case, 41 years old multipara, presented with menorrhagia and dysmenorrhoea for last two years. Abdominal examination revealed a mass of 28 weeks pregnant uterus, firm in consistency, non tender with restricted mobility. Per speculum examination shows cervix is taken up with open cervical os (3 cm) through which a pink mass is seen. On internal examination the mass occupied the pelvis and abdomen, firm in consistency. Ultrasonographic examination diagnosed it as a large leiomyoma of cervix. Emergency hysterectomy was done for severe per vaginal bleeding after uncared internal examination by junior doctors. Patient had an uneventful post operative recovery and went back home in a happy mood.

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Key words: Leiomyoma, Fibroid, Total abdominal Hysterectomy

Introduction

Leiomyoma (fibroid) is the commonest of all uterine tumours with an incidence of 20% in women of reproductive age.^{1,2} Mostly the leiomyomas are situated in the body of the uterus but in 1-2% cases they are confined in the cervix.³ A cervical leiomyoma is commonly single and is either interstitial or subserous, rarely become submucous or polypoidal.³ Large cervical fibroid usually causes pressure symptoms.^{4,5} Uterine fibroid are responsible for about one third of the hospital admission in the gynaecological department.⁶ Cervical fibroids develop in the wall of the cervix.⁷ They can change the shape of the cervix or may lengthen it. If cervical fibroid get bigger, it may push the uterus upwards. Large cervical fibroid is rare, only handful of cases have been reported in the literature.^{8,9} Large cervical fibroids are difficult to handle and need an expert hand to operate these cases.¹⁰

Case Report

A 41 old multipara patient presented with history of menorrhagia and dysmenorrhea for

last two years. She had no history of urinary retention, urinary frequency, constipation or sensation of something coming down. She is widowed for last 10 months and gave history of abstinence for last 10 years due to husband's sickness. She is para 2, and her last child is 22 years old. Both of the babies were delivered by normal vaginal delivery.

Patient's general and systemic examination was normal except for severe pallor. Abdominal examination revealed a mass of about 28 weeks of size, non tender, and solid in consistency with restricted mobility. On speculum examination cervix was taken up with os open (3 cm), a pale pink mass was seen through the os. Vaginal examination revealed a large solid mass filling the pelvis and abdomen. On investigation, Hb was 7.0 g/dl, peripheral blood film shows normocytic normochromic anemia. Liver and renal function tests were normal. Ultrasonographic report showed a large cervical myoma. IVU showed left sided ureteric obstruction. ECG

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showed ischemic change. Patient was admitted in the hospital for preoperative fitness and one unit of blood was transfused. Patient was examined by enthusiastic post graduate medical students without the due care, causing injury during internal examination – leading to severe per vaginal bleeding. Per speculum examination showed bleeding coming through the os, but the main source was obscure. The bleeding was continuing and the haemoglobin label fell to 4.0 g/dl. Emergency leparotomy was done

under spinal anesthesia, and revealed a large cervical fibroid of 20 x 15 x 15 cm in size with a normal sized uterus and bilateral ovaries sitting on top of the fibroid (figure 1). Total abdominal hysterectomy was performed preserving both ovaries as they were healthy. Patient received 2 unit of blood intra operatively and 2 unit of blood post operatively. Her post operative recovery was uneventful and the patient was discharged on 6th POD. Histopathological report confirmed a case of cervical leiomyoma.

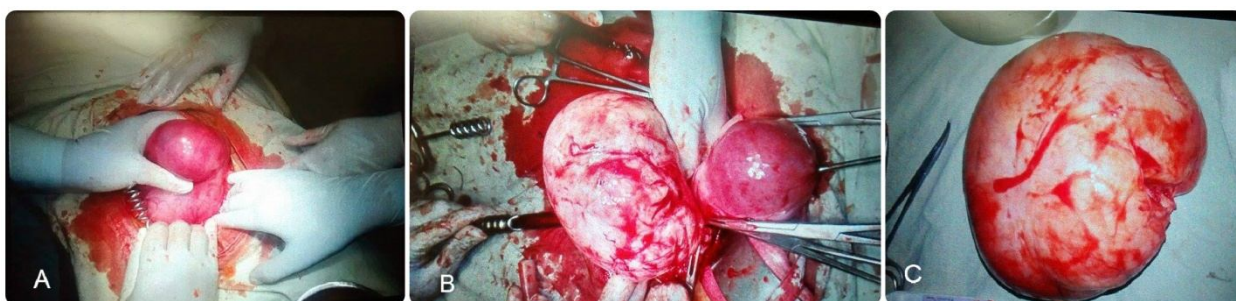


Figure 1. Excision of large cervical fibroid. A - uterus. B - large cervical fibroid with uterus. C - the excised cervical fibroid.

Discussion

Cervical fibroid with excessive growth are uncommon. They are grossly and histologically identical to those found in the corpus. Our case with large cervical fibroid presented only by menorrhagia and dysmenorrhea without any pressure effect. They give rise to a great surgical difficulty by virtue of their relative accessibility and close proximity to ureter and bladder.¹¹

Susmita Sharma and co-workers from Sri Lanka reported a case of large cervical fibroid clinically mimicked ovarian tumor as the patient had no pressure symptoms like urinary or bowel complaints.¹ That patient had abdominal distention and loss of weight. Banset N and co workers in Nepal also reported a case of unusual presentation of huge cervical fibroid.⁵ In their case patient had gradual abdominal swelling, scanty and irregular menstruation. That case also had no

bladder or bowel complaints. In the first case, left ureter was injured during separation and left uretero-ureteric anastomosis was done. In the second case, bladder injury occurred during separation which was repaired. Bilateral internal iliac arteries were ligated on both side to secure hemostasis.

Our patient had a cervical fibroid which grew not only occupying the pelvic cavity but became a huge abdominal mass pushing the uterus upto the umbilicus.

Conclusion

Careful vaginal examination is mandatory in case of cervical fibroid as injury may cause severe per vaginal bleeding threatening patient's life. Large cervical fibroid is very difficult to handle and needs a expert hand to manage and operate as in the present case. New diagnostic modalities like USG and CT scan can improve the accuracy of pre

operative diagnosis but final diagnosis can only be made at leparotomy.

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