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Cervical Fibroids: A Surgical Challenge

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Abstract: *Leiomyoma is the most common of all uterine and pelvic tumors. The incidence of leiomyoma is 20% in the reproductive age group, but only 1-2% are found in the cervix. Cervical fibroid develops usually in the supravaginal part of cervix. The symptoms most commonly presented are retention of urine, menstrual abnormalities, constipation, and sometimes can present only as an abdominal mass. Large cervical fibroids are rare and can present with surgical difficulties at the time of either myomectomy or hysterectomy, and have an increased risk of urinary tract injuries and intra operative bleeding. We hereby present four such cases of large cervical fibroid, in women of varying parity from 0 – 3 who underwent a hysterectomy successfully. Dissecting and enucleating a large fibroid (whether cervical or uterine) by limiting the dissection to within the capsule of the fibroid is a key surgical technique to prevent ureteric injury in addition to careful dissection of ureters and bladder and clamping any pedicle with keeping ureters under direct vision. We thereby conclude with the note, that large cervical fibroids are a very rare scenario and require an expert hand to operate them to avoid blood loss, prevent inadvertent injury to ureters or the bladder.*

Keyword: *Cervical fibroids, Hysterectomy, surgical expertise, bladder injury.*

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I. Introduction

Uterine fibroids are the commonest benign smooth muscle tumors of the uterus, with an incidence of ~ 20% while that of cervical fibroid is 0.5 – 1% of all fibroids. Cervical fibroids may arise from either supra-vaginal or vaginal portion of cervix. Depending on the site of their origin, they are classified as anterior, posterior, lateral & central. Each fibroid presents differently with varying symptoms like menstrual abnormalities, acute urinary retention, constipation, etc., They can change the shape of the cervix or may even lengthen it. If cervical fibroid grows rapidly, it may push the uterus upwards or obstruct the cervical canal. Location often makes presentation atypical and removal more challenging. Large cervical fibroids are difficult to handle, with increased risk of urinary tract injuries and increased intra operative bleeding, and needs an expert hand to operate these cases4.

II. Methods

A retrospective case study was carried out at our tertiary health care centre, Sri Ramachandra Medical Centre And Research Institute (2015-2017). A total of 4 cases of Cervical fibroid were identified and studied. Demographic details, Common Presenting Complaints, Clinical examination findings, Imaging techniques, Optimal Treatment Modality, Intra operative findings and Histo pathology were studied .

Table 1 Clinical Profile Of Patients

No.	NAME	PARITY	PRESENTING COMPLAINTS	PAST HISTORY
1	Ms. A, 61 Years	P2L2/ Sterilized	Post menopausal x 10years Hematuria x 15days	K/C/O Type II diabetes x 5years
2	Ms. B, 53 Years	Unmarried/ Nulliparous	Post menopausal x 7years Recurrent UTI x 5years	K/C/O Type II Diabetes x 15years
3	Ms. C, 48 Years	P2l2/ Sterilized	Excessive, Irregular Bleeding for 1 year	K/C/O tyoe II diabetes x 2years K/C/o systemic hypertension x 2years.
4	Ms. D, 47 Years	P1L1A2/ prev. LSCS/ Not Sterilized	Menorrhagia x 6 months	K/C/O Hypothyroidism

Table 2 Examination findings

	General Examination	Per Abdomen	Per Speculum	Per Vaginum
Mrs. A	resent	A firm mass of 20weeks in size, with restricted mobility arising from pelvis was noticed. No Ascites.	Cervix was not visualized , was pulled high up. A bulging mass was seen in upper vagina.	A firm mass was felt anteriorly and through all fornices. Posterior lip of cervix was felt as a rim. Uterus was not felt separately.
Mrs. B	Obese (BMI – 50)	A firm mass of 24weeks size noted.	Cervix was not visualized , was pulled high up. A bulging mass was seen in upper vagina.	Cervix could not be felt separately, and growth was continuous with the uterus.
MRs. C	Pallor +	A firm mass of about 28 weeks of size, non tender, with restricted mobility.	Cervix – os open and pink mass was visualized through the os.	large solid mass filling the pelvis and abdomen.
Mrs. D	No pallor;	Soft; No organomegaly.	mass of a size of about 5 cm x 3 cm, coming out of vulva and there was bleeding per vaginum.	large solid mass filling the pelvis through all fornices was felt. Pedicle could not be reached.

Table 3: Imaging Findings

	Imaging Findings
Mrs.A	CT scan with contrast : A large mixed echogenic mass of 20 x 14 cm, with mild vascularity noted, probably Fibroid. Right Hydroureteronephrosis was noted.
MRS. B	CT Scan – Homogenously enhancing lesion 22 x 10 x 8cm was noted extending from pelvis. Right Hydroureteronephrosis – Present.
Mrs. C	Usg Abdomen and Pelvis: 24 x 10 x 9cm cervical myoma , with Left Hydroureteronephrosis.
Mrs. D	TVS Pelvis: A 4.6 x 3.8 cm , well defined lesion is present in the Anterior cervix.

Table 4 Treatment Modality

	Treatment	Intra Op Findings	Post op period	HPE findings
Mrs. A	Total Abdominal Hysterectomy with bilateral Salphingoopherectomy	Bladder drawn up; Large cervical fibroid with characteristic Lantern on the dome of St. Paul's appearance.	Patient was observed in ICU x 48hrs due to blood loss of 1800mL. 3 units packed cell transfusion was given.	Consistent with Leiomyoma with hyaline changes.
Mrs. B	ominal Hysterectomy ıteral Salphingoopherectomy	A well encapsulated cervical fibroid of 28×18 cm size noted. Uterus was deviated to right side	Patient developed post operative wound infection, was treated with saline dressing and IV Antibiotics.	Leiomyomata.
Mrs. C	Total Abdominal hysterectomy with bilateral Salphingoopherectomy	BLadder drawn up. Uterus was Normal in size, with a well encapsulated cervical fibroid of 25 x 14cm was noted.	Patient was discharged on post op Day 4 , in good health.	Consistent with Leiomyomata.
Mrs. D	Total Abdominal hysterectomy with bilateral Salphingoopherectomy	Pedunculated fibroid polyp seen coming out of vagina with bosselated surface of size approx. 7×5 cm.	Patient was discharged on post op Day 4 , in good health.	Cervical Fibroid polyp with ischemic changes.

III. Results

The patients mentioned in the above case series presented with varying presenting complaints of Menorrhagia, Recurrent Urinary Tract Infections, and Menorrhagia . Parity of the women ranged between 0 -3, with a mean age of 51years. The investigations done included TVS Pelvis,MRI Pelvis and CT scan with the findings consistent with Fibroid associated with Hydroureteronephrosis in 3 women. Surgical treatment was the treatment modality opted in all four cases, and everyone underwent Total Abdominal hysterectomy with Bilateral Salphingoopherectomy. Only one patient required ICU admission in the Post operative period with Blood products transfusion. Intra operative damage to the Urinary tract was not noted in these patients due to surgical expertise.

IV. Discussion

Uterine myoma is the most common indication of hysterectomy. Cervical fibroids with excessive growth are uncommon. They may arise either from supra-vaginal or vaginal portion of cervix. Supra-vaginal fibroids can be central surrounding the entire cervical canal and lying centrally in pelvis displacing the ureters

superiorly. Pedunculated fibroids arise from endocervical canal or from uterine cavity and protrude through the cervix [2]. Cervical fibroids may be classified as: anterior, posterior, lateral, central and lastly multiple. The symptoms of cervical fibroid depend upon the type of cervical fibroid. Anterior fibroids may present with urinary symptoms, posterior may present with difficulty passing stools, lateral would extend to broad ligament and central fibroid pushes the uterus upwards Central cervical fibroid expands the cervix equally in all directions. Upon opening the abdominal cavity, a central cervical myoma can be recognized at once because of its characteristic "the lantern on the dome of St Paul"s appearance. The problems anticipated during hysterectomy for cervical fibroid are: 1) displaced uterine vessels 2) distortion of normal anatomy of the ureter and bladder. Therefore, chances of injury to ureter, bladder and uterine vessels are more likely. The ureter and uterine artery may be in extracapsular relation to the fibroid [5]. The knowledge of this fact can turn potentially dangerous procedure into a relatively safe operation.

V. Conclusion

We conclude that cervical fibroids have varied presentations; they may grow into the body of the uterus presenting either as abdominal mass or as a pelvic mass. Women with cervical fibroid requires Hospitalization, detailed clinical evaluation, and clear definition of pathology coupled with the knowledge of the altered anatomical structures is essential. Meticulous surgery by an expert remain the mainstay of successful management, for tackling injuries to the Urinary tract and avoiding Intra operative blood loss.

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