IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 21, Issue 10 Ser.2 (October. 2022), PP 32-37
www.iosrjournals.org

Large Cervical Fibroid

Dr.C.Sunitha
Professor, NRI General Hospital

Dr Shaik Hapsa Banu PG,
Dr K. Gangadhar Rao, Professor Nri General Hospital(NRIGH).

Date of Submission: 20-09-2022 Date of Acceptance: 05-10-2022

I. INTRODUCTION:

Leiomyoma is the most common of all uterine and pelvic tumors. The incidence of leiomyoma is 20% in the reproductive age group, and only 1-2% are found in the cervix [1].They can change the shape of the cervix or may lengthen it. A central cervical fibroid is usually either interstitial or sub mucous in origin and usually arises from supravaginal portion of the cervix so that it expands the cervix equally in all directions and can displace uterine vessels & ureters. On laparotomy it can be recognized at once, as it fills pelvis, with uterus on top of tumour like "The Lantern on the top of St. Pauls dome". The symptoms most commonly presented are retention of urine, menstrual abnormalities, constipation, and sometimes canpresent only as an abdominal mass without any other symptoms and may mimic an ovarian tumor [2,3].As they arise from deep pelvis and get impacted, surgery poses difficulties and complications are not uncommon. Large cervical fibroids are difficult to handle andneed an expert hand to operate these cases[4].We hereby present 7cases of cervical fibroid who underwent hysterectomy with insitu cervical fibroid successfully.

Key Words: cervical fibroid, vaginal myomectomy, enucleation, total abdominal hysterectomy

II. CASE REPORT:

Case 1 :

A 43-year old multipara presented with a history of insidious onset of abdominal pain and heavy menstrual bleedingfor1 yearduration. No bowel andurinary complaints. General and systemic examination revealed no abnormality. P/A-Soft, tubectomy scar noted. P/S-cervix andvaginahealthy. On bimanual pelvic examination mass feltthrough posteriorfornix, which is firm and mobile. uterus could not be felt separately from the mass.On investigations- Hb10g/dL,LFTand RFT within normal limits.. Ultrasound scan report showed a normal size uterus with a solid lesion of 9x7x6 cm in the cervix arising from posterior wall suggestive of a cervical fibroid with bilateral adnexa normal.Patient and relatives are counseled about surgical line of management and they were willing for total abdominal hysterectomy. Laparotomy was done, cervical fibroid of around 11x8x6 cm was seen occupying almost whole of the pelvic cavity along with a small uterus sitting on top. After ligating bilateral uterine artery and dissection of bladder, the mass was infiltrated with diluted vasopressin solution to decrease blood loss. Fibroid was held by myoma screw and dissected and separated skilfully and total abdominal hysterectomy with bilateral salpingo-ophorectomy done.post-operative recovery. Histopathological examination showed a cervical fibroid with hyaline degeneration.

Case 2:

40 years old multipara came to Outpatient department with complaint of lower abdominal pain and dysuria since15 days. She had no menstrual complaints. On examination she was vitally stable. P/A- NAD, P/S-cervix and vagina healthy. On bimanual pelvic examination mass felt through posterior fornix, which is firm and mobile. Uterus couldn't be felt separately from the mass.Ultrasonography of the pelvis showing bulky uterus with central cervical wall fibroid of 6x4cmx4cm with bilateral adnexa normal. After anesthetic fitness patient posted for Hysterectomy.Intra-op diluted vasopressin was given to decrease blood loss. Total Abdominal Hysterectomy with Enucleation of the cervical fibroid done successfully after the meticulous urinary Bladder dissection. Preservation of ovaries done.

Case 3:

47-years old P3L3 reported to our Hospitalwith a history of heavy menstrual bleeding Since 2 months, associated with clots but no dysmenorrhea. There was no history of postcoital bleeding or urinary complaints. no history of any chronic illness. Per abdomen examination was normal. on per speculum examination cervix and vagina healthy. On bimanual pelvic examination soft to firm mass was felt on left side but cervix could not be defined clearly. USG showed a sub serosal fibroid of 8x6x4cm on lateral side of uterus. She was posted for total abdominal hysterectomy. The intraoperative findings at surgery were moderate adhesions in the pelvis, more on the posterior uterine wall and left adnexae . . Both fallopian tubes and ovaries were grossly normal. Postoperative period was uneventful, folley's catheter was removed on 3 rd day and stitches were removed on 10th post-operative day and patient was discharged in good condition. Histopathology confirms the diagnosis of cervical fibroid with chronic ecto-endocervicitis and proliferative endometrium.

Case 4:

42 years old female, multigravida, married since 20 years presented with complaints of menorrhagia since 3 months. On examination general condition was fair, her vitals were stable, and pallor was absent. Per abdomen was soft, per speculum showed small mass inside endocervical canal. On per vaginal examination 6 cmx5 cm of cervical fibroid felt posteriorly. Uterus size appeared to be bulky. Pelvic ultrasonography showed cervical fibroid extending up to lower uterine segment of size 6.8cm x 5.2cmx 4.5cm with uterus of 11cm x 5.6 cm x 4.8cm with normal bilateral ovaries. Myomectomy done by taking incision over the cervix anteriorly after dissecting the uterovaginal fold of peritoneum and dissecting the urinary Bladder by sharp dissection. Later hysterectomy done after separating cornual structures and ligating uterine arteries. Patient withstood procedure well. Post operative period was uneventful and pt discharged on day 8 after suture removal. Histopathology shown leiomyoma.

Case 5:

47 years old female, Para 3, living 2,dead 1 married since 23 years presented with complaints of menorrhagia since 6 months. On examination general condition was fair and vitals were stable. Per abdomen was soft, per speculum showed mass of 6 cmx 4cm arising from cervix with smooth and regular surface and effacement of cervix . On per vaginal examination uterus size 14 weeks mass of 6x4 cm arising from cervical canal felt.Ultrasonography showed cervical fibroid extending up to lower uterine segment of size 5x 5 cm with uterus of 9.6x 5.5 x 5.2 cm with posterior wall fibroid 2.9 x1.8cm with normal bilateral ovaries. Patient and relatives are explained about surgical line of management, about myomectomy and total abdominal hysterectomy and patient and relatives were willing for total abdominal hysterectomy so fitness done. Intraoperatively incision taken over lower uterine segment to identify the origin of cervical fibroid and fibroid was held by myoma screw after injection intralesional vasopressin , dissected and separated and total abdominal hysterectomy done . Patient withstood procedure well.

Case 6 :

45 years perimenopausal, Para 2, living 2, with previous 2 LSCS, presented with complaints of

Heavy menstrual bleeding since5 years, pain abdomen.On examination general condition was fair and vitals were stable. Per abdomen soft and fatty abdominal wall, per speculum cervix drawn up . On per vaginal examination cervix was bulky with bilateral forniceal fullness felt. Ultrasonography revealed uterus of size 7.5x 4.6x 4.8cm with intramural fibroid of 6.5cms x 8.2 cms arising from posterior wall of uterus towards cervix. After getting consent from patient and attendants , she was taken for total abdominal hysterectomy. Intraoperatively a fibroid of 7x8cms noted arising from lower uterine segment extending into cervix noted. Enucleation of fibroid with myoma screw done after injecting vasopressin and proceeded for hysterectomy. Patient withstood the procedure well.

Case 7 :

40 year perimenopausal , Para 2, living 3, presented with complaints of heavy menstrual bleeding since 3 months, white discharge per vaginum since 3 months , difficulty in micturition since 2 days and known case of hypothyroidism on T.Thyronorm 5omcg since 8 years. On examination general condition was stable. Per abdomen mass of 18 weeks palpable in midline, per speculum examination mass protruding through cervix seen. On per vaginal examination mass of 7x7cm globular mass, firm in consistency felt protruding through os felt. After getting consent from patient, total abdominal hysterectomy done. Patirnt withstood the procedure well.

III. DISCUSSION:

Presence of isolated fibromyoma in cervix with intact uterus is infrequent. These fibroids grossly and histopathologically are identical to those found in corpus. Cervical fibroid may be classified as anterior, posterior, central and lateral according to their position.The symptoms of cervical fibroid depend upon the type of

cervical fibroid. Anterior fibroid bulges forward and undermines the bladder causing urine retention and frequency. Posterior fibroid flattens the pouch of Douglas compressing rectum against sacrum resulting in constipation.As the anterior and central cervical fibroids undermine the bladder and displace the ureters, there is every chance for them to be injured as seen in similar case report published in Katmandu university medical journal [5]. Lateral cervical fibroid starting on the side of cervix burrows out into the broad ligament and expand it. Central cervical fibroid expands the cervix equally in all directions but produces mainly bladder symptoms. Treatment of cervical fibroid is either myomectomy or hysterectomy. They give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter[6]. Wherever the ureters and uterus are in relation to fibroids, they will always be extracapsular[7]. The knowledge of this fact can turn potentially dangerous procedures into a relatively safe one.

IV. CONCLUSION :

In our case the patient had a huge posterior cervical fibroid with heavy menstrual bleeding and abdominal pain without any urinary symptoms which is very uncommon for such fibroid. Inspite of the fibroid being large, vascular and deeply impacted in pelvis, there was no injury to any adjacent structures. Intra operative diluted vasopressin injection also helped by reducing blood loss. Thus, we conclude that proper preoperative evaluation, preparation and knowledge of altered anatomical structures are important for performing hysterectomy for cervical fibroid.

References:

[1]. Bhatla N. Tumours of the corpus uteri. *In*: Jeffcoates Principles of Gynaecology. 5th ed. London: Arnold Publisher; 2001. pp. 470.
[2]. Suneja A, Taneja A, Guleria K, Yadav P, Agarwal N. Incarcerated procidentia due to cervical fibroid: An unusual presentation. Aust N Z J ObstetGynaecol. 2003;43:252-253.
[3]. Dutta DC. Benign lesions of the uterus. In: Textbook of Gynaecology including Contraception. 3rd ed. India: New Central Book Agency (p) Ltd; 2004. pp. 264.
[4]. Buttram VC Jr., Reiter RC. Uterine leiomyomata: etiology, symptomatology, and management. FertilSteril 1981;36:433 .
[5]. Basnet N, Banerjee B, Badani U, Tiwari A, Raina A, Pokharel H, Yadav P, Agrawal A, Chhetri S. An unusual presentation of huge cervical fibroid.Koirala Institute of Health sciences, Kathmandu University Medical Journal (2005) Vol. 3, No. 2, Issue 10, 173-174.
[6]. Kshirasagar SN, Laddad MM. Unusual Presentation of Cervical Fibroid: Two case reports. Int J Gynecol Plastic Surg. 2011;3(1):38-9.
[7]. Singh S, Chaudhary P. Central cervical fibroid mimicking as chronic uterine inversion, Int J ReprodcontraceptObstetGynnaecol. 2013;2(4):687-88.

SPECIMEN OF UTERUS WITH CERVICAL FIBROID