Cervical Fibroid With Amenorrhoea

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Abstract: Fibroid are benign common tumour in reproductive age group arises from smooth muscles cells of uterus. Incidence is about 30-50%, vary from sizes very small to big, may be one or multiple[1]. Fibroid usually presents with menorrhagia/menstrual irregularities, but Cervical Fibroid with amenorrhoea is very rare entity. Usually 30-40 % hysterectomy are done for fibroids. Degenerative changes can occur, hyaline is common, while in 0.5% Malignant changes may occur. While operating a huge tumour the anatomy gets disturbed , so due care for the surrounding structure is to be taken otherwise we may land up in complications. In these Huge cervical fibroid Abdominal hysterectomy was proceeded up to uterine vessels, then transverse incision was kept over the anterior vaginal wall of cervix after pushing the bladder down, & fibroid was held with myoma screw & enucleated. Then routine Hysterectomy was completed. Bilateral ureteric tracing done. So meticulous examinations with a suspicion is needed for diagnosis & management of such case. [Gaishnav G et al NJIRM 2013; 4(1) : 134-135]

Key Words: Fibroid , Amenorrhoea, Cervical Fibroid surgery

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Case Report : A 42 year old Patient with G2 P2 , sterilized was admitted on July 2011 with complaints of lower abdominal pain and abdominal lump since 9 months, difficulty in passage of urine since 4 to 5 months and urinary retention since 2 to 3 days. She was admitted with history of amenorrhea of 4 months (UPT-Neg.).

On Examinations - Patients vitals were stable except for a severe pallor clinically. Per abdomen examination revealed a 26 to 28 weeks lump in abdomen; firm to hard in consistency, with regular borders, no ascites. There was no guarding, rigidity or tenderness and bowel sounds were normal. On P/S exam Cervix was not visualized, mass seen with obliteration of all fornices. On bimanual exam, the mass of 26-28 weeks felt , not separately from the uterus, freely mobile, Cervix can not be reached per vaginally on account of huge mass . On P/R exam, Rectal mucosa free, same mass felt.

Investigations : CBC revealed a Hb of 5.2 gm% with TC & PC are Normal, For which she was transfused 2 units PCV. LFT (S. bilirubin, ALT) and RFT (S creat. & BU), RBS were normal. Haemolytic profile to rule out other causes of anaemia commonly prevalent here like G6PD deficiency, sickling test and PSMP were negative. PS revealed a hypochromic microcytic picture. On USG abdomen and pelvis revealed mild Hepatosplenomegaly, severe hydronephrosis of both kidneys seen, due to obstruction by pelvic mass. A large heterogeneous hypo echoic mass of 20 x 18 cm^2 in cervical region giving an impression of cervical fibroid. Bilateral adnexae were normal. Uterus was 61 x 47 x 40 cm^3 in size with a fluid collection of 4 x 3 cm^2 in endometrial cavity on top of mass.

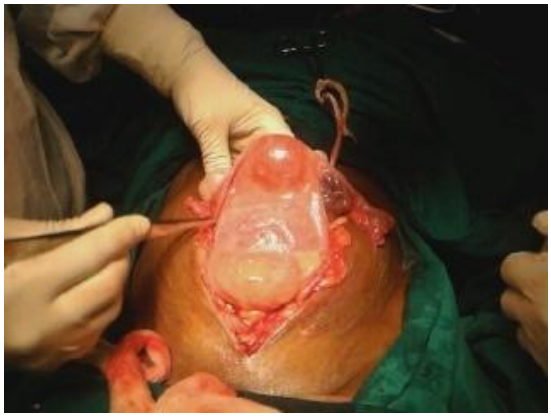
Diagnosis : Considering the clinical examinations & Invistigations a diagnosis of cervical fibroid was kept.

Management : She was posted for an elective total abdominal hysterectomy. Preoperative cystoscopy guided ureteral catheterisation was attempted to clearly outline the anatomy of the ureters to prevent intra operative injury but was not possible due to large mass compressing the ureters[2].

Abdomen was opened with midline vertical incision extended supra umbilical. on carefully opening the abdomen, bladder was stretched up to umbilicus , uterus appeared bulky with the cervix not separately seen, Uterus was seems to be lying on the top of a large fibroid of 20 x 18 x 15 cm giving a characteristic look of *'Lantern on the top of the dome of St. Paul' appearance*. Bilateral fallopian tubes and ovaries were normal and did not reveal any pathology with no disturbance of tubo-ovarian relationship. Considering above finding Abdominal hysterectomy was proceeded

up to uterine vessels, then transverse incision was kept over the anterior vaginal wall of cervix after pushing the bladder down, then fibroid was held with myoma screw & enucleated. Then routine Hysterectomy was completed & vault was closed & complete haemostasis was secured. Bilateral ureteric tracing done & confirmed. There were no adhesions or any congenital anomalies noted. Uterine cavity and cervical cavity showed blood clots corresponding to USG finding of a collection. Four units of PCV were infused intra & post operatively. On cut section mass was s/o fibroid weighing 2.5 Kg. The postoperative period was uneventful and the patient was given I.V Antibiotics for 2 day then oral antibiotics. Suture Removal Done on 8th Day. Wound well healed.

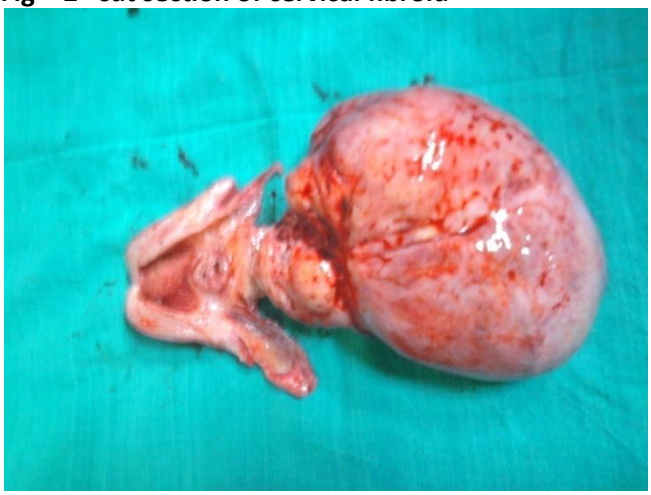
Fig – 1 'Lantern on the top of the dome of St. Paul'



Histopathological examinations : the mass was s/o leomyoma (fibroid), with normal uterus, cervix, endometrium. both ovarian tissue & tubes are normal.

Discussion : Patient presented with menorrhagia followed by amenorrhoea can be due to obstruction resulting in endometrial collection & Hydronephrosis & retention of urine is also explained by the huge mass obstructing bladder, urethra & ureter[3,4]. While operating this kind of huge mass, cervical fibroid if due care is not taken we can land up in the complications like bladder, ureteric injury. Some time we may land up in bowel injury [1,2,4].

Fig – 2 cut section of cervical fibroid



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