Leiomyoma demanding multidisciplinary approach: Case report

Dr Shikha Rani[1], Dr Alka Sehgal[2], Dr Vidur Bhalla[3], Dr Navneet Takkar[2]

[1]Senior Research Associate, [2] Associate Professor, Department of Obstetrics and Gynecology, Government medical college and hospital, Chandigarh

[3]Associate Professor, Department of Urology, Government medical college and hospital Chandigarh

Corresponding author email: shikhataneja2000@yahoo.co.in

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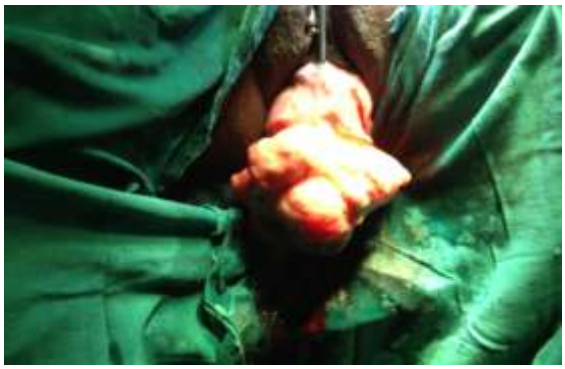
Introduction

Leiomyoma are the most common solid pelvic tumor in reproductive women.[1]Usually affecting uterus and vaginal involvement is rare. Primary vaginal leiomyoma was first detected in 1725. At times it may involve rare sites requiring multidisciplinary approach for diagnosis and treatment.

Case report

We are reporting a case of 40 years female, came with complaints of fleshy mass protruding through the introitus. She noticed the mass 1yr back when it was the size of an orange and protrudes slightly through the introitus and slowly progressed to present size (Figure 1). There was no history of menorrhagia, intermenstrual bleeding or post coital bleeding, urinary or bowel complaints or any treatment. She was cachexic and severely anemic with no lymphadenopathy or hepatosplenomegaly .Her abdomen was soft without any distension or tenderness. Local examination revealed an irregular, bosselated, non- reducible growth of 12x10 cms lying outside the introitus with no ulcers or pigmentation, urethral meatus was broadened and urethra was prolapsed. Speculum could not be introduced as growth was occupying whole of the introitus.

Figure1VaginalLeiomyoma



On per vaginal examination 12x10 cms firm to hard mass with irregular surface was felt at the introitus which seems to be arising from the anterior vaginal wall just 2cms from the anterior lip of the cervix , cervix felt separately from the mass with normal uterus and adnexa.

All investigations were normal except her hemoglobin, which was 2.8gm%.On ultrasonography uterus, cervix and ovaries were normal. Kidneys, ureters and urinary bladder were also normal on ultrasonogram. CT urography showed normal kidneys and ureters, urinary bladder prolapsed along with soft tissue attenuating mass at the vaginal introitus and the urethral opening into the bladder is displaced inferiorly, delayed film showed contrast in vaginal region. After transfusing 5 units of blood biopsy was taken which showed leiomyoma. Patient was taken for vaginal myomectomy. Cystoscopy was done before giving the incision showing normal urinary bladder with ballooned up posterior urethral wall. Vaginal myomectomy along repair of urethra was done which was injured while enucleating the fibroid. Bladder was catheterized for 14 days. Post- operative period was uneventful and she was discharged. Final histopathology showed leiomyoma.

Discussion

Vaginal leiomyoma constitutes 4.5% of all vaginal masses. They usually present about the age of 40yr because of its slow growing nature and distensibility of vagina. They are mostly located in the anterior wall but can arise form lateral or posterior wall. [2] They are usually well circumscribed single solid or cystic mass which may be asymptomatic or can present with varied symptoms. Symptoms vary from lower abdominal or back pain, vaginal bleeding or discharge, dyspareunia, urinary complaints, constipation or protrusion of mass. [3] Preoperative diagnosis by ultrasonography is difficult. Magnetic resonance imaging helps in diagnosis and differentiating it from leiomyosarcoma. [4]Although rare, vaginal leiomyosarcoma too has been reported.[5] Preoperative biopsy helps not only to make a diagnosis but to rule out any malignant focus. Surgical excision

through vaginal route is preferable. For large tumors abdomino-perineal approach is pre. Recurrences are infrequent.

Conclusion

Since vaginal leiomyoma has a varied clinical presentation it always remains a clinical dilemma demanding a multidisciplinary approach as in our case.

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