

Giant Leiomyoma (11kg Fibroid) Of The Uterus : A Case Report And Review Of Literature

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Abstract: Fibroids are the most common benign tumors of the uterus, arising from the smooth muscle of the uterus. They are mostly situated in the body of the uterus. Leiomyomas decrease in size around the menopause due to their estrogen dependent nature. Fibroids undergo various types of degenerations, most common being hyalinization in 60% cases. They may compress the urethra, bladder neck, or ureter producing symptoms of varying degrees of urinary outflow obstruction. Large fibroids are a rare scenario and require an expert hand to operate them to avoid blood loss, prevent inadvertent injury to ureters or the bladder which was done in our case. Here we present a case large uterine fibroid (12 kgs) which was managed with expert surgical skills [Katke R SEAJCRR 2018; 7(4):39-42]

Key Words: Fibroid, Leiomyomas, Hyalinization

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Introduction: Myomas are the most common tumors of the female genital tract. They are estimated to occur in 20% to 50% of women, with increased frequency during the later reproductive years^{1,2}. Fibroids are the most common benign tumors of the uterus, arising from the smooth muscle of the uterus. They are mostly situated in the body of the uterus, but the incidence of cervical fibroid is also increasing. Fibroids are often asymptomatic but 30% of the patients affected by fibroids present heavy menstrual flow or other alterations such as pelvic discomfort, menometrorrhagia, dyspareunia, urinary disorders, back pain or infertility^{2,3,4}.

There are different management approaches for myomas³. Surgical treatments for myomas tend to be invasive and expensive, but they are associated with better quality of life⁴. Operative strategy of myoma is determined according to size, number, and location of the fibroids.

Giant uterine leiomyoma with cystic degeneration are exceedingly rare and can be mistaken for ovarian or retroperitoneal cysts and neoplastic tumor^{5,6}. Symptomatic fibroids require hysterectomy by laparotomy or laparoscopy of the classic option. This condition is responsible for 60% of hysterectomies performed in Western countries. Another possible treatment is surgical myomectomy by laparotomy, laparoscopy or hysteroscopy. It is also possible to administer a preoperative treatment in order to reduce the volume of the myoma and the uterine bleeding with gonadotropin-releasing hormone agonist or, preferably, Ulipristal Acetate. Non-surgical options such as: embolization selective trans-arterial and

therapy HIFU High Intensity Focused Ultrasound^{2,3,4} are added to the classic surgical treatments.

In the case of giant fibroids, scientific evidence on prescribed treatment is limited or null in terms of conservative techniques. The size increase often makes it difficult to perform the usual surgical techniques and a total or even a subtotal hysterectomy is indicated. The literature is limited to the technique of excision of giant uterine fibroids and reconstruction.

Case Report : 38 years old multipara presented to our hospital with distention of abdomen and heavy menstrual bleeding since 3 months. Patient also complained of weakness since 2 months. On examination, patient was vitally stable, but clinically pale. On per abdominal examination mass of 36 weeks arising from pelvis with restricted mobility, firm in consistency felt. On per vaginal examination cervix was taken up and bilateral fornices were obliterated. Patient was evaluated for the same.

On admission Hemoglobin was 6.2g%, 2 pints whole blood were transfused before operation. Ultrasonography was suggestive of large pelvic heterogenous mass lesion of size 25 x 18 x 13 cm showing profuse intramural vascularity of venous origin. Magnetic Resonance Imaging was suggestive of intramural fibroid 11.1 x 18.5 x 18.9 cm in Right anterolateral uterus wall with small subserosal component. Decision for hysterectomy was taken.

Intra-operatively highly vascular uterine fibroid of 36 wks seen with dilated vessels all over surface of the uterus. Bladder was adherent, fine dissection done.

Total Abdominal Hysterectomy was done. Patient withstood procedure well. Specimen was send for Histopathology. Histopathology report was suggestive of Leiomyoma. Post operatively 1 Pint whole blood was transfused. Post operative period was uneventful .

Figure 1- Huge Fibroid with vascular surface

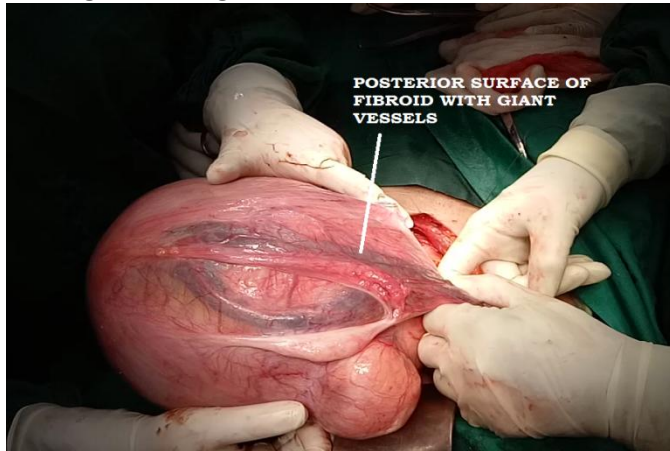


Figure 2 -Fine ureteric dissection

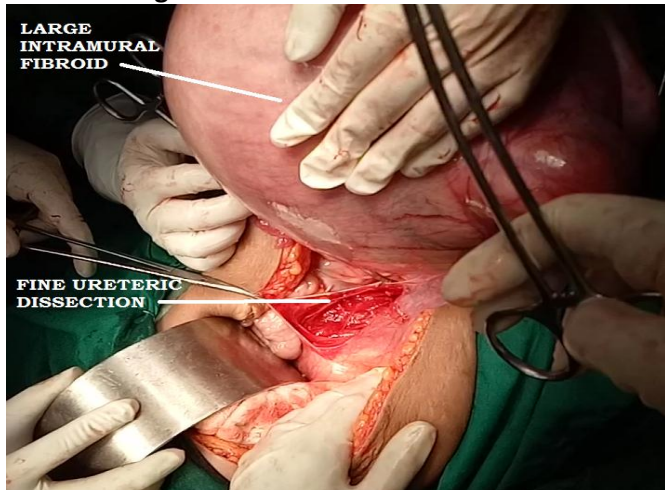


Figure 3 – Huge Fibroid

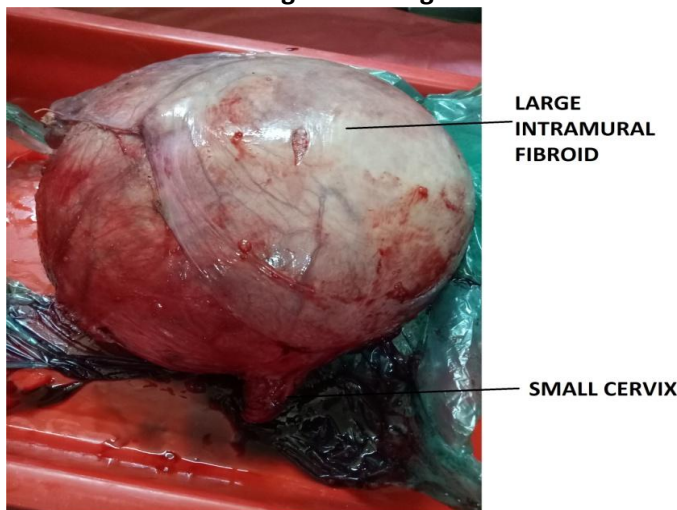


Figure 4 - Cut section of fibroid

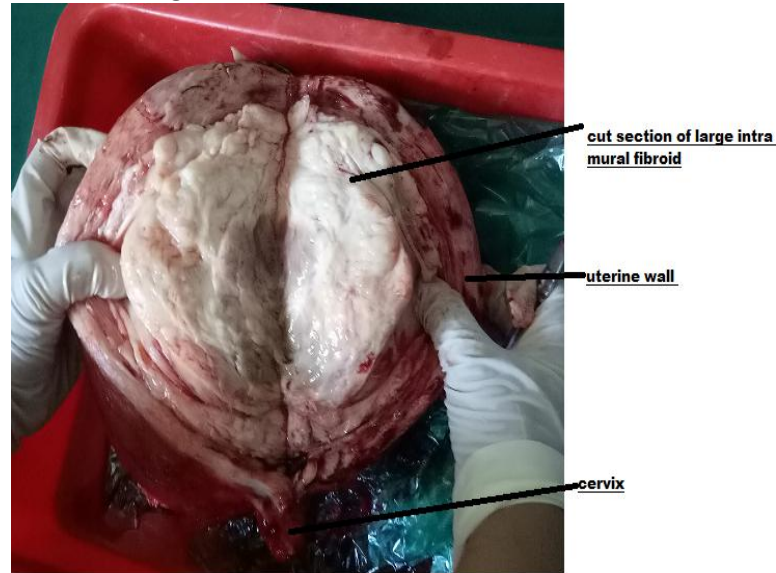


Figure5 – Uterus with Large Intramural fibroid - 11KG



Discussion: Fibroids are the most common benign tumors of the uterus. Most of the patients remains asymptomatic but in patients with large fibroids mostly present with pressure symptoms depending on location of fibroid. The symptoms include a wide range of possibilities such as ⁷: menometrorrhagia, pelvic pressure, urinary symptoms due to compression of urethra with hydronephrosis or bladder compression with symptoms of urgency and urge incontinence, edema, or pelvic varices, thrombosis or compression symptoms sacral plexus. Other symptoms described included unusual pulmonary hypertension, respiratory failure, pseudo-Meigs syndrome, difficulty to walk, tiredness and arthrogyriposis in pregnancy ^{8,9,10} .

The treatment of uterine fibroids may involve one of the following approaches or a combination thereof: expectant management, surgical management, medical management, myolysis management and selective uterine artery embolization^{7,8}. The chosen approach should be individualized for every patient. Nowadays a surgical management is the most frequent preferred. But it is important to treat women with large leiomyomas in high specialized gynecological or oncological surgery departments.

There are reports of fibroids found in the retroperitoneal space, having to make the differential diagnosis with other masses found in the same area, which sometimes can be malignant, for example: the mucinous cystadenoma, cystic lymphangioma, cystic mesothelioma and Mullerian cyst. In other cases, the tumors are benign such as urinomas and lymphoceles. Myomas have also been described in Retzius space⁹. Gynecological trans-vaginal ultrasound is the technique of choice for the diagnosis because it is the most cost-effective with perfect display. If the fibroid exceeds the pelvis, abdominal ultrasound is required to view the complete mass. However, MRI is considered more accurate for the diagnosis and if the fibroid is too large, an abdominal and pelvic MRI will also be required for its evaluation.

Some fibroids present as large pelvic masses posing a diagnostic difficulty to differentiate from large ovarian tumors. As leiomyoma enlarges, they may outgrow their blood supply resulting in various degenerations like hyaline, cystic, myxomatous, calcific, red degeneration.¹¹ Although fibroids usually have a characteristic ultrasound appearance, in cases of huge size and in cases of degenerations, it may create some confusion at the diagnosis¹².

Radiological investigations can be of help, but intraoperative surprises are not uncommon. Studies have shown that round ligament is the guiding factor to go in the anatomical plane in cases of huge fibroids and guides us for further surgeries^{13,14}.

Conclusion : Giant uterine leiomyomas are exceedingly rare. Clinical symptoms of the large myoma are: pain, distension, constipation, occurring more often menstrual bleeding and micturation and reproduction affect.

Transvaginal or through the abdomen ultrasound is usually the initial tool for diagnosis of uterine myoma. In such cases of large fibroids, there is always a diagnostic dilemma whether it is uterine mass or adnexal mass. Hence it is very important to confirm diagnosis with imaging modalities such as CT scan or MRI.

The treatment should be individualized for every patient depending on size, location, number and parity. Women with large leiomyomas should be treated in high specialized gynecological or oncological surgery departments. In such huge fibroids anatomy is distorted so great surgical expertise is required to avoid injuries to adjacent structures, fine dissection is required to prevent ureter injury which was done skillfully in our case. At the end we conclude that extreme surgical expertise is required for successful outcome in such cases.

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