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Case Report

Diagnostic and management dilemma in a case of a huge broad ligament fibroid with retroviral disease

Ashok R. Anand, Dhruv Pravin Gohil*, Gamli Angu

Department of Obstetrics & Gynaecology, Grant Government Medical College and Sir JJ Group of Hospitals, Mumbai, Maharashtra, India

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***Correspondence:**

Dr. Dhruv Pravin Gohil,

E-mail: detartsurf@gmail.com

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ABSTRACT

Extrauterine sites of fibroids are known to occur but are extremely rare. Because of its rare occurrence it poses a diagnostic dilemma and management. This is one such case report. A 44 year old retroviral disease positive patient on therapy presented with distension, pain in abdomen and weight loss. Clinical findings and CT scan were consistent with diagnosis of ovarian neoplasm. On exploratory laparotomy a huge broad ligament fibroid was found. Mass removal with total abdominal hysterectomy with bilateral salpingoophorectomy with appendectomy was done. Post operatively, due to bradycardia and hypotension, patient was re explored and retroperitoneal clot evacuation with bilateral internal iliac ligation was done. Extra-uterine fibroids are uncommon. In this case the examination findings and CT scan findings were consistent with diagnosis of an ovarian neoplasm. Possibility of a giant fibroid with cystic degeneration was distant. Complete haemostasis doesnot always gurantee post-operative haemorrhage. Hence putting a drain in abdomen and observation of vitals is important. Sometimes we believe that a prophylactic internal iliac ligation in cases of huge fibroids may avoid such complications.

Keywords: Huge fibroid, Retroviral internal iliac ligation

INTRODUCTION

Fibroids are the most common uterine tumours. They have a very diverse disease spectrum with a complexity that is indefinite with extreme variation in terms of size, number and patient complaints. Extrauterine sites of fibroids are known to occur but are extremely rare. Because of its rare occurrence it poses a diagnostic dilemma and management. What might otherwise be a simple disease to treat may sometimes be extremely complex.

We are presenting one such case report where a diagnosis was doubtful. Only after opening the abdomen, it turned out to be a very huge broad ligament fibroid causing complete torsion of uterus with a stormy post-operative course in a patient with retroviral disease.

CASE REPORT

A 44 year old patient, para 4 living 4, known case of retroviral disease (sero concordant couple) since 7 years on anti-retroviral therapy, came to us with complaints of distension of abdomen, pain in abdomen and weight loss since 4 months. She had no menstrual complaints. On examination vitals were stable, per Abdomen a huge solid mass felt arising from pelvis extending upto xiphisternum, with restricted mobility. Per speculum and per vaginum examination revealed no abnormality except that cervix could not be visualised as it was pulled up.

Provisional diagnosis of ovarian neoplasm was made. Both Ultrasound and CT Scan were suggestive of a huge 20x18x18 cm well defined solid, heterogenous mass in

right adnexae with multiple cystic areas, suggestive of an ovarian neoplasm.

Intra-operatively a huge pelvic mass was found extending upto liver superiorly and spleen on the left side. The mass was adherent at many places to the abdominal wall and intestines. Adhesions present were separated. The origin of the mass was traced to the right broad ligament. Whole of the uterus had undergone torsion. Impression was a huge degenerated broad ligament fibroid. Mass was delivered and total abdominal hysterectomy with bilateral salpingo-oophorectomy followed by appendicectomy (for enlarged inflamed appendix) was done. Haemostasis was doubly checked and abdomen was closed with a drain *in situ*.

Post operatively after 4 hours patient had tachycardia and blood pressure started falling and abdominal girth stated increasing although the drain did not show any increase in output. When the blood pressure did not increase even after 2 pints of blood transfusion, decision was taken to re-explore the patient. On re-exploring, a haemoperitoneum of 750 ml was found with retro peritoneal clot of size 15x12x10 cm ~ 750 ml. No active bleeding was noted from any pedicle. All pedicles were tied again followed by bilateral internal iliac ligation. Patient recovered well after that and post-operative course was uneventful.

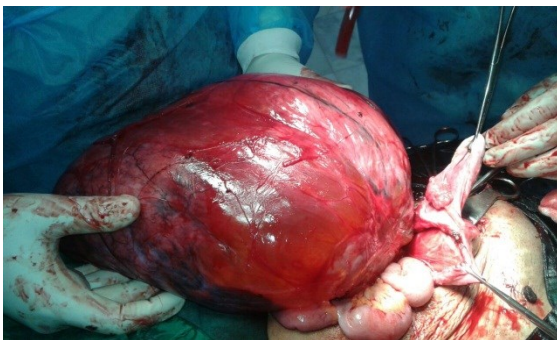


Figure 1: Intra-operative findings: a huge broad ligament fibroid with torsion of uterus.

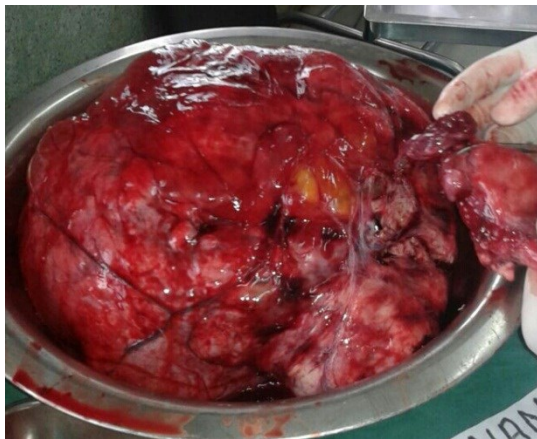


Figure 2: Gross specimen of the fibroid.

DISCUSSION

Fibroid or leiomyoma is the commonest of all uterine tumours. They are common in child bearing age group. They are classified as subserous, interstitial, and submucous depending on their origin. Submucous fibroids arise beneath the endometrial layer and often project into endometrial cavity, interstitial or intramural fibroids arise within the myometrium, and subserous fibroids arise from serosal layer and present as adnexal masses. Extra-uterine fibroids are uncommon. Extra-uterine fibroids develop due to existence of smooth muscle at other sites,¹ broad ligament being the most common site. Common symptoms of fibroids include menstrual disturbances, dysmenorrhea, and pressure related symptoms (urological and gastrointestinal).² Women with fibroids may experience recurrent pregnancy loss, decreased fertility, chronic pelvic pain and sizeable pelvic masses. These symptoms are neither mutually inclusive nor exclusive and cause significant disruption to patients well-being and quality of life. 30-50% patients become symptomatic and out of these many experience significantly elevated levels of distress and lower health related quality of life. Degenerative changes in the leiomyomas are due to inadequate blood supply and degenerative changes seem to depend on the degree and rapidity of the onset of vascular insufficient changes are the commonest form of degeneration. Cystic degeneration occurs in 4% of cases as a sequale of edema.³

In this case the examination findings and CT scan findings were consistent with diagnosis of an ovarian neoplasm. Possibility of a giant fibroid with cystic degeneration was distant. The diagnosis was confirmed on histopathological examination.

CONCLUSION

Epidemiologists, demographers and clinicians are beginning to provide a clear picture of the true cost on the society due to uterine fibroids. Approximately 200000 hysterectomies and 30000 myomectomies are performed every year in the U.S. alone. These patients also require frequent OPD visits, hospitalisation, medications for symptom control, absence from work, psychological disturbances. Although fibroids are benign tumours they can grow to enormous size and often be mistaken as ovarian neoplasms. Although surgery can be done safely in experienced hands, sometimes when the anatomy is completely distorted, operative complications are unavoidable. Blood loss during surgeries can be decreased by preoperative GnRh analogues, uterine artery embolization, etc. and treated with blood and blood product transfusion. Complete haemostasis does not always guarantee post-operative haemorrhage. Hence putting a drain in abdomen and observation of vitals is important. Sometimes we believe that a prophylactic internal iliac ligation in cases of huge fibroids may avoid such complications.

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