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Case Report

Cervical fibroid: an uncommon presentation

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ABSTRACT

Fibroids arising from cervix are rare tumours accounting for 2% of all fibroids. A cervical leiomyoma is commonly single and is either interstitial or subserous, rarely it becomes submucous and polypoidal. Anterior cervical fibroid may press on urinary bladder and urethra and displace the urethro-vesical junction giving rise to urinary frequency and retention. Management of symptomatic cervical fibroid is hysterectomy or myomectomy and need an expert hand. Here we report a case of huge anterior cervical fibroid of 15x15x7cm with an unusual presentation of menorrhagia of only 2 days and no urinary symptoms. Inspite of the fibroid being huge and impacted, hysterectomy was done successfully without any injury to bladder and ureters.

Keywords: Cervix, Myomectomy

INTRODUCTION

Leiomyomas are the most common benign tumours of the uterus. Growth of leiomyoma is estrogen dependent, thrive during reproductive years and gradually regresses after menopause.

Cervical fibroids are rare and account for 2% of all fibroids.[1] They arise either from supravaginal or vaginal portion of cervix.

They are classified as anterior, posterior, central and lateral depending on their site of origin. A cervical fibroid can lead to menstrual irregularities, urinary retention, urinary frequency, constipation, dyspareunia and post coital bleeding depending upon their location.

Large cervical fibroids are difficult to handle and need an expert hand to operate these cases.[2]

CASE REPORT

We report a case of 38-year female p1L2 (twin delivery) reported at HinduRao Hospital with a short history of heavy bleeding p/v since, 2 days, associated with clots but no dysmenorrhea. Her previous cycles were regular with average flow for 3-4 days. There was no history of postcoital bleeding or drug intake or any chronic illness. However, she gave history of CuT insertion 5 year back. On examination, she was severely anaemic, Hb 4gm%. Per abdomen examination was normal. On per speculum a profusely bleeding, congested mass was seen in upper vagina but neither cervix nor CuT thread was visible. On gentle p/v a soft to firm mass of around 6x6 cm was felt on left side but cervix could not be defined clearly.

She was stabilized with blood transfusion and hemostatic agents and was then worked up for sugery. USG showed a sub serosal fibroid of 10x9 cm on left side of uterus

with bilateral adnexa normal. MRI showed a large exophytic soft tissue mass arising from anterior wall of cervix measuring 13x8.4x9.7cm. The mass was predominantly solid with areas of cystic degeneration, necrosis and foci of hemorrhage seen within. On intravenous pyelogram both ureters were found to be normally placed with no evidence of hydronephrotic changes.

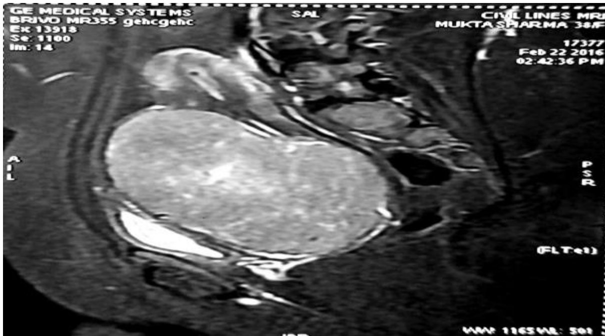

Figure 1: MRI showing the huge anterior cervical fibroid.

The patient received single dose of GnRH agonist (Leuprolide 3.75mg) 2 weeks before sugery. Laparotomy was done with abdomino-perineal approach with patient in lithotomy position. A huge cervical fibroid of around 15x15x7 cm was seen occupying almost whole of the pelvic cavity along with a small uterus sitting on top, slightly deviated to right. After ligating bilateral uterine artery and dissection of bladder, the mass was infiltrated with diluted adrenaline solution to decrease blood loss. A longitudinal incision was given over the myoma and it was removed in piece meal followed by hysterectomy. Fortunately, there were no injury to bladder and ureters or any other adjacent structures.

Figure 2: Cervical fibroid removed in piecemeal.

Postoperative period was uneventful, folley's catheter was removed on 3rd 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.

DISCUSSION

Presence of isolated fibromyoma in cervix with intact uterus is infrequent. These fibroids grossly and histopathologically are identical to those found in corpus. Supravaginal fibroids may be interstitial or subperitoneal but rarely polypodal. Interstitial growth may displace the cervix or expand it so much that it disturbs the pelvic anatomy and ureter. Vaginal fibroids are usually pedunculated and rarely sessile.

Cervical fibroid may be classified as anterior, posterior, central and lateral according to their position. 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. 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 direction but produces mainly bladder symptoms. On laparotomy they give a typical appearance of "Lantern on St Paul's Dome."[3]

Treatment of cervical fibroid is either myomectomy or hysterectomy.[4] They give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter.[2] Wherever the ureters and uterus are in relation to fibroids, they will always be extracapsular.[3] The knowledge of this fact can turn potentially dangerous procedures into a relatively safe one. Preoperative GnRH analogue administration for 3 months reduces intraoperative blood loss and facilitates surgery.[5] Principle to be followed during surgery is enucleation followed by hysterectomy.[6]

CONCLUSION

In our case the patient had a huge anterior cervical fibroid with a very short duration of menorrhagia (2 days) and without any urinary symptoms which is very uncommon for such fibroid. Inspite of the fibroid being huge, vascular and deep impacted in pelvis, there was no injury to any adjacent structures which was a great advantage to the patient. Preoperative GnRH agonist injection also helped by reducing intraoperative blood loss. Thus, we conclude that proper preoperative evaluation, preparation and knowledge of altered anatomical structures are important for performing hysterectomy for cervical fibroid.

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