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***Case Report***

# A HUGE PARASITIC FIBROID OF RECTOVAGINAL SPACE: - A CASE REPORT

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## ABSTRACT
Leiomyomas are the most common uterine and pelvic tumours. The usual anatomical location is the body of the uterus. Rectovaginal leiomyoma are very rare. Case of a 42-year-old female is reported here, who presented with increased frequency of menstruation and pain in abdomen since 2 years. No lump was palpable on abdominal examination. On vaginal examination uterus was 10-12 weeks size. Ultrasonography showed a large sub-serous fibroid 80mm×40mm arising from the posterior wall of uterus. On laparotomy, uterus was 8-10 weeks size and a large firm mass was found much lower down in the rectovaginal space adherent to posterior surface of posterior vaginal wall. Cervix and vagina were normal. Fibroid was posterior to vagina and cervix. There was no connecting pedicle between uterus, cervix and fibroid. Total abdominal hysterectomy was done. Fibroid was removed separately by blunt dissection of rectovaginal space. Histopathological examination of the specimen revealed chronic cervicitis, and uterine intramural leiomyoma and the separate mass (rectovaginal) was also found to be leiomyoma. Patient had an uneventful post-operative recovery.

***Keywords:*** *Rectovaginal, Leiomyoma*

## INTRODUCTION
Leiomyoma is the most common of all uterine and pelvic tumours. The incidence of leiomyoma is 20% in the reproductive age group (Bhatla, 2001). They are most commonly intramural, subserosal, submucosal and cervical. Myomas and fibromyomas are not uncommon in the round, ovarian and broad ligaments (Jonathan, 2002), they are found in association with similar uterine tumours and their pathology and complications are the same as fibroids. Among the extrauterine fibroids, broad ligament fibroids are the most common to occur[1]. When a subserous fibroid becomes adherent to other structures, especially the omentum, they obtain their blood supply from such structures and the uterine pedicle either disappears completely or becomes avascular. The resultant tumour is known as "parasitic or ectopic leiomyoma". Parasitic myomas are rare but have been reported in literature. These could be myomas detached from the uterus, which have taken blood supply from adjacent organs or could be retained myomas (Parasitic, 2009).

## CASES
A 42 years old Para 2 woman belonging to upper middle socioeconomic status came complaining of increased frequency of menstruation and pain in abdomen since 2 years. Both her deliveries were vaginal deliveries, the last being 7 years back. She had tubal ligation done. Her last menses was 9 days before surgery. She was a known case of hypothyroidism since 10 years and was controlled on levothyroxine 100 micrograms per day. No history of bladder/bowel disturbance was reported. No history of sudden weight loss/anorexia/fever or bleeding per rectum. No history of genital, colon or breast malignancy in the family. General and systemic examination of the patient was normal.
Abdominal examination showed normal findings. On vaginal examination, erosion was present on the cervix. Uterus was 10-12 weeks size and lateral fornices were free, there was fullness in posterior vaginal wall.
Her haemoglobin was 12.4 gm/dl, leucocytes count7.440/m**3**, differential count – P-64 L-33 E-03, ESR 12mm first/hour, blood group O Rh+ve, fasting blood sugar 79 mg/dl, postprandial blood sugar 84 mg/dl, serum creatinine 0.66 mg/dl, blood urea 13 mg/dl, bleeding time 2 minutes 30 seconds, clotting time 4

minutes 30 seconds, serum sodium 138mEq /dl, and serum potassium 4.17 mmol/L. Her ECG and chest x-ray were normal. Ultrasonography showed a large sub-serous fibroid 80mm×40mm arising from the posterior wall of uterus and ovaries were seen normally.

Abdomen was opened by Pfannenstiel's incision. Uterus was 8-10 weeks size and both ovaries were found to be normal. A mass was found in the rectovaginal space. Total abdominal hysterectomy was done. A mass of about 8cm×4.5cm was removed from rectovaginal space separately by blunt dissection followed by obliteration of the cavity maintaining the haemostasis.

Total operative time was 2 hours .One unit packed red cells was transfused intraoperatively. On gross examination uterus was 8-10 weeks size and cervix was eroded and hypertrophied. On cut section a 2cm×2cm size intramural leiomyoma with myohyperplasia was seen. The patient stood the procedure well and her postoperative period was uneventful. Stitches were removed on 8th postoperative day and she was discharged in good condition. Histopathological examination of the specimen revealed chronic cervicitis, and uterine intramural leiomyoma and the separate mass (rectovaginal) was also found to be leiomyoma.

## DISCUSSION

This case had presentation like leiomyoma of uterus. Her three preoperative USG (figure 1 and 2) showed posterior wall subserous leiomyoma, the later reports may have been biased with the previous report. On laparotomy it was found to be a leiomyoma of rectovaginal space (parasitic fibroid) and was removed with difficulty.

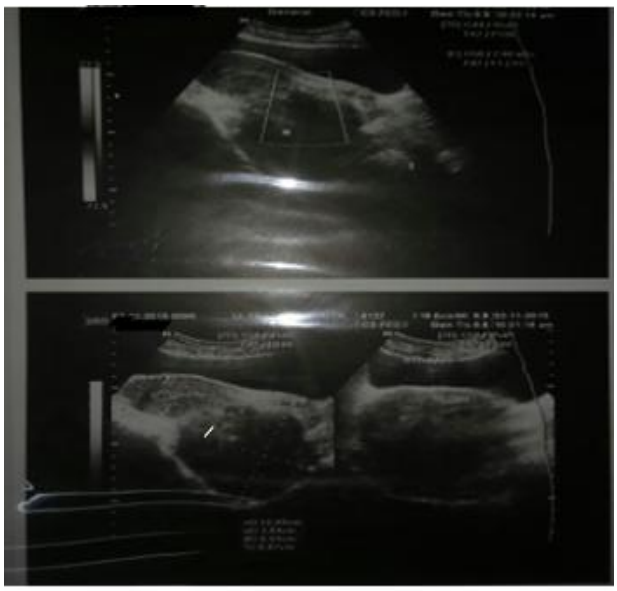

**Figure 1: Ultrasonography film of the patient**

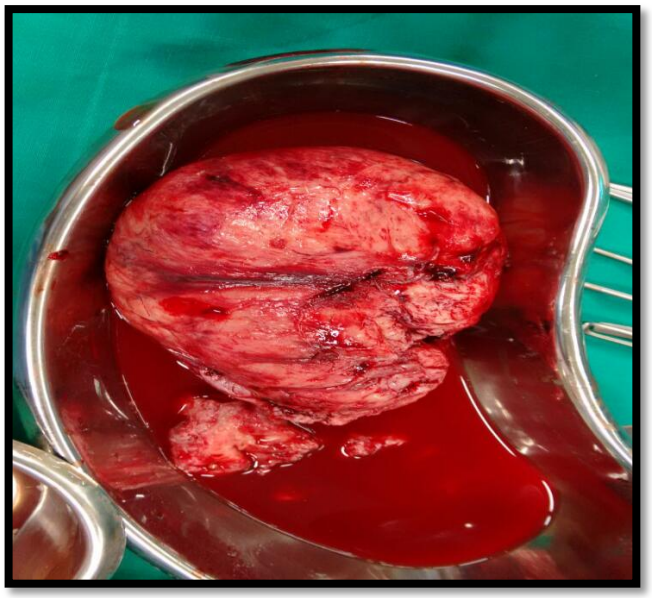

**Figure 2: Gross appearance of fibroid of rectovaginal space**

Leiomyoma of rectovaginal space is a rare entity. In most reported cases of parasitic leiomyoma the diagnosis is made at the time of surgery. Zaitoon (1986) reported a case of retroperitoneal parasitic leiomyoma causing ureteric obstruction.

Uterine leiomyoma are common benign pelvic tumours with an incidence of 20% in women aged 30 years and above. The majority of myomas arise in the uterus but they may also arise from the round ligament, infundibulopelvic and uterosacral ligaments, vagina, and vulva.

There may be variable clinical presentation and a broad differential diagnosis that can lead to preoperative misdiagnosis. Therefore even though parasitic leiomyomas are rare tumours they should be included in

the differential diagnosis of pelvic or abdominal tumours in female subjects (Buhimschi and Marvel, 2001).

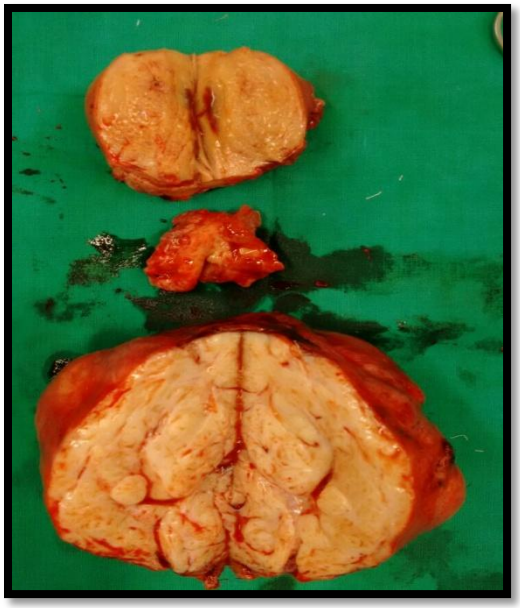

**Figure 3: Cut section of uterus(above), cervix(middle), fibroid(bottom)**

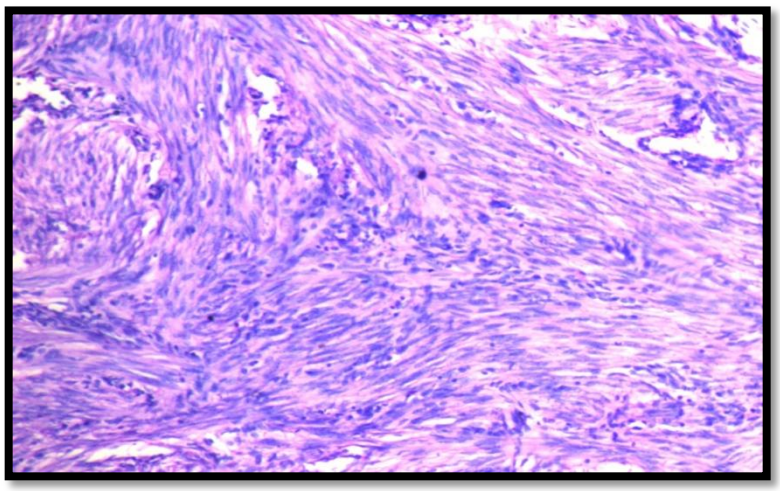

**Figure 4: Histopathology confirming leiomyoma in the mass of rectovaginal space**

**REFERENCES**

**Bhatla N (2001).** Tumours of the corpus uteri. In: *Jeffcoates Principles of Gynaecology*, 5th edition (London: Arnold Publisher) 470.

**Buhimschi CS and Marvel RP (2001).** Degenerated uterine eiomyoma mimicking a hematoma associated with gas formation. *International Journal of Gynecology & Obstetrics* **73** 271-273.

**Jonathan S Berek (2002).** Benign Diseases of the Female Reproductive Tract. In: *Novak's Gynecology*, 13th edition (Lippincott Williams & Wilkins) Philadelphia 380.

**Parasitic Myoma (2009).** After Morcellation Rakesh Sinha, Meenakshi Sundaram, Smita Lakhotia, Pratima Kadam, Gayatri Rao, and Chaitali Mahajan. *Journal of Gynecological Endoscopy and Surgery* **1**(2) 113–115.

**Zaitoon MM (1986).** Retroperitoneal parasitic leiomyoma. *Journal of Urology* **135**(1) 130-1.