

Case Report

ASYMPTOMATIC MULTIPLE LARGE UTERINE FIBRIOD IN YOUNG WOMAN

***Shilpa Tiwari and Sonal Agrawal**

Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences Bhopal

**Author for Correspondence*

ABSTRACT

Uterine fibroids are the commonest benign uterine tumors in women. It has an estimated incidence of 20%–40% in women during their reproductive years. They are often asymptomatic but they can cause a multiple symptoms such as abnormal uterine bleeding, a feeling of pelvic pressure, urinary incontinence or retention or pain. They may also be associated with reproductive problems such as infertility and miscarriage. Though most fibroids are asymptomatic and are discovered accidentally during pelvic examination or during ultrasonography ordered for some other reasons, there is a recommendation to remove asymptomatic large leiomyomata as it is impossible to predict which and when the patient will start developing symptoms. We present a case report of asymptomatic multiple large fibroid in a nulligravida patient.

Keywords: *Leiomyoma, Large Fibriod, Myomectomy*

CASES

A 35 year old female came to gynaecology opd with complaints of pain abdomen on and off which was diffuse, dullache and was relieved without any medication since one year. There were no associated bowel and bladder complaints. Her menstrual cycles were regular, normal flow without dysmenorrhoea. She was nulligravida with a marital life of one year. There was no significant medical or surgical history. On examination, her general condition was fair and vitals were stable.

On abdominal inspection, abdomen was slightly uniformly distended, no dilated veins or scars were present, umbilicus was centrally situated and inverted.

On palpation, a large firm irregular, non tender mass of around 26-28 weeks occupying right iliac, right lumbar, right hypochondrium and umbilical region found. Mass was slightly mobile from side to side and lower end of the mass could not be reached.

On per speculum examination, cervix and vagina were normal looking and healthy. Pap smear was taken.

On per vaginum examination, a large firm irregular non tender mass of 26-28wks with restricted mobility felt, uterus cannot be felt separately, movements of mass are transferred to cervix, fullness on adnexa felt.

On ultrasound uterine size was 16x10x10 cm. A big fibroid of 12 x 9 cm seen at anterior wall compressing the myometrium and endometrium. Another 11.7 x 9 cm subserosal fibroid seen at fundus. Both ovary were normal. On MRI, approximately 117 x 100 x 130 mm sized large intramural/ subserosal fibroid seen on anterior uterine wall in fundal region extending downward upto cervix causing compression of uterine endometrium posteriorly and towards right side of abdomen. The myometrium also compressed by fibroid. About 115 x 112 x 150 mm sized another big subserosal fibroid seen in right adnexa extending into right iliac fossa. Uterus is compressed posteriorly by big fibroid.

Myomectomy planned for the patient keeping in mind her future fertility prospect. Abdomen opened through transverse incision. Peritoneum was stretched over the mass. After careful assessment three masses were found, one large (12x8cm) intramural fibroid arising from anterior surface of uterus upto cervix, one large subserosal fibroid (12x8cm) arising from intramural fibroid, one subserosal fibroid with of 5x5cm. Figure (A) (B). Right Fallopian tube was stretched over the mass, left tubes were found to be normal. Bilateral ovaries were normal. Myomectomy and uterine reconstruction done successfully Figure (C). The resected specimen was of 2kg weight. She received one PRBC intraoperatively and one in postoperative period. Blood loss was 1500ml. Postoperative period was uneventful and patient was discharged on 8th postoperative day.

Case Report

HPE report confirmed the diagnosis of leiomyomata.

DISCUSSION

Uterine fibroids (also known as leiomyomas or myomas) are the commonest benign uterine tumors, with an estimated incidence of 20%–40% in women during their reproductive years (Ryan et al., 2005; Wallach and Vlahos, 2004). They composed mainly of smooth muscle cells but containing varying amount of fibrous connective tissue.

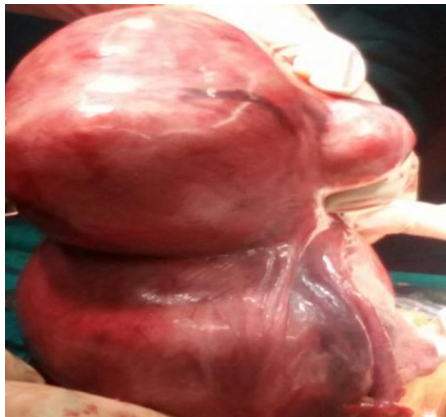


Figure (A)

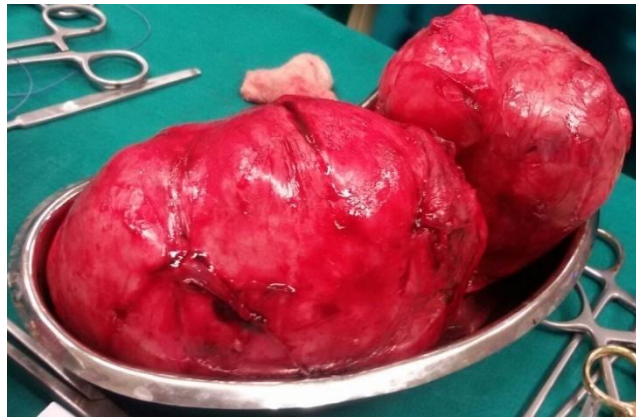


Figure (B)

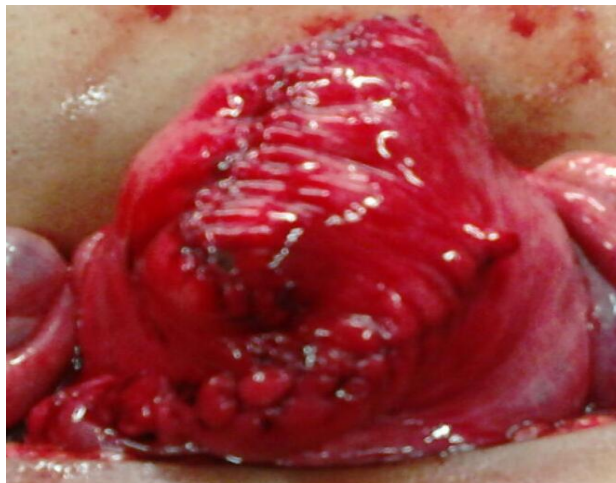


Figure (c)

The growth of leiomyoma is estrogen dependent. Continuous estrogen secretion uninterrupted by pregnancy is thought to be most important risk factor in the development of myoma., other risk factor include black race, heredity, nulliparity, obesity, polycystic ovary syndrome, diabetes and hypertension (Okolo, 2008). They are classified by their location relative to the layers of the uterus (as subserous, intramural, or submucous) and can be single or multiple. Among the three, submucous variety is known to show maximum symptoms and the subserous is least symptomatic. Fibroids can lead to symptoms like menorrhagia, abdominal pain, pressure symptoms on nearing viscera and abdominal swelling, pelvic pain or bulkiness, dyspareunia, increased urinary frequency and infertility. Though majority of fibroids are asymptomatic (Okolo, 2008; Schwartz *et al.*, 2000) and are discovered accidentally during pelvic examination or during ultrasonography ordered for some other reasons, there is a recommendation to remove asymptomatic large leiomyomata as it is impossible to predict which and when the patient will start developing symptoms. Hence, it is better to remove them when the patient has less operative risk and

Case Report

when the size usually is 12-14 weeks gestational size. Treatment options include hysterectomy, myomectomy, uterine artery embolization (UAE), myolysis, and medical therapy. Treatment must be individualized based on such considerations as the presence and severity of symptoms, the patient's desire for definitive treatment, the desire to preserve childbearing capacity. According to rcog guideline 2013 the evidence for the beneficial effect of myomectomy or UAE on infertility or pregnancy is weak (myomectomy) or lacking entirely (UAE). And Cochrane review 2012 (Gupta *et al.*,) mentions that UAE is associated with higher rates of minor complications and increased likelihood of requiring surgical intervention within two to five years of initial procedure. In this patient the decision of open myomectomy was taken keeping in consideration the size of fibroid and the future fertility aspect. Although asymptomatic fibroid was impinging the endometrium, so to improve patients fertility prospectus, decision of myomectomy was taken.

REFERENCES

- Gupta JK, Sinha A, Lumsden MA and Hickey N (No Date).** Cochrane database of systemic reviews: uterine artery embolisation for symptomatic uterine fibroid. Available: <http://onlinelibrary.wiley.com/doi/10.1002/14651858>.
- Okolo S (2008).** Incidence, aetiology and epidemiology of uterine fibroids. *Best Practice & Research Clinical Obstetrics & Gynaecology* **22**(4) 571-88.
- Ryan GL, Syrop CH and Van Voorhis BJ (2005).** Role, epidemiology, and natural history of benign uterine mass lesions. *Clinical Obstetrics and Gynecology* **48** 312–324.
- Schwartz SM, Marshall LM and Baird D (2000).** Epidemiologic contributions to understanding the etiology of uterine leiomyomata. *Environmental Health Perspectives* **108**(Suppl 5) 821–827.
- Wallach EE and Vlahos NF (2004).** Uterine myomas, an overview of development, clinical features, and management. *Obstetrics & Gynecology* **104** 393–406.