Two Uncommon Presentation of Cervical Fibroids

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Abstract:

Most of the leiomyomas are situated in the body of the uterus, but in 1-2% of the cases, they are confined to cervix and usually to the supravaginal portion. A cervical leiomyoma is commonly single and is either interstitial or subserous. Rarely it becomes submucous and polypoidal (Kumar et al, 2008). Two cases of cervical leiomyoma admitted with symptoms of menstrual abnormality are being presented. Cervical fibroids were attached to the cervical lips, were sub-mucous, sessile and were removed by vaginal myomectomy leaving the uterus intact.

Key Words: Cervical Fibroid, Vaginal myomectomy

Introduction:

Leiomyomas are the most common tumours of the uterus. They are responsible for about 1/3rd of hospital admissions to Gynaecology Department. Growth of leiomyoma is dependent on oestrogen production. The tumour thrives during the period of greatest ovarian activity. Continuous oestrogen secretion especially when uninterrupted by pregnancy and lactation is thought to be the most important risk factor in development of myomata. After menopause, with regression of ovarian oestrogen secretion, growth of leiomyoma usually ceases. Cervical fibroids develop in the wall of cervix (Tiltman, 1998). They can change the shape of the cervix or may lengthen it. If cervical fibroid get bigger, it may even push the uterus upwards. In some cases, cervical fibroid may grow rapidly and can obstruct the cervix. A cervical fibroid can lead to urinary retention, urinary frequency, constipation, menstrual abnormalities, dyspareunia, and sometimes post coital bleeding. Large cervical fibroids are difficult to handle and need an expert hand to operate these cases (Kshirsagar & Laddad, 2011).

Case 1:

A 20 years old patient came with the history of off and on bleeding per vaginum for last 6 months. She was married 1 year back and was nullipara. On general examination her blood pressure was 100/60 mm Hg and pallor +++. Her systemic examination including per abdominal examination was normal. Local examination of perineum showed a mass of a size of about 5 cm x 3 cm, coming out of vulva and there was bleeding per vaginum. Per speculum examination, revealed, growth coming out of cervix. Per vaginum examination showed uterus of normal size and fornices were clear. Per rectal examination revealed no additional finding.

Fig I: Cervical Fibroid seen on Local Examination.

Fig II: Cervical Fibroid seen on per Speculum Examination.
Her haemoglobin was 3.4gm/dl, TLC 6300/cmm, DLC-P90, L08, E01 & M01, Blood Group was AB+ve. She was given blood transfusion. Vaginal myomectomy was done under aseptic conditions. It was removed by blunt and sharp dissection. Mass was attached to inside of the anterior cervical lip. It was sessile and had broad attachment at cervix. Haemostasis at base of attachment was achieved by haemostatic sutures and cautery. On Gross examination, it was found to be 6cm x 7cm in size, smooth with irregular surface. Cut section showed whorled appearance suggestive of leiomyoma.

Histopathological examination confirmed the diagnosis of leiomyoma.

Case 2:

A 25 years old female was P4+1, admitted with complaints of off and on bleeding per vaginum for last 6 months. Her general examination was normal. On per speculum examination, an ulcerating growth was seen filling up whole vagina. Cervix could not be visualised. On per vaginal examination, cervix could not be felt and growth was continuous with the uterus. The uterus was around 12-14 weeks in size and fornices were clear. Per rectal examination was normal. Her haemoglobin was 8gm/dl; TLC 9,700/cmm; DLC- P76, L20, E04 & M0. Blood transfusion was given to her. Examination under anaesthesia was done. A large firm solid growth was seen filling whole vagina. A thin rim of cervix surrounding growth was seen on posterior part of the growth. The growth was sessile with broad attachment, arising from inside the cervical lip on right lateral part. Cervical canal was dilated. Whole of the mass was removed by blunt and sharp dissection. Bleeding at the base of growth was controlled by haemostatic sutures and electro-cauterization. On gross examination, size of the leiomyoma was 9cm x 7cm. It had irregular surface with some areas of ulcerations. On cut section, it had whorled appearance suggestive of leiomyoma. Histopathological examination confirmed the diagnosis of leiomyoma of the uterus.

Discussion:

Uterine myoma is the most common indication of hysterectomy. Presence of isolated fibromyoma in cervix with intact uterus is frequent. Cervical fibroids with excessive growth are uncommon. Cervical fibroids generally don’t affect women’s ability to become pregnant though cervical fibroids with pregnancy is rare. These fibroids grossly and histopathologically identical to those found in the corpus. Fibroids with excessive growth may cause pressure symptoms. Treatment of cervical fibroid is either hysterectomy or myomectomy (Basnet et al, 2005). They may give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter (Kshirsagar & Laddad, 2011). But difficulty may be avoided by vaginal myomectomy, as tumour is inside cervical canal. Myomectomy can be performed by vaginal route in selected cases with low morbidity and a good short term success rate. It requires no skin incision and can be performed on the patients with submucous fibroids (Davies et al, 1999).

Bibliography:


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