

CASE REPORT

A case of Giant Uterine Fibroid in a Young Woman

Safa M.Al-Obaidi , Mohammed Abd-Zaid Akool

ABSTRACT:

The incidence of uterine fibroid tumor increase as women grow older and they may occur in more than 30 percent of women 40 to 60 years of age. Risk factors include nulliparity, obesity, family history, black race, and hypertension.

These neoplasms frequently cause abnormal period, pelvic pain, and pressure symptoms. We present a case report of a large leiomyoma in an adult woman.

KEYWORD: leiomyoma, giant uterine fibroid

CASE REPORT:

An adult unmarried woman of 40 year old presented to us in private clinic at 4 May 2010 with painless lump and abdominal distension for 3 years duration. Initially the lower abdominal swelling not associated with any symptoms apart from vague abdominal discomfort especially after meals.

In the next months this swelling increases in its size in both direction upward and lateral direction in manner similar to pregnancy. There was history of nausea, vomiting, and loss of appetite, weight loss of more than 15 kilogram in the last year. There was history of bowel and bladder

discomfort (constipation, difficulty in initiation of micturition and sometime urgency), bilateral leg edema especially at the end of day.

Menarche was at 13 year and menstrual irregularity was reported for about 10 years prior to presentation .She denial prior sexual activity and use of hormones. Her past medical and surgical history was not significant.

On abdominal examination there was hugely distended abdomen asymmetrical, although restricted but still move with respiration, centrally everted umbilicus but no visible cough impulse through it, an intraabdominal mass occupying hypogastrium, umbilical region extending into iliac and lumber areas bilaterally.

No tenderness or indentation and cannot get around it whether from above (as it extend under costal margins) or from below (as it extend deeply into pelvis). In spite of that still there was little bimanual sideway motility but not moving in craniocaudal direction.

Digital rectal examination: solid mass impinging into the cal de sac (Douglas pouch) no excitation, no mucosal tethering .Fig.(1),(2).



Figure(1)



Figure(2)

Al-Ameer private Hospital Najaf-Iraq.

GIANT UTERINE FIBROID

Abdominal ultrasound: very big mass occupying whole abdominal cavity mostly solid (hyperechoic in nature with area of hypoechoic due to cystic degeneration) mostly of pelvic origin.

Abdominal computed tomography: revealed very big mass occupying whole peritoneal cavity, displaced bowel upward and laterally, solid in

nature with area of cystic degeneration mostly of uterine in origin.

On laparotomy: through mid-line incision we found big mass extended from diaphragm to pelvic floor, and after adequate assessment with extension of incision delivery of the mass done .Fig.(3),(4).



Figure(3)



Figure(4)

After careful assessment of this mass, we found it arise from posterior wall of stretched atrophied uterus with very big tortuous blood vessels between them, also there was atrophied ovaries with very big multiple cystic degeneration.

Stretched peritoneum alters normal anatomy of the pelvis, where we found the right ureter arching over the anterolateral aspect of the mass, while the bladder pushed inferolaterally.Fig.(5),Fig. (6).



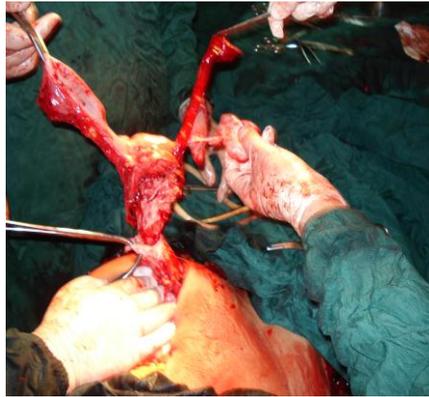
Figure(5)



Figure (6)

Total hysterectomy with bilateral salpingoopheractomy done, due to inability to separate the myometrium (the mass) from the atrophied uterus and also because diseased

multicystic ovaries. Great effort to avoid injury to a lot of vital pelvis structures in spite of altered anatomy owing to the effect of giant fibroid. Fig (7),Fig(8).This operation done totally by surgical team only .



Figure(7)

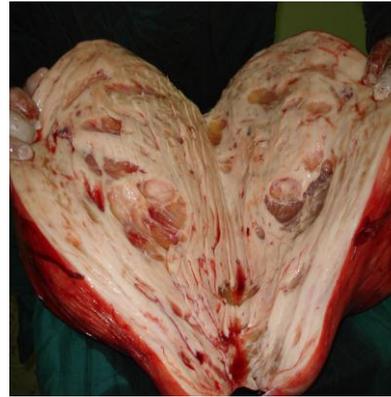


Figure (8)

The resected specimen was 19.8 kg in weight and dimensions were 60 x 45 x 25 cm. Postoperative period was uneventful. Histopathology showed benign fibroid of uterus and cystic degeneration of benign ovarian tissue. Patient had uneventful follow-up for one year.

DISCUSSION:

Leiomyoma of the uterus is the most common tumor of the female pelvis. These tumors are present in approximately one-third of women of reproductive age. These neoplasms frequently cause abnormal periods, pelvic pain, and pressure symptoms of surrounding organs. Large leiomyoma may compress the bladder and/or uterus, with potential for renal damage if not correlated^(1,2,3)

Although a causal relationship has not been established, fibroid tumors are associated with menorrhagia, pelvic pain, or urinary obstruction symptoms, infertility, and pregnancy loss. Transvaginal ultrasonography, magnetic resonance imaging, sonohysterography, and hysteroscopy are available to evaluate the size and position of tumor. Ultrasonography should be used initially because it is the least invasive and most effective investigation. Knowing the full range of treatment options enables surgeons and physicians to counsel patients about the optimal management of symptomatic uterine fibroid tumors. The number of treatment options is increasing and includes expectant management, surgery, uterine artery embolization, ablation technique, and medical management.^(4, 5, 6)

So treatment options include hysterectomy, myomectomy, uterine artery embolization, 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, the importance of uterine preservation, infertility related to uterine cavity distortion, and previous pregnancy complications related to fibroid tumor.^(7, 8)

Hysterectomy: The presence of uterine fibroid tumors is the most common indication cited for hysterectomy, accounting for more than 30 percent of these procedures. Although most hysterectomies in women with fibroid tumors are performed for symptom relief, the procedure is sometimes recommended to symptomatic women whose uterine size is estimated to be greater than 12 weeks gestation. Common justifications for this recommendation include the risk that tumor of this size could potentially mask other adnexal pathology, increase operative morbidity rates, and become malignant.^(9, 10, 11)

Medical therapy for abnormal bleeding and chronic pelvic pain in association with uterine fibroid produced significant improvements, but one quarter of the non-surgical group subsequently underwent hysterectomy.^(12, 13)

Not all women who treated surgically reported improvement and bilateral oophorectomy was significantly associated with poor outcome.⁽¹⁴⁾

Most studies evaluating the effect of hysterectomy on sexuality are poorly designed, but the available evidence suggested that hysterectomy does not adversely affect sexuality.⁽¹⁴⁾

Other treatment options:

Expectant management:

Expected management with observation is increasingly recognized as a reasonable course for women with asymptomatic small and large fibroid uteri.^(15, 16)

Myomectomy:

Myomectomy (i.e., surgical removal of fibroid tumors while preserving the uterus) traditionally

has been performed by laparotomy. Endoscopic myomectomy is now treatment of option for many women, and hysteroscopic myomectomy may be considered in women with symptomatic sub mucosal fibroid tumors^(17, 18,19)

Uterine artery Embolization:

Uterine artery embolization is performing under intravenous sedation. Using a femoral approach, a micro-catheter is introduced into the uterine artery. Polyvinyl alcohol foam particle or other occlusion agents are then injected^(19, 20)

Myolysis:

Myolysis (i.e., delivering energy to tumor to desiccate them directly or disrupt their blood supply) is most often performed with the neodymium-doped yttrium aluminum garnet (Nd:Yag)laser or bipolar needles^(19,20)

MEDICAL TREATMENT:

Medical therapy is available for women with symptomatic fibroid tumor who prefer conservative management. This is mainly relied on hormonal therapy.^(19,20)

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