

FIBROID UTERUS: A CASE REPORTAbid Rashid¹, Sultan Ayaz^{2*}, Riaz ur Rehman², Ejaz Mohiuddin³

ABSTRACT: The most frequent benign tumors in females are fibroids which are muscular tumors and classically seen throughout the middle and later fertile years of reproductive cycle. These tumors arise usually from the smooth muscle layer of the uterus. Leiomyoma is the alternative medical term used to represent these fibroids tumors. Its size may be as little as a seed of an apple or it may be as large as a melon. In some exceptional cases, they can develop very huge. The use of high frequency ultrasonography and magnetic resonance imaging for diagnostic purpose has now made it easy to identify such cases at an early stage. Uterine fibroids tumors with asymptomatic features are often not subjected to any treatment. Giant fibroids tumors are the fibroids having two or three tumors jointly. Such type of fibroid usually appears as a single fibroid. These Giant uterine fibroid are very infrequent tumors and characterizes a significant diagnostic and prognostic challenges to clinicians and surgeons. This article demonstrates a case of 20 years old female diagnosed with a mass in lower abdomen with pain, gradually increasing abdominal size with speedy growth in the past 6 months connected with difficulty of breathing, significant anemia and pain in lower abdomen. Surgical excision of fibroid tumor was done. Post operatively patient recovery was uneventful.

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INTRODUCTION

Leiomyoma also known as fibroid tumors are characterized as benign tumors which usually arise in the uterus (1). Even though they are structurally made of the smooth muscle fibers which the structural fibers of the uterine wall, however fibroids fibers are usually considerable thicker than normal myometrium of uterine wall. These benign tumors are usually round shaped. They are most often found inside the uterine cavity. Some uterine tumors known as subserosal fibroids are situated below the serosa which is the membrane layer located outside of the uterus. These fibroids frequently are usually restricted to the outer layer of the uterus (2). Some tumors known as submucosal fibroids tumors are situated on inner side of the

uterus under the inner lining of the uterine cavity. Some tumors known as intramural fibroids are situated inside the muscular wall of the uterine cavity (3). They are found in nearly half of women over age forty; the prevalence increases during the reproductive age and decreases after menopause. But large fibroid now a day with advent of easy availability of ultrasonography is a rare condition. These tumors frequently cause abnormal menstrual blood loss, pelvic pain and pressure symptoms (4). The uterine fibroids that carry no symptoms are sometimes not given any treatment until and unless no critical emergency situation arises (5). However, large uterine fibroids often create surgical difficulties as it grows as a huge fibroid mass (6). A well-managed and interesting case of a fibroid uterus is presented here.

CASE REPORT:

A 20 years girl, resident of Faisalabad presented in a private hospital with a painful mass in lower abdomen and gradual enlargement of abdomen for last 6 months. She presented with clinical history of nausea, vomiting, decrease in weight, loss of appetite and pain in lower abdomen and on and off constipation. Regarding menstrual history menarche was at 13 years and she noticed menstrual irregularity and menorrhagia for last 6 months.

She was unmarried. She noticed a mass for last one year which was gradually increasing in size. She took some homeopathic and herbal medicine for treatment, in spite of this the mass was gradually increasing in size. Her previous medical, surgical and family history was unremarkable. She presented to this clinic as she noticed that over the past one year, the mass was growing more rapidly and she started to feel abdominal discomfort and shortness of breath. On physical examination, she was severely anaemic and had a grossly visible large mobile abdominal mass, which had extended up to the supra-umbilical region. On pelvic examination, she had a posteriorly displaced cervix with no lesions or inflammation. Her shortness of breath was likely due to the elevated diaphragm and severe anemia. Her hemoglobin level was 9.2 gm/dl.

Abdominal ultra-sonographic finding showed massive soft tissue mass originating from uterine cavity with partial cystic area in different regions. Her intravenous urography report was normal. After correcting anaemia with 2 pints bags of packed cell, laparotomy was done. Midline abdominal incision was given. Uterus was hugely enlarged tightly occupying whole abdomen. Uterus was adherent posteriorly to the sacrum, occupying whole of the pelvis with restricted mobility. Fallopian tubes and ovaries could not be reached. Transverse incision was given in the uterus and single mass of fibroid tumor was removed to reduce the size of uterus. The resected specimen was 3 kg in weight. As the

tumor was with degenerative changes, bleeding was not as heavy as assumed. Although bleeding was average, one pint of blood transfusion was given during operation. Histopathology showed leiomyoma.

DISCUSSION

Leiomyoma/fibroma/fibroid is the commonest benign uterine tumor and accounts for the most common indication for hysterectomy (7). They are usually diagnosed on physical examination. These fibroids usually exist in around one-third of female of middle and late reproductive age cycle (8). The weight of the above discussed tumour was 3 kg. Fibroid uterine tumors are uncommon. These fibroids most often result in irregular menstrual cycles, pain in pelvic region, and exerts pressure symptoms on adjacent tissues and organs (9). They may be fatal in some cases when pressure effects involve the lungs, urinary bladder, ureters and other neighboring organs (10).

The case presented here, indicates that the myoma was intramural and pedunculated. After removal of the myoma of uterus, fallopian tubes and ovaries were visualized. Right ovary was polycystic and diathermy cauterization was done. She had at first no symptoms: so patient herself enjoyed expectant management and consulted with doctor when pressure symptoms started. Myomas are initially screened by ultrasound which is used as a first diagnostic tool for this purpose (11). With the arrival of MRI scan as a diagnostic tool, the accuracy for diagnosis, size, and position of these fibroids tumors, as well as distinction from an adnexal mass has been highly improved, MRI has also been characterized to be the highly costly tool used for assessing uterine fibroid (12). Computed tomography (CT) scan has also been utilized as a diagnostic feature to assess the fibroids tumors. But the utilization of this tool is not frequently recommended to assess cases of uterine fibroids because it carries high rate of uterine complications such as necrosis and malignant transformation of benign fibroid tumors (13). In this case ultrasonography and intravenous urography was done to explore the

position of ureters. The treatment possibilities to treat this fibroid contains uterine artery embolization, ablative procedures, expectant management, surgery, and medical management (14). Medical management includes prescription of gonadotropin-releasing hormone analogue which has been used to suppress estrogen production, which ultimately decreases the mass of prevailing fibroids to make them feasible for laparoscopic surgery (15). Even fast developing lumps may not be excised as routine practiced because the possibility of a malignant leiomyosarcoma is very rare, only 0.23 percent has been reported in one study (16). Proper counseling and probability of myomectomy is suggested in patients carrying symptomatic fibroids as well as in those patients with huge, asymptomatic fibroids in order to maintain productiveness and menstrual function in young female patients (17). If the medical treatment continued for long time, it is usually connected with extraordinary cost, weakness of bone due to demineralization, high risk of reoccurrence and menopausal symptoms. Before surgery, it is important to counsel the patients. This is needed because patients undergo an extreme amount of stress, anxiety, and depression when faced with such a big tumor (18). Discussing the low likelihood of malignancy will help to quell above feelings as well as assist in obtaining informed consent for surgery. Surgical resection of huge fibroids tumors may also result in loss of fertility and may affect the outcome of pregnancy (19). For our patient, surgical management was

needed. An exploratory laparotomy was the only method available due to the size of the mass. Large fibroid tumors as diagnosed in this patient, carries a high surgical task. In patients with fibroid tumors, the combined preoperative and postoperative mortality rates were observed as 14-16% in non-pregnant patients (20). The risk of massive blood loss specifically due to increased vascularity of the tumors is the major technical hazard of surgical removal of large uterine fibroids. There might be other technical difficulties which also carries increase risk of injury to the ureter (21). In some research studies it was found very effective to use Uterine Artery Embolisation (UAE), as a pre-surgical management to reduce intraoperative blood loss. This type of treatment was described to be highly cost effective than myomectomy and hysterectomy (22).

CONCLUSION:

An atypical presentation of fibroids is often confusing to clinicians. A fibroid can grow to a large size as exemplified in this case. Uterine fibroids should be considered in young women who presents with complaints of abdominal pain and pelvic mass. The plan of management of uterine fibroids in this age group should include the surgical procedures with the special objective to preserve fertility of young female patient. Precise analysis of the etiology of uterine fibroids in this age group is highly significant for future counseling and proper management of the patients.



Fig.1



Fig.2



Fig.1

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