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Managing Cervical Fibroids: A Challenge for the Gynaecologist

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Abstract **Original Research Article**

Cervical fibroids are rare varieties of leiomyomas. They can present with abdominal mass, menstrual abnormalities, urinary problems. Operating cervical fibroids are a real challenge for the gynaecologists because of high risk of intraoperative hemorrhage. We hereby present four cases of cervical fibroids managed by Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy. We conclude that large cervical fibroids are extremely rare and require utmost expertise to operate without causing bladder injury or hemorrhage.

Keywords: Cervical fibroids, hysterectomy, bladder injury.

INTRODUCTION

Leiomyomas are benign smooth muscle tumors. Leiomyoma of the uterus, also called fibroid, is the commonest uterine tumor. The incidence of leiomyoma is 20% in the reproductive age group. However, cervical fibroids are relatively rare, only 1-2% [1]. Anatomically, cervical fibroids may develop from supravaginal and vaginal part of cervix [2]. Positionally, they are classified as anterior, posterior, lateral & central. The symptoms vary according to the type. Patients commonly present with menstrual abnormalities, acute retention of urine and constipation. Sometimes patient can come with only abdominal distension or abdominal mass and weight loss mimicking an ovarian tumor [3]. Rapidly growing cervical fibroids can push up the uterus, distort the cervix, cause obstruction in the cervical canal and can even cause cervical elongation. Large cervical fibroids can compress adnexal structures causing complications like hydroureter and urinary emergencies [4]. Operating large cervical fibroids is quite challenging to the gynaecologist because of high risk of intraoperative hemorrhage which may end up with ligating bilateral internal iliac arteries.

MATERIALS AND METHODS

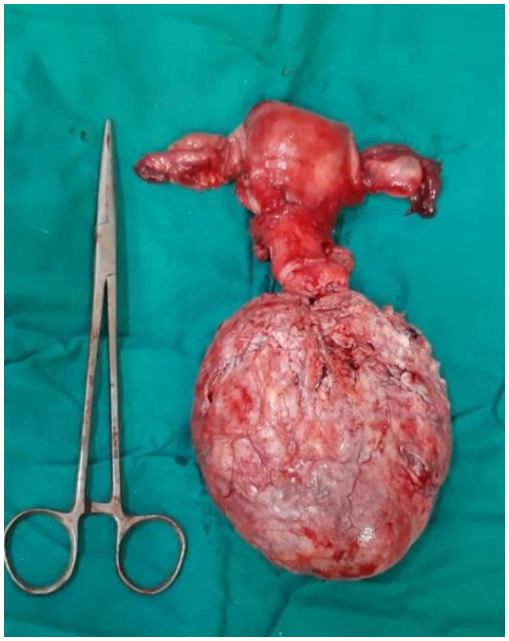
A prospective study was carried out at our institute, Bankura Sammilami Medical College, in rural part of West Bengal, from July 2017 to June 2019. During this period, 4 cases of cervical fibroid were diagnosed, worked out and managed. Relevant history, presenting complaints, clinical findings, diagnostic images, surgical details, intra-operative findings and histopathology were all recorded. Individual cases are summarized in Table 1 and Pictures 1,2,3,4.

Table-1: Summary of 4 cervical fibroid cases

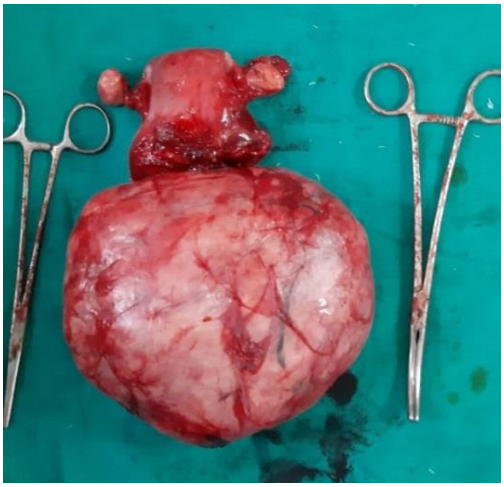
Parameters	Case 1	Case2	Case 3	Case 4
Age	51 years	42 years	44 years	48 years
Parity	P3L3, bilateral tubectomy done	P2L2, not sterilized	P4L4, not sterilized	P2L2, sterilized
Complaints during presentation	Perimenopausal irregular bleeding for 2 years, pain abdomen, excessive whitish discharge per vaginum	Menorrhagia for 1 year not controlled by medications	Menometrorrhagia for 8 months refractory to treatment, heaviness in lower abdomen	Excessive irregular bleeding per vaginum for 1year 6 months
Past history	Hypothyroid	Patient had fibroadenoma of breast which was removed 15 years ago. Also Cholecystectomy was done 2 years back	Nothing significant	Diabetic for 6 years, Hypertensive for 10 years, Hypothyroid
Significant general findings	BMI 29, mild pallor	Obese, BMI 32, severe pallor	Mild pallor	Mild pallor
Per abdominal examination	Firm mass, 18 weeks size	Firm mass, 24 weeks size, non-tender, non-mobile	Uterus 16-18 weeks size with restricted mobility, non-tender	Uterus bulky
Per speculum examination	Cervix posteriorly directed. A buldging mass seen in upper vagina.	Cervix not visualized, pulled high up. A buldging mass seen in upper vagina.	Cervix not visualized. A buldging mass seen in upper vagina.	Mass of size 6x4 cm coming out per vaginum
Per vaginum examination	Variegated huge mass felt anteriorly. Fornices obliterated. Cervix is extremely posteriorly directed. Uterus not felt separately.	Firm mass felt anteriorly. Cervix could not be felt separately. Uterus was not felt. Pouch of Douglas obliterated. Pedicle could not be reached.	Cervical opening not found. Huge growth felt in pelvis. Bilateral fornices obliterated. Uterus not felt separately. Huge mass, proper size could not be assessed.	Large solid mass coming from cervix. Pedicle could not be reached. Cervical rim felt posteriorly.
USG	9x7 cm mass in lower part of uterus. (?) Posterior wall fibroid or cervical fibroid. Right and left ovary normal.	15x10 cm cervical fibroid with bilateral mild hydrouretero- nephrotic changes	Anterior wall fibroid 18x14 cm. Right and left ovary normal.	8x6 cm cervical fibroid. Uterus bulky. Right and left ovary normal.
CECT scan	A large mixed echogenic mass 10x14 cm with signs of degeneration. Possibly degenerated cervical fibroid. Mild left hydro-Ureteronephrosis noted.	Not done	Large mixed 20x15 cm mass with mild vascularity probably fibroid arising from lower part of uterus or cervical fibroid. Right hydrouretero-Nephrosis present.	Not done

Table-1: Summary of 4 cervical fibroid cases (cont)

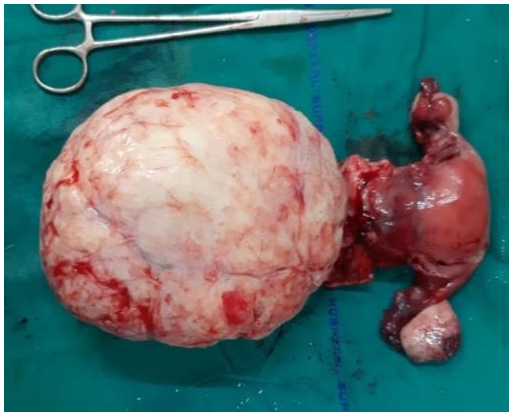
Parameters	Case 1	Case2	Case 3	Case 4
Treatment	Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy	Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy	Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy	Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy
Intraoperative findings	Bladder drawn up. Huge pedunculated cervical fibroidal polyp degenerating in nature arising from upper part of cervix and coming out of vagina.	16x14 cm well capsulated cervical fibroid noted. Uterus was deviated posteriorly. Uterus and both ovaries normal size.	Uterus normal size. 20x15 cm well capsulated cervical fibroid removed.	Bladder drawn up. 10x7 cm cervical fibroid with characteristic Lantern on the dome of St. Paul's appearance.
Histopathologic findings	Degenerated leiomyoma with chronic cervicitis (Hyaline degeneration and multiple calcifications)	Leiomyoma	Cervical leiomyoma	Leiomyoma with hyaline degeneration



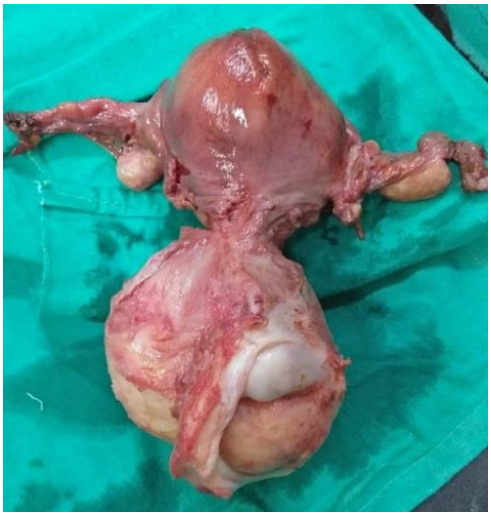
Picture-1: Case 1



Picture-2: Case 2



Picture-3: Case 3



Picture-4. Case-4. Lantern on the dome of St. Paul's appearance

RESULTS

All patients were in perimenopausal age group; mean age was around 46 years. Parity of the women ranged between 2 - 4. They presented with various menstrual abnormalities. One patient in addition had whitish discharge per vaginum. Two cases had abdominal lump, while other two had bulky uterus. In all cases, cervix was displaced or not visualized. The investigations done were USG Pelvis and contrast enhanced CT scan which revealed hydroureteronephrosis in 3 cases. In all cases, Total Abdominal Hysterectomy with bilateral Salphingo-oophorectomy was done.

DISCUSSION

There are several types of cervical fibroid with discrete modes of presentations. Cervical fibroids can originate from supravaginal or vaginal portion of the cervix. Supravaginal fibroids can be central surrounding the entire cervical canal and lying centrally in the pelvis displacing the uterus superiorly. They could also be unilateral or bilateral, intramural or subserosal and could be lying in the pelvis [5]. Pedunculated cervical fibroids can arise from the endocervical canal or from the uterine cavity and protrude through the cervix causing recurrent vaginal bleeding [6]. All of our patients underwent total abdominal hysterectomy with bilateral salphingo-oophorectomy. Operating on large cervical fibroid is indeed a surgical challenge as there is every possibility of urinary tract damage and fulminant hemorrhage. One of our cases was a central cervical fibroid characterized by typical Lantern on the dome of St. Paul's appearance. Mild hydroureteronephrosis was associated in almost all cases. Similar findings have been reported by other authors also [7].

CONCLUSION

Large cervical fibroids present rarely but with a wide range of clinical spectrum. It requires extreme

operative skill to avoid intraoperative bleeding and inadvertent injury to urinary tract.

REFERENCES

1. Bhatla N. Tumours of the corpus uteri. In: Jeffcoates Principles of Gynaecology. 5th ed. London: Arnold Publisher; 2001, 470.
2. Tiltman AJ. Leiomyoma of uterine cervix: A study of frequency. *Int J Gynaecol*. 1998;17:231-234
3. Suneja A, Taneja A, Guleria K, Yadav P, Agarwal N. Incarcerated procidentia due to cervical fibroid: An unusual presentation. *Aust N Z J Obstet Gynaecol*. 2003; 43:252-253.
4. Dutta DC. Benign lesions of the uterus. In: Textbook of Gynaecology including Contraception. 3rd ed. India: New Central Book Agency (p) Ltd; 2004,264.
5. Katz VL, Dotters DJ, Droegemueller W. Complications of uterine leiomyomas in pregnancy. *Obstetrics and Gynecology.* 1989; 73(4):593–596.
6. Oruc S, Karaen O, Kurtul O. Coexistence of a prolapsed pedunculated cervical myoma and pregnancy complications: a case study. *Journal of Reproductive Medicine.* 2004; 49(7):575–577.
7. Selvaraj S, Syamala O, Usharani G. Cervical Fibroids: A Surgical Challenge. *IOSR Journal of Dental and Medical Sciences.* 2018; 17(3): 68-70.