

A Rare Case of Large (6.5kg) Parasitic Leiomyoma

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Abstract

Case Report

Parasitic myomas are very rare tumours and hence they pose a real challenge to a clinician to have a correct preoperative clinical diagnosis. It may present with variable symptoms or maybe asymptomatic. We present this case of a large pedunculated highly vascular myoma of 36 wks size uterus (6.5kg) acquiring its blood supply from omentum and small gut mesentery mimicking a GIST tumor. Clinical and histopathological presentation and management is discussed in the current case.

Keywords: Wandering fibroid, Migrating fibroid, Parasitic Leiomyoma.

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INTRODUCTION

Uterine leiomyoma (UL) is the most common tumor affecting woman genital tract [1]. By the age of 35 years, at least 20% of women develop UL. When it occurs in its usual site, presentation, diagnosis and management are straightforward. But when it exists in unusual area, the diagnosis becomes challenging for both the treating gynaecologist and the histopathologist [2]. As per FIGO classification, Parasitic Leiomyoma (PL) has been categorized as Type 8 leiomyomas with no myometrial involvement and uterine attachment [3]. PL is an extremely rare disease with less than 30 reported cases in literature [4]. Studies suggest that a pedunculated subserosal myoma may develop a long stalk and become a “wandering or migrating leiomyoma [5]” such a tumor can grow on and adhere to surrounding structures and develop an auxiliary blood supply hence called Parasitic Leiomyoma (PL).

CASE REPORT

We report a case of 43 years old female, Para 2, Living 2 tubectomised came to a gynaecology outpatient department with chief complaints of pain, heaviness & distension of abdomen since 1 year. She was apparently alright one year back when she noticed distension and dull pain in lower abdomen for which she took treatment from a local practitioner without any relief, over last one year the mass had grown to the huge present size of about 36 wks pregnant uterus for which she was referred to SMBT hospital. Her

menstrual cycles were regular painless with moderate flow, she bled for 3-4 days every 30 days. In her obstetric history, she had previous full term normal vaginal deliveries, all home deliveries and uneventful. Her past history /personal/family history was not significant.

On physical examination, she was lean in built weighing 46kg, height 151cm. her general condition was fair, she was afebrile & vitals were stable, she did not have pallor. On per abdominal inspection the mass occupied the whole abdomen up to the xiphisternum. Palpation revealed the mass was soft, about the size of 36wks gravid uterus, surface was smooth and it was dull on percussion. Lower limit of mass could be reached. On per speculum examination cervix and vagina was healthy. On per vaginal examination revealed normal size uterus with regular surface, mobile, non-tender and the separate mobile mass of 35cm×40cm size was felt in the fornix separate from uterus. Keeping the provisional diagnosis of large pedunculated fibroid/ ovarian tumour, Patient was investigated; her ultrasonography revealed normal sized uterus and adnexa with 40×30×35cm size large heterogeneous lesion occupying the whole abdomen separate from uterus and ovary ?malignant. Her CT scan revealed 38×25×36 cm large heterogeneously enhancing soft tissue lesion in the pelvis and extending upto upper abdomen with multiple vascular channels from gastrophrenic, gastrocolic and anterior abdominal wall. Her CA125 –16.9u/ml, CEA-1.48ng/ml, CA19-9-57.99u/ml. USG guided biopsy revealed benign

leiomyomatous neoplasm negative for malignancy. Her preoperative blood investigations were normal. Patient was taken for exploratory laparotomy after appropriate counselling and arranging blood.

A vertical midline incision was taken over abdomen. Abdomen opened in layers. Multiple (50-60) large vascular channels were supplying the tumour from the omentum wrapped around it with a diameter ranging from 6-10mm and length ranging from 10-20 cm. All vascular supply to the tumor was ligated. The tumor was smooth and soft. The posterior surface of the tumor was firmly adherent to 10 cm portion of ileum and multiple vascular channels were connecting the mesentery and the tumor in that area. Resection and anastomosis of ileum was done and 10 cm of ileum attached to tumor was removed with tumor (keeping GIST/ PARASITIC FIBROID in differential diagnosis on table). The uterus and adenexa was completely separate from mass. TAH –BSO was performed. The highly vascular omentum with all its enlarged vascular channels was removed by doing omentectomy. Drain was kept and abdomen was closed in layers.



Fig-1: Highly vascular supply

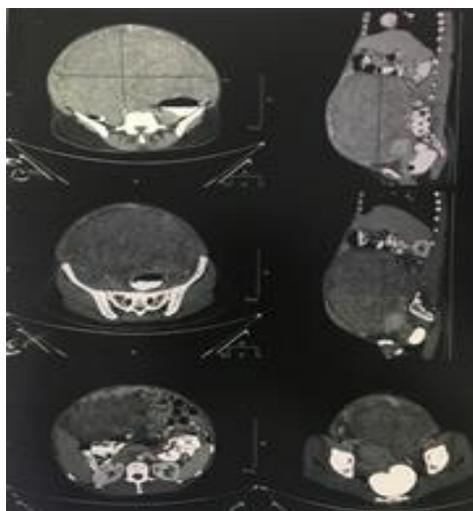


Fig-2: CT-Scan Images

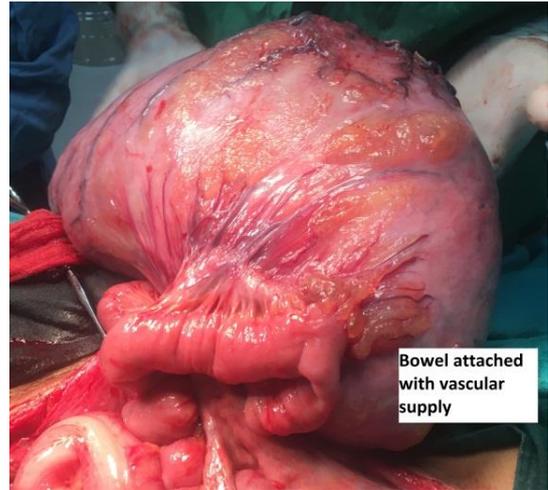


Fig-3: Bowel attached to Tumor

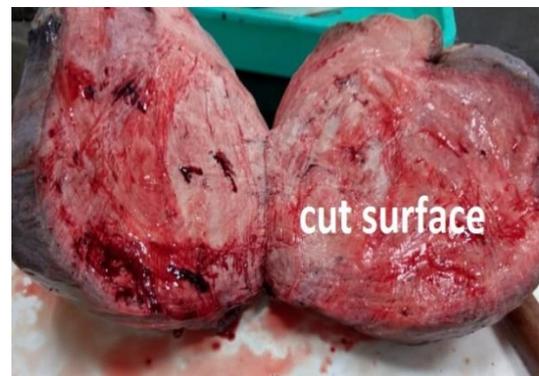


Fig-4: Cut Section

DISCUSSION

Myoma affects 20-50% of females in reproductive age group and they are easily diagnosed clinically and ultrasonographically [2]. PL are very rare extra-uterine tumors which are known for their atypical clinical presentation, unusual location and unusual blood supply making clinical and radiological diagnosis difficult for clinicians [2, 6]. Keeping PL as differential diagnosis of various abdominopelvic masses will prevent intraoperative surprises. Differential diagnosis for PL includes ovarian masses (primary tumour or metastatic disease), broad ligament fibroids and cysts. Transvaginal US may be of great help in differentiating broad ligament leiomyomas/cysts as it allows clear visual separation of the uterus and ovaries from the Parasitic Leiomyoma. MRI imaging, with its multiplanar imaging capabilities, also may be extremely useful for differentiating broad ligament leiomyomas, tuboovarian masses (broad ligament cysts, solid malignant pelvic tumors) and PL. In our case, the diagnosis of PL was made on the table though the radiologist had given us the very good clue of subserous pedunculated fibroid with multiple vascular supplies. As in our case Surgery for PL can be difficult in case of bowel and mesentery involvement hence bowel needs to be kept prepared in anticipation and patient should be informed about the extensive surgery and need of bowel resection, Laparoscopic surgeons should be aware of

this situation, and further investigation should be made in case of suspicion[7, 8].

CONCLUSION

Parasitic fibroids are a very rare presentation, difficult to diagnose clinically and radiologically, mimicking non-uterine abdomino-pelvic tumors especially when huge and need a definite histopathological reporting.

REFERENCES

1. Zaitoon MM. Retroperitoneal parasitic leiomyoma causing unilateral ureteral obstruction. *The Journal of urology*. 1986 Jan;135(1):130-1.
2. Grover A, Bhalla S. Parasitic leiomyoma: a rare complication following laparoscopic myomectomy with review of literature. *Current Medicine Research and Practice*. 2015 Dec 1;5(6):278-81.
3. Munro MG, Critchley HO, Broder MS, Fraser IS, FIGO Working Group on Menstrual Disorders. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. *International Journal of Gynecology & Obstetrics*. 2011 Apr 1;113(1):3-13.
4. Agha RA, Fowler AJ, Saeta A, Barai I, Rajmohan S, Orgill DP, Afifi R, Al-Ahmadi R, Albrecht J, Alsawadi A, Aronson J. The SCARE statement: consensus-based surgical case report guidelines. *International Journal of Surgery*. 2016 Oct 1;34:180-6.
5. Robbins SL, Cotran RS, Kumar V. *Pathologic basis of disease*. 3rd ed. Philadelphia (PA): WB Saunders; 1984.
6. Kelly HA, Cullen TS. *Myomata of uterus*. Philadelphia: W B Saunders; 1909
7. Okoro I, Ododo N, Egejuru R. Parasitic leiomyoma: a diagnostic dilemma: a case report. *Niger. J. Clin. Pract*. 2007;10(4):349–351.
8. Temizkan O, Erenel H, Arici B, Asicioglu O. A case of parasitic myoma 4 years after laparoscopic myomectomy. *J Minim Access Surg*. 2014;10(4):202-3.