

## A Rare Discovery of a Voluminous Cervical Myoma Prolapsed Out of the Introitus at Day 15 Post Spontaneous Vaginal Delivery

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### Abstract

### Case Report

Leiomyomas of the uterus are the most common pelvic tumors, occurring in nearly 70% of 45-year-old women. This case report presents a multiparous woman who presented with an intracervical myoma that remained undiagnosed prenatally and during pregnancy (with no antenatal checkups). The vaginal delivery was uneventful. The patient presented on day 15 of post-partum with a large sub mucosa fibroid which prolapsed out of the introitus. A myomectomy was performed by twisting and rotation via the vagina, without complications.

**Keywords:** Fibroids, postpartum, localization, twisting and rotation.

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## INTRODUCTION

Uterine fibroids or myomas or uterine leiomyomas are benign tumors that develop from the muscle fibers of the uterus. They can interfere with all stages of the reproductive period, from conception to pregnancy to child birth. They can be found in several locations: subserosal, intramural, intracavitary and cervical myomas. The latter, which are rare, can sometimes ulcerate, become infected and/or bleed.

In some cases, there is a prolapse which can range from a simple sensation of pressure or mass in the pelvis to the stage of exteriorization outside the genital tract.

The discovery of a myoma is a common situation that will raise questions and concerns depending on the context [1].

## CASE PRESENTATION

This is a clinical case of a patient, aged 40, G5 P4 with four previous vaginal deliveries; the last being four years ago. There were no complications in the immediate and late postpartum period during all her pregnancies. The patient never knew she had a myoma.

Her pregnancy, which was not monitored; was completed to term. In fact, she did not know the exact date of her last period and had not benefited from

prenatal checkups. She presented to the gynecology-obstetric emergency room at full dilation for imminent delivery

During this first contact with the patient, the obstetric examination found a fully dilated cervix, an engaged cephalic presentation, the fetal heart rate was well perceived. No intracervical mass was seen through the internal orifice. She gave birth without difficulty vaginally, without instrumental extractions of a eutrophic newborn. Her immediate postpartum follow-up was unremarkable

She presented on day 15 postpartum following the perception of a lump suddenly externalizing per vaginam associated with minimal bleeding and intense pain.

Examination on admission finds a tissue formation appearing to be necrotic in places; coming from the endocervix. This formation, which respected the vaginal walls, was pinkish, with a smooth, soft, painful surface, approximately 10 cm long and 10 cm thick.

Vaginal examination was possible because the mass did not obstruct the vaginal canal. A pedicle with a broad implantation base was observed. Speculum examination was impossible due to the mass.

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An ultrasound carried out showed an enlarged uterus with a cervicovaginal formation showing a degenerated myoma measuring 10x9 cm (delivered through the cervix).

After a biological assessment returned without abnormalities, she benefited from twisting and rotation

The excised mass weighed 900 grams.  
Pathology of the surgical specimen concluded that it was a uterine leiomyoma.  
The postoperative period was uneventful.



**Voluminous cervical myoma prolapsed out of the introitus**

## DISCUSSION

Uterine fibroids are the most common benign tumors of the female genital tract in women of childbearing age. They affect 20 to 25% of them and are three to nine times more common in black women than in white women [2].

From the age of 50, 70 to 80% of women have to deal with myomas [3].

It is a well-known pathology among black populations, especially Africans; in fact, myomas have the bad reputation of being the cause of certain and permanent sterility.

The cervix is the rarest location for fibroids (less than 2% in most studies) [4-6].

Due to the rarity of this location compared to others, its clinical implications are rarely described.

The diagnosis of cervical myomas is based on clinical examination. Cervical myomas, especially if prolapsed into the vagina, may be visible with a speculum. Some are palpable during a bimanual abdominopelvic palpation.

An abdominal or transvaginal ultrasound is often sufficient to confirm the diagnosis. In certain cases it can be supplemented by a pelvic MRI.

Generally, fibroids can develop in different ways:

- Volume changes
- Transformations: hyalinization; thrombosis; calcification, adipose involution, aseptic

necrobiosis - delivery through the cervix of long-pedicated submucosal fibroids with infection and necrosis (sphacelus) which are often associated with this event [1].

Concerning the link with pregnancy, most studies indicate a significant increase in fibroid volume during the first trimester, no change during the second and third trimesters and regression after delivery [7].

But it could be that in this case report, the myoma increased in volume during pregnancy and then was expelled at the end of pregnancy because of the volume.

The involvement of estrogens in the pathophysiology of myomas has long been debated due to their non-existence in prepubertal females, and the regression of these myomas at menopause.

Several elements, in our clinical case, are in favor of a low location of the myoma:

- The outcome of the pregnancy at term.
- The cephalic presentation, therefore eutocia.
- Intravaginal expulsion of the myoma

In fact, myomas are known for their complication during pregnancy, such as spontaneous miscarriages or threat of premature delivery and obstructed presentations [8-12].

The location of our patient's myoma is indeed cervical and pedunculated, the pedicle being short, this can therefore explain the maintenance of the tumor in the vagina followed by its protrusion out of the cervix in the postpartum period.

While the threat of preterm labor is a known complication of fibroids, preterm labor itself is a controversial complication [13].

The myomas that affect fertility are mainly those of type 0, 1 and 2, that is to say those which have an impact on the uterine cavity. The involvement of other types of fibroids is controversial depending on their size.

The mechanisms of this infertility are:

- Deformation leading to abnormalities in endometrial receptivity.
- The hyper-estrogenic hormonal environment.
- Alteration of endometrial development [10-14].

Therapeutically; small, asymptomatic uterine fibroids do not need to be treated (50 to 80% of fibroids); on the other hand, symptomatic fibroids must be treated; this treatment is different depending on the age of the woman and her desire to conceive.

The treatment of cervical myomas is similar to the treatment of uterine fibroids.

Small asymptomatic myomas are not treated. Most symptomatic cervical myomas are removed either by twisting and rotation, by myomectomy (particularly, if childbearing capacity is significant) or, by hysterectomy. Prolapsed myomas should be removed trans-vaginally if possible.

In some centers, embolization is prioritized which makes it possible to reduce its size and therefore make the accompanying symptoms disappear. There is a treatment known as "Laparoscopic Myolysis", which is based on the combination of prior medical treatment with a GnRH analogue followed by devascularization of the fibroid carried out by Yag laser shots on its vascular corona (spotted by Doppler ultrasound during the procedure) [1].

In our patient, whose pregnancy was not monitored and who presented to the gynecology-obstetric emergency room for imminent delivery, the vaginal route was inevitable; and her unremarkable postpartum. The twisting and rotating of the resulting fibroid turned out to be the best therapeutic option; and ended in success.

## CONCLUSIONS

Fibroids are the most common and best known benign tumors in women. Indeed, their supposed impact on fertility makes them a formidable pathology in the general population. Giant uterine leiomyomas prolapsing through the cervix are rare. Ultrasound remains the first reference examination. Magnetic resonance imaging; whether it is immediately accessible; is also has notable contribution. Treatment can be conservative by twisting and rotation or radical (hysterectomy) depending on several parameters, mainly whether or not the desire to become pregnant is desired. Due to the complications that remain possible, a hospital delivery remains desirable.

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