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RESEARCH ARTICLE

A LARGE INTRAMURAL FIBROID WITH STAGE 3 UTERO VAGINAL PROLAPSE - A RARE CLINICAL PRESENTATION

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Abstract

Fibroid uterus are the benign tumors of the uterus comprising of smooth muscle fibres. There are 3 main types of fibroid uterus - submucosal, subserosal and intramural. Fibroid with the prolapse usually present as submucosal fibroid prolapsing into the vagina or intramural fibroid becoming submucosal and prolapsing out. A large intramural fibroid usually pulls up the uterus due to its growth and hence uterine prolapse is little rare scenario. In this case a perimenopausal women with mass descending per vaginum and pain abdomen for four years, on examination found to have a large intramural fibroid of size 20*10 cm and uterovaginal prolapse with cervix as leading point with cystocele, enterocoele and rectcoele. After routine pre operative work up, hysterectomy was planned by abdominovaginal route. Supracervical hysterectomy done abdominally followed by removal of cervical stump and anterior and posterior colpoperineoraphy by vaginal route.

Introduction:-

Uterine prolapse is the herniation of the uterus into or beyond the vagina as a result of failure of the ligamentous and fascial supports. It often coexists with prolapse of the vaginal walls, involving the bladder or rectum.(1) Risk factors for prolapse include Older age, Increased body mass index, Higher parity, Vaginal delivery, Constipation, Intra partum variables (macrosomia, prolonged second stage of labor), Menopause, Increased abdominal pressure due to chronic cough, heavy weight lifting, pelvic masses etc.(2,3) Usually a fibroid uterus (large sub serosal or large intramural) will pull up the uterus due to their relative growth. In some cases long standing sub mucosal fibroids may present as mass descending per vaginum.(4) But in the case presented below, our patient had large intramural fibroid along with uterovaginal prolapse with cervix as leading point. This is a unique case as there was secondary supravaginal cervical elongation due to huge fibroid along with grade 3 uterovaginal prolapse associated with cystocele and rectocele.

Case Presentation

52-year women P2 L2 A1 with previous two normal vaginal deliveries and last child birth 21 years ago with no known medical comorbidities presented to our gynecology OPD with complaints of lower abdominal pain on and off for 3 to 4 years and mass descending per vaginum for 4 years.

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Patient was apparently normal four years ago, when she developed mass descending P/V which was insidious in onset, progressive in nature, mass increased in size on coughing and straining. Initially it was reducible manually and now for a month the mass has become irreducible. She had no history of urinary symptoms like incomplete emptying of bladder, difficulty in initiation of micturition, increased frequency of micturition etc. and normal bowel habits. She complained of vague lower abdominal pain for 4 years, which was non progressive in nature and no aggravating or relieving factors. No history of menstrual disturbances or mass abdomen. No history of loss of weight or loss of appetite.

On abdominal examination the uterus corresponded to 20 to 22 weeks gravid uterine size, mobile(horizontal mobility present), no ascites noticed. On speculum examination, third degree cervical descent with grade 2 cystocele, enterocele, rectocele noted(figure 1).

Investigations

In USG imaging, uterus measured 17*8.9 cm. Endometrium 4mm in thickness. A fibroid measuring 10.6*8.4cm seen in anterior myometrium. Bilateral kidneys normal(figure 2).

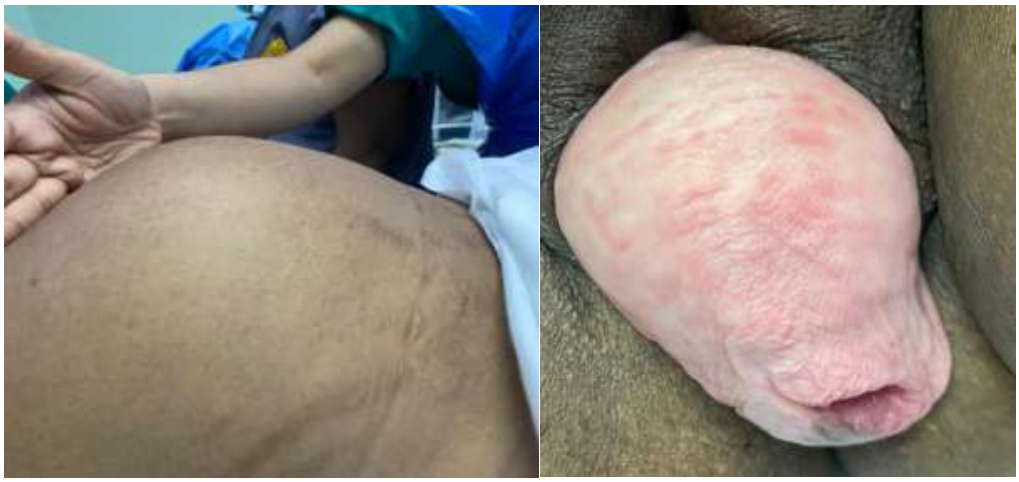

Figure 1:- Abdominal examination shows 22 weeks uterus and local examination shows prolapse with cervix as leading point with cystocele.

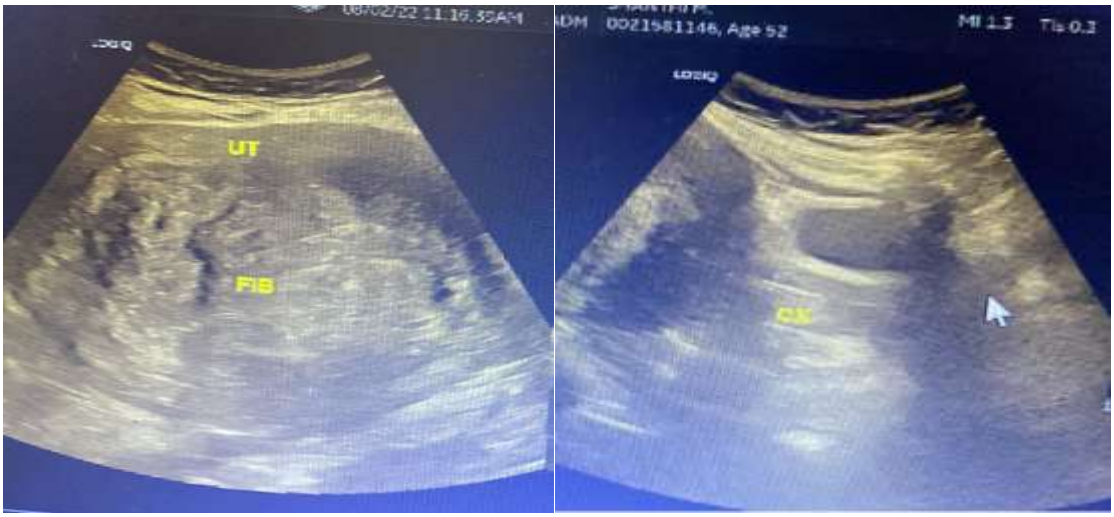

Figure 2:- TAS-showing intramural fibroid and tubular cervix.

Treatment

She was planned for HYSTERECTOMY WITH BILATERAL SALPINGO-OOPHORECTOMY WITH PELVIC FLOOR REPAIR (HYSTERECTOMY- ABDOMINAL AND VAGINAL APPROACH)

Intraoperative findings: Huge cystocele noted, external cervical os- 6cm outside the introitus noted. Rectocoele and enterocoele noted. Uterine Fibroid of size 20 x 10 cm. Cut section showed large intramural fibroid extending and involving the cavity. Supravaginal elongation of cervix noted(figure 3).

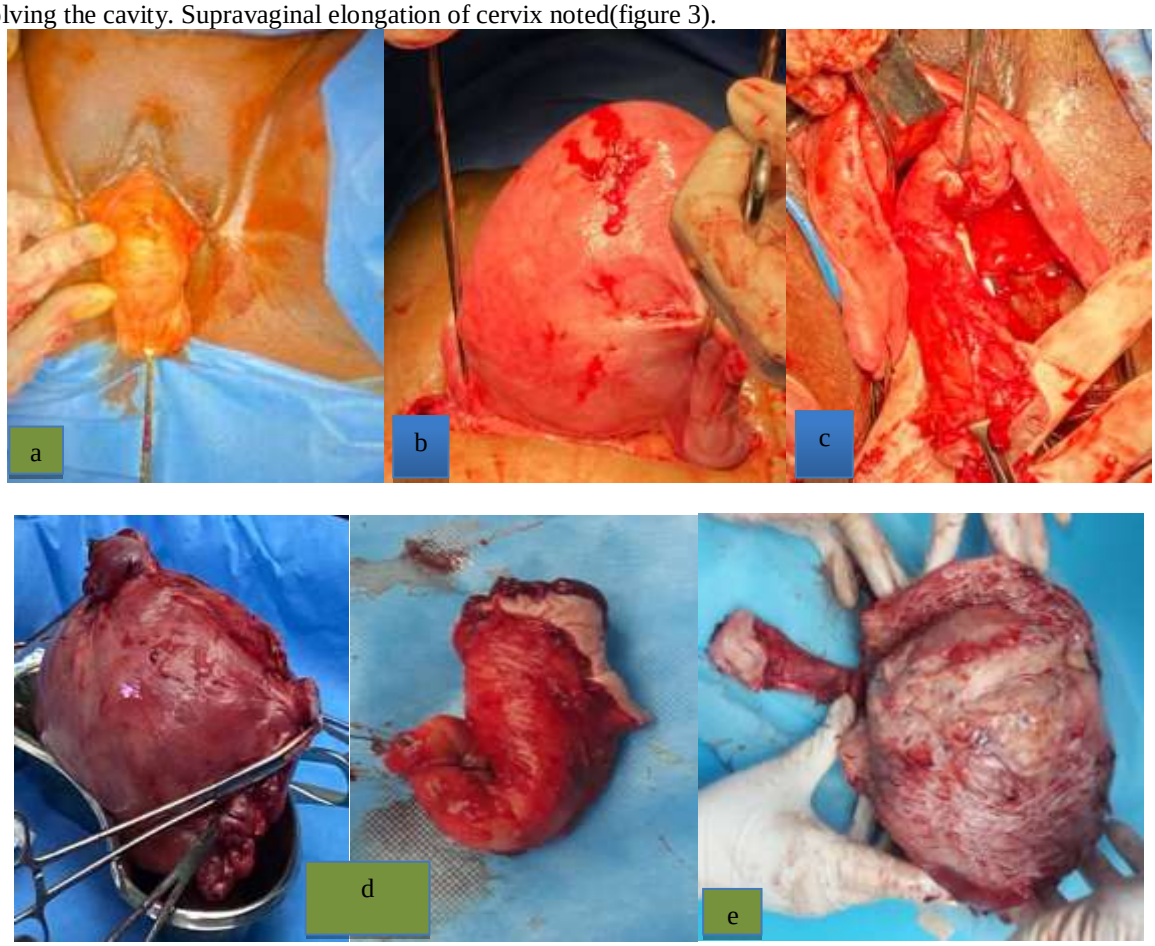

Figure 3:- a)UV prolapse with cervix as leading point and cystocele b)uterine fibroid of size 20*10cm c)cervical stump removal d)supracervical hysterectomy and cervical stump specimen e)cut section showing intramural fibroid

Under general anesthesia, Abdomen opened in layers using cherney's incision. Uterus of size 20*10 cm together with fibroid noted. Bilateral tubes and ovaries were normal. Proceeded with hysterectomy. Bilateral round and infundibulopelvic ligament identified clamped, cut and transfixed. UV fold of peritoneum dissected and bladder pushed down. Bilateral uterine artery identified, ligated and cut. Part of uterosacral ligament clamped cut and transfixed and proceeded with supracervical hysterectomy. On vaginal approach, Cervix was elongated and huge cystocele noted. As in vaginal hysterectomy inverted T-shaped incision given on the anterior vaginal wall and bladder dissected. Incision extended posteriorly. Pouch of Douglas opened proceeded with clamping of the remaining bilateral uterosacral Mackenrodts ligaments and the remaining cervical stump removed. Cystocele repair done by kelly's stitch. Enterocele repaired by both internal and external mccall'sculdoplasty. Vault closed and vaginal pack kept. Proceeded by closing the abdomen in layers. Postoperative period was uneventful. Urinary catheter was removed after 7 days and she voided freely.

Outcome andfollow up

Follow up of the patient after a month, patient was fine with no complaints. She was ambulating freely, normal bowel and bladder habits, no complaints of pain abdomen and her speculum examination showed a healthy vault.

Discussion:-

Uterine fibroids are benign tumors comprising of smooth muscles and fibrous tissues. They commonly occur in the women of reproductive age group. The size and location of fibroids determine the symptomatology. Most of the

fibroids are asymptomatic. Some patients may have following symptoms like heavy menstrual bleeding, abdominal pain, dysmenorrhoea, dyspareunia, increased frequency of micturition, constipation, even infertility.[5]

The main cause of prolapse of the uterus and vaginal vault is the failure of supportive ligaments, such as Mackenrodt and uterosacral ligaments. There are well-known risk factors for pelvic organ prolapse, including aging, childbirth trauma, multiparity, congenital weakness, traumatic and prolonged labor and operative vaginal deliveries, chronic increased intra-abdominal pressure, genetic factor, smoking, prior surgery, myopathy and collagen abnormalities.[1,2]

Pelvic masses are one of the known risk factors for pelvic organ prolapse.[3] But large fibroids usually pull up the uterus as they grow in size. Utero-vaginal prolapse in association with prolapsed submucous uterine fibroid has been reported.[6] Large intramural fibroid with a third degree uterovaginal prolapse is a little rare scenario.

In our case scenario the uterovaginal prolapse, cystocoele, entercoele and rectocele are due to the increased intra-abdominal pressure because of large fibroid as well as weakened ligaments owing to her peri menopausal status. The uterine prolapse that has occurred in this case was mainly because of supra vaginal cervical elongation due to the growing uterine fibroid, which along with vaginal prolapse presented as uterovaginal prolapse with cervix as the leading point. The hysterectomy approach we did here was abdominovaginal approach as the fibroid was upto 22 weeks size with cervical elongation and the fibroid would not be accessible from vaginal route. Supracervical hysterectomy was performed abdominally followed by cervical stump removal, vault closure and anterior and posterior colpoperineorrhaphy by the vaginal route. Postoperative period was uneventful and patient was discharged on 7th post operative day when she voided normally after catheter removal. Follow up of the patient after a month, patient was fine with no complaints.

We have managed so many uterovaginal prolapses and fibroid uterus as separate entities, but both present in same patient like in our case, a huge intramural fibroid with third degree uterovaginal prolapse is a rare entity with only few literature studies. It has been managed appropriately with abdominovaginal approach and the patient was followed up with good results.

Learning Points

Large uterine fibroids can also present with uterovaginal prolapse. The route of surgery in such patients becomes challenging, where the entire hysterectomy with pelvic floor repair either by abdominal/laparoscopic or vaginal route alone would have been difficult requiring additional expertise and prolonged timing increasing the morbidity to the patient. Here the abdominovaginal route of hysterectomy turned out to be an useful approach reducing the morbidity of the patient.

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