Journal of Research in Medical and Dental Science
2021, Volume 9, Issue 9, Page No: 60-61

Available Online at: www.jrmds.in
eISSN No.2347-2367: pISSN No.2347-2545

Cervical Fibroid: A Case Report

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ABSTRACT

Leiomyoma are most common tumors of uterus, usually presenting in the reproductive age group. However, only 1-2% fibroids are confined to cervix. Cervical leiomyoma is mostly single and are sub serous or interstitial in origin. They arise either from supravaginal or vaginal portion of cervix. We report a case of 45year old female presented with heavy menstrual bleeding and was diagnosed with cervical fibroid, underwent enucleation followed by total abdominal hysterectomy. We conclude that cervical fibroids are a challenge to the gynaecologist due to close proximity to the ureter and bladder. Careful dissection is needed in the management of such cases. With proper pre-operative evaluation and knowledge of altered anatomical structures is essential to perform myomectomy or hysterectomy for cervical fibroid.

Key words: Cervical fibroid, Enucleation, Laparotomy, Ureteric stenting

HOW TO CITE THIS ARTICLE: Vidhya R, Pavitthra ND,Cervical Fibroid: A Case Report, J Res Med Dent Sci, 2021, 9(9): 60-61

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Received: 09/08/2021
Accepted: 06/09/2021

INTRODUCTION

45 year old female, P2L2, sterilized with complaints of heavy menstrual bleeding for 2 months.

Associated with clots. No dysmednorrhea. Previously regular cycles with average flow of 3-4 days

On Examination: She looks pale. Vitals are stable.

Per abdomen examination: Obese, Soft and non-tender, Healthy Sterilization scar present

Per Speculum examination: Profuse Bleeding present

Bimanual pelvic examination revealed fullness in the anterior and both lateral fornices. A firm mass around 8*8 cm was felt through the fornices moving along with the cervix. Uterus could not be felt separately.

Investigations: Haemoglobin 7gm%

Ultrasound: A subserosal fibroid 8*7cm on left side of uterus. Bilateral Adenexa normal.

MRI: A large exophytic soft tissue mass arising from anterior wall of cervix measuring 9*8*7. 5cm. Mass was predominantly solid with areas of cystic degeneration and foci of haemorrhage seen within.

IVP: Bilateral ureters were normal

After stabilization and blood transfusion patient was taken up for surgery.

Laparotomy was done through abdomino-perineal approach. A cervical fibroid of size 8*8*7cm was seen occupying the pelvic cavity with small uterus on top of it. Bilateral round ligament clamped, cut and transfixed. Bilateral ureters were dissected and course identified in the pelvis Bilateral in fundibulo pelvic ligament clamped, cut and ligated. Uterovesical fold of peritoneum identified, cut and bladder pushed down. Cervical fibroid was enucleated using myoma screw. Hysterectomy was preceded by clamping, cutting and ligating the uterine vessels, bilateral mackenrodt's and uterosacral ligament. Intraoperative 1 unit packed cell was transfused. Post-operative period was uneventful. Histopathological report revealed cervical fibroid with chronic ectocervicitis with proliferative endometrium.

DISCUSSION

Cervical fibroid is rare and this patient presented with no pressure symptoms. These fibroids are grossly and histopathological identical to those found in corpus [1]. Cervical fibroids can be anterior, posterior, central and lateral. Anterior fibroid causes urinary retention whereas posterior fibroid compress rectum and results in constipation [2]. Lateral cervical fibroid burrows in broad ligament and expands it. Central cervical fibroid equally expands in all directions and produces mainly pressure symptoms [3]. Diagnostic dilemma is usually there with such large cervical fibroid. Although MRI and ultrasound has improved pre-operative diagnosis, but final diagnosis is always at laparotomy. Treatment of cervical fibroid is myomectomy or hysterectomy. Myomectomy in such cases is technically difficult as there is increased risk of injury to the ureters because of distorted pelvic anatomy and hence it is always better to trace the course of ureter,

retroperitoneal before removing such huge fibroids or applying clamps while doing hysterectomy [4]. On laparotomy, it gives typical appearance of lantern on St. Paul's Dome. Due to inaccessibility and close proximity to bladder and ureter, surgery should be done meticulously [5].

CONCLUSION

We conclude that with proper pre-operative evaluation and knowledge of altered anatomical structures is essential to perform myomectomy or hysterectomy for cervical fibroid.

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