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Uterine Fibroid with Incisional Hernia- A Case Report

Dr. Eda. Indira[1], Dr. G. Ratna[2],
Dept of OBG, Siddartha Medical college,NTRUHS,Vijayawada.
[1]Assistant professor, Department of Obstetrics and Gynecology, Siddartha MedicalCollege, Vijayawada.
[2,]Associate professor Department of Obstetrics and Gynecology, Siddartha MedicalCollege, Vijayawada.

Abstract: *Uterine leiomyoma , most common estrogen dependent benign tumour of the uterus. 5 to 20% occur in the reproductive age group. It is composed of smooth muscle and fibrous tissue. Asymptomatic myomas present in 50% of cases, it causes mainly menstrual problems like- menorrhagia, metrorrhagia, dysmenorrhoea and also infertility. Incisional hernia is one that develops in the scar of surgical incision. We are presenting a case of fibroid uterus with incisional hernia in a 40 year old woman, P3 L3, delivered vaginally, following which she had puerperal sterilization on 3rd post-natal day- 16 years back. She came with complaint of swelling in the lower abdomen associated with pain, history of menorrhagia and pain during menstruation. She was subjected to Ultrasound and CT abdomen which confirmed fibroid uterus with incisional hernia. Management of the case is discussed.*

Keywords: *Uterine fibroids, Incisional hernia, Total Abdominal Hystrectomy, Repair of incisional hernia.*

I. Introduction

Uterine fibroids, commonest benign tumour of the uterus. The cause of leiomyoma is unknown, several studies have suggested that, each leiomyoma arise from a single neoplastic cell with in smooth muscle of the myometrium there appears to be an increased familial incidence, and may be more common in women who are obese. Fibroids commonly arise from the body of the uterus (intramural or interstitial 75%, sub mucous 15%, sub serous 10%) and cervix. These may also arise from round ligament, utero-ovarian and uterosacral ligaments, vagina and the vulva. The intramural fibroids mainly causes the symptoms like menorrhagia due to increased vascularity, endometrial hyperplasia and enlarged uterine cavity.

Incisional hernia usually develops in the scar of surgical incision. The incidence of low midline incisions following gynecological operations is 0.5 -1%, the incidence increases to 10% following wound infection. Similarly re-closure after dehiscence increases the chance of hernia formation to about 25%. Predisposing factors are age, obesity, wound infection, incisions more than 18 cms. Common contents are omentum, transverse colon, loops of small bowel and stomach[1]. Occurrence of incisional hernia after 16 years of minilap tubectomy is rare.

II. Case Report

A 40 year old woman reported to gynec OPD with complaint of swelling in the lower abdomen associated with pain, history of menorrhagia and pain during menstruation since one year. On examination she was obese (BMI of 32), hypertensive, anemic with normal vitals and lungs are clear. She is a known asthmatic since 20 years.

On examination P/A: There was a tubectomy scar, abdomen soft with swelling of 5x6 cms of size present in the midline infra umblical region more towards the right side, which was not completely reducible, cough impulse present, with negative trans-illumination.

P/ S: cervix and vagina healthy. **PV:** Uterus 16 weeks size, cervix moves with swelling, fornices free.

Investigations: Hb 8 grams, Blood urea 20mg/dl, Serum creatinine 0.9, serum TSH – 4.9µ IU per ml. CA 125 – 6.7 U per ml. Blood grouping and Rh typing is B +ve. Urine - albumin, sugar and microscopy were normal. ECG, 2D Echo were normal. CT and US abdomen shows incisional hernia of size 5x5 cms defect with herniation of bowel loops and omentum. A uterine fibroid of 9x6 cms present in the anterior wall of the uterus.

Pap smear: shows inflammatory smear.

D&C Report: proliferative changes in the endometrium.

III. Management

Pre-operative measures including control of asthma, hypertension and weight reduction was done. Under combined spinal and epidural anaesthesia, case is posted for exploratory laparotomy by vertical midline incision. Plenty of omental adhesions present, which were released. Uterus was enlarged to 16 weeks size, having anterior wall fibroid. Total abdominal hysterectomy was done. Repair of incisional hernia by wide dissection of subcutaneous fat from the lateral boundaries of hernia, hernial sac was identified and opened, adherent bowel and omentum were released, redundent hernial sac has been excised followed by repair of hernia with synthetic non absorbable prolene mesh closure. One unit of blood transfusion was given, post-op was uneventful, and the patient was discharged on the 8th post-op day

HPE Report: Endometrium is in secretory phase, myometrium shows intramural fibroid and adenomyosis, cervix- non specific cervicitis and nabothian cyst.

IV. Discussion

Most of the leiomyomas are asymptomatic, some fibroids cause pressure symptoms, infertility, menorrhagia[2]. Rapid growth of fibroids suggest its tendency for malignancy[3] and these should be removed as early as possible when they cause symptoms. Gonadotropin releasing hormone agonists suggested in asymptomatic pre menopausal women for shrinkage of myoma[4]. If the uterus is more than 12 weeks size, regardless of symptoms in addition to the location, surgical removal is mandatory[5]. Hystrectomy is most effective treatment for leiomyoma, in case of symptomatic fibroids and it offers high rate of patient satisfaction [6]. Other management options include myomectomy, uterine artery embolization, Magnetic Resonance guided Focused Ultra Sound (MRgFUS) [7] and laparoscopic myolysis has a role in the treatment of fibroids in selected women.

Pain abdomen is due to strangulation of hernia and may be due to sarcomatous change in fibroid. Incidence of sarcomatous degeneration is 0.7%. Leiomyoma of monoclonal origin, arise from benign cases are may develop denova[8]. Sarcomatous degeneration occurs more commonly in intramural and submucous myomas. It is rare for the malignant change to develop in a woman under the age of 40 years. Other type of degeneration that occurs in intramural fibroids is cystic degeneration, it occurs following menopause.

Most of the incisional hernias (66%) develop with in 5 years, remaining (33%) develop with in 5 to 10 years[9]. The occurrence of incisional hernia after 16 years of minilap tubectomy is rare. The causative factor in this case is obesity and associated bronchial asthma as a predisposing factor. The operative method used in this case was synthetic non absorbable prolene mesh closure. Other methods are shoelace repair and laparoscopic mesh closure.

V. Conclusion

It is very rare to see incisional hernia after 16 years of minilap tubectomy. In the perimenopausal women having menorrhagia to be “normal” because she is on the verge of reaching menopause. Abdominal distension and swelling in the abdomen was mistaken for fat in view of her obesity, these women should be properly investigated, treated and advised. Every women should have periodic health checkups and the message should be passed to the community level.

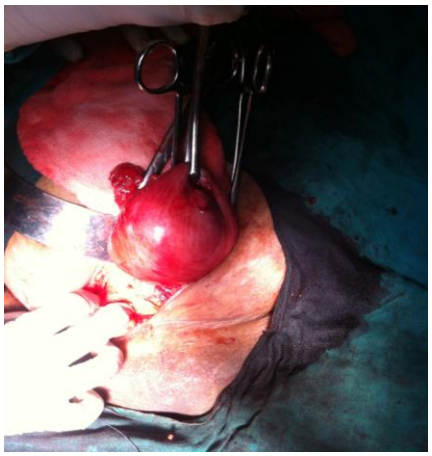

Fig 1

Fig 2

Fig 3

Fig 4

Fig1. Picture showing the per operative uterus with fibroid.
Fig2. Specimen showing uterus with fibroid.
Fig3. Picture showing the incisional hernial sac.
Fig4. Cut section of uterus showing intramural fibroid.

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