IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 19, Issue 1 Ser.19 (January. 2020), PP 04-07
www.iosrjournals.org

Management of a Huge Cervical Fibroid by Laproscopy

Dr.Shivani[1], Dr.Rekha Verma[2]
Consultant jeevan mala hospital,karol bagh ,delhi
Consultant Vishakha hospital, jaipur

Abstract:
Minimally invasive hysterectomy is a standard procedure. Different approaches, as laparoscopic assisted vaginal hysterectomy, vaginal hysterectomy, and subtotal and total laparoscopic hysterectomy, have been described and evaluated by various investigations as safe and cost-effective methods , In particular, in comparison to abdominal hysterectomy, the minimally invasive methods have undoubted advantages for the patients. . Management of symptomatic cervical fibroid is hysterectomy or myomectomy and need an expert hand. Here we report a case of huge anterior cervical fibroid of 15x12 CM with an unusual presentation of post-menopausal spotting and no urinary symptoms. Inspire of the fibroid being huge and impacted, hysterectomy was done successfully without any injury to bladder and ureters.

Keywords: *fibroid, myomectomy*

Date of Submission: 14-01-2020 Date of Acceptance: 30-01-2020

I. Introduction

Fibroids are smooth muscle tumors that develop within the myometrium, but occasionally can be seen arising from cervix, broad ligament and even ovaries. The incidence of cervical fibroids is 1-2% .The presence of cervical fibroid in the absence of an abnormal uterus is a rare finding. (1, 2)They are classified as anterior, posterior, and central and lateral depending on their site of origin. A cervical fibroid can lead to menstrual irregularities, urinary retention, urinary frequency, constipation, dyspareunia and postictal bleeding depending upon their location. Large cervical fibroids are difficult to handle and need inexpert hand to operate these cases. (3)

Although a benign condition, surgery for large myoma of the uterus with extensive adhesions may be challenging, due to the high level of difficulty of the TLH procedure and difficulties with the identification of the uterine artery and ureter, which are mainly attributed to difficulty securing the visual field and operative space and poor uterine mobility (4-6)

II. Case Report

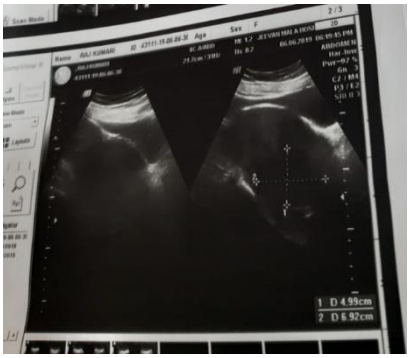
A 55 year old lady P3L3 with history of previous laparoscopic sterilization came at JEEVAN MALA HOSPITAL OPD. Patient attended menopause 8 year back. . Patient complaint of post-menopausal spotting twice, one in month of March and another in month of JULY 2019.Bleeding was slight in nature and history of passage of some clots. Previously her menstruation history was normal. Her menstrual cycle was normal.3-4/28 days .No history of urinary retention, dysmenorrhea or excessive flow during the cycles She have history of diabetes and hypertension since 10 year and patient was taking medicine for it and under control On general examination patient was obese and her weight was 84 kg. Vitals were normal .all pre-operative blood reports were normal

P/S A tongue shaped polyp was seen protruding through cervical os which bleed on touch

P/V Cx (d), UT (AVAF), 14 WKS size, F (mobility restricted)

USG shows the uterus is anteverted ,bulky of 13.5 x11 cmx12.5 cm size.USG shows multiple intramural and subserosal fibroid largest one is measure was 62x54 mm.Right ovary was bulky in size measuring 63x40 mm with cyst of size 55x 45 mm

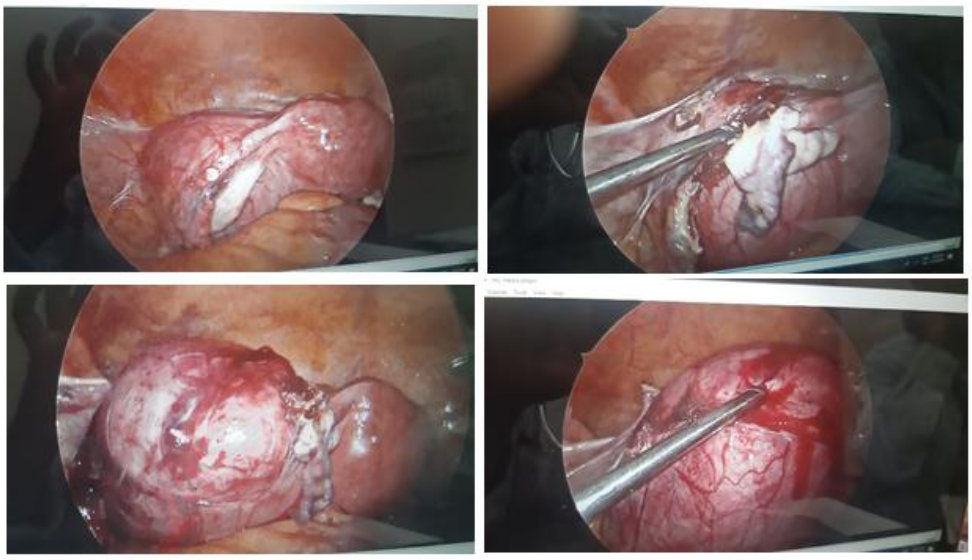
Left ovary was normal in-size



MRI reports shows the bulky anteverted uterus with well marginated encapsulated lobulated hypo intense lesion ,two in number, lying adjacent to each other ,involving the [posterior myometrium . The large subserosal fibroid in left lateral wall approximate 12.5 cmx 8cm, the intramural lesion measuring approximate 2.8 cmx 2.4 cm size .no obvious post contrast enhancement seen. Endometrial Cavity is significantly distended with 7mmx 2.5 mmm heterogeneously enhancing mixed intensity lesions with solid and cystic components

On date 11/6/19 hysteroscopy guided polypectomy done .On operation 5 cm fibroid polyp is seen, arising from anterior wall of uterus Endometrium is fluffy and shaggy all over .Bilateral Ostia not visualized, end cervical canal otherwise normal. Polypectomy followed by D&C done & Cx biopsy taken. Tissue sent for HPE, reports shows the benign endometrium, secretory in phase and benign polyp. Cervix shows the chronic cervicitis.

Operative notes Patient was put in lithotomy position ,part prepared .After assessing p//v examination verres needle was introduced through umbilicus ,once the pressure reached up to the 3 liter ,primary port introduced in left lateral fossa ,3 cm upper and medial to anterior superior iliac spine ..Anatomy was survey, uterus uplifted .camera port was decided 5cm upper to umbilicus, remain port s introduced under vision/ Upper abdomen normal. Uterus normal in size .A large 15x 12 cm cervical fibroid extending into left broad ligament and right broad ligament present , occupying the complete pouch of Douglas. .Bilateral tubes and ovaries were normal. .Bilateral tubal structure & round ligament cauterized and cut using the ligature vessel sealer. After that broad ligament leaflet was opened and same was extending anteriorly up to the bladder fold and bladder was pushed down ward. Posteriorly myoma spiral was introduced and myoma was lifted out with gentle traction and counter traction and myomectomy was done and only leaving uterus top of myoma and cervix. .Bilateral uterine vessels cauterized with ligature vessel sealer and following which the vault was opened with unipolar. . .Check cystoscopy was done to check ureteric orifice. Vault closed with no.1 vicryl Blood loss was approximate 20 to 30 ml. Myoma was delivered in pieces by doing morcellation .and uterus delivered in usual way. Post-operative period was uneventful, as there was no intraoperative bladder, bowel or ureteric injury.



Histopathology report shows the leiomyoma and chronic cervicitis

III. Discussion

KENTARO et al treatment of advanced adhesions and cases with an unclear cervical region regarding large myoma of the uterus, TLH is applicable even for uterine myoma weighing >1,000 g. It has been reported that the rate of switch to laparotomy was 4.2–9.7%, a small incision in the abdominal wall was necessary to extract the specimen in 21% of the cases, and the incidence of complications was 2.8–11.4% (3). Our department has performed TLH in 25 cases with a uterine weight of >500 g, with no reported ureteral damage or switch to laparotomy although the myoma was sizeable and the excised specimen weighed 1,100 g, TLH was completed without complications. However, 94 min were required to extract the specimen, during which bleeding from the vaginal stump continued and blood transfusion was required. Based on this experience, the vaginal stump is sutured in advance when removing a large myoma specimen is likely to be time-consuming, and the umbilical port is extended by incising the region by 3 cm to extract the specimen. No blood transfusion was required in any of the large myoma cases managed thereafter in our department. The use of an electric morcellator to remove specimens is associated with the risk of scattering, an electric morcellator is not used in our department; the tissue is cut into pieces using a cooper forceps and transvaginally collected through the umbilical port. Surgery may be safely performed using a large isolation bag as reported in another study, but the use of this method was off-label and further investigation is required (7-8)

John C Ekweani et al. the lady was 45-year-old, who had history of heavy menstrualBleeding and her examination revealed a huge cervical fibroid of 21 weeks. She underwent total abdominal hysterectomy, Intraoperative findings were of a large cervical fibroid of 20 × 13 cm. ureteric injury was encountered and managed thereafter. Blood loss was 600 ml. (9)

B Kavitha et al. Reported a case of a large central cervical fibroid of 20 weeks size. Transection of right ureter, accidental ligation of left ureter and bladder injury was encountered in this case while proceeding to total abdominal hysterectomy and was managed with the help of urologists. (10)

Sumanlata et al posterior fibroid flattens the pouch of douglas compressing rectum against sacrum resulting in constipation. Lateral cervical fibroid starting on the side of cervix burrows out into the broad ligament and expand it. Central cervical fibroid expands the cervix equally in all direction but produces mainly bladder symptoms. On laparotomy they give a typical appearance of "Lantern on St Paul's Dome. Treatment of cervical fibroid is either myomectomy or hysterectomy. They give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder and ureter. Preoperative GnRH analogue administration for 3months reduces intraoperative blood loss and facilitates surgery. Principle to be followed during surgery is nucleation followed by hysterectomy. (11)

IV. Conclusion

In our case the patient had a huge anterior cervical fibroid with a very short history of post-menopausal bleeding and without any urinary symptoms which is very uncommon for such fibroid. In spite of the fibroid being huge, vascular and deep impacted in pelvis, there was no injury to any adjacent structures which was a great advantage to the patient. Thus, we conclude that proper preoperative evaluation, preparation and knowledge of altered anatomical structures are important for performing hysterectomy.

Reference

[1]. Kaur AP, Saini AS, Kaur D, et al. Huge cervical fibroid- unusual presentation. The Journal of Obstetrics and Gynaecology of India 52 (2002): 164.

[2]. Tiltman, Andrew J. Leiomyoma of the uterine cervix: a study of frequency. International Journal of Gynecological Pathology 17 (1998): 231-234.

[3]. Kshirasagar SN, Laddad MM. Unusual Presentation of Cervical Fibroid: Two case reports. Int J Gynecology Plastic Surg. 2011;3(1):38-9.

[4]. Brummer TH, Jalkanen J, Fraser J, Heikkinen AM, Kauko M, Mäkinen J, Seppälä T, Sjöberg Tomás E, Härkki P. FINHYST, a prospective study of 5279 hysterectomies: Complications and their Risk factors. Hum Reprod. 2011; 26:1741–1751. doi: 10.1093/humrep/der116. [PubMed] [CrossRef] [Google Scholar]

[5]. Ceccaroni M, Roviglione G, Pesci A, Quintana S, Bruni F, Clarizia R. Total laparoscopic Hysterectomy of very enlarged uterus (3030 g): Case report and review of the literature. Wideochir Intec Maloinwazyjne. 2014;9:302–307. [PMC free article] [PubMed] [Google Scholar]7/20/2019 Total laparoscopic hysterectomy for large uterine cervicalmyomahttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC5431257/ 11/11

[6]. Uccella S, Cromi A, Serati M, Casarin J, Sturla D, Ghezzi F. Laparoscopic hysterectomy in case of uteri weighing1 kilogram: A series of 71 cases and review of the literature. J Minim Invasive Gynecol. 2014;21:460–465. doi: 10.1016/j.jmig.2013.08.706. [PubMed] [CrossRef] [Google Scholar]

[7]. Kentaro Nakayama, Mayu Tsukao, Masako Ishikawa, Tomoka Ishibashi, Kohei Nakamura, Kaori Sanuki, Hitomi Yamashita, Ruriko Ono, Toshiko Minamoto, and Satoru Kyo Total laparoscopic hysterectomy for large uterine cervical myoma10 Mol Clin Oncol. 2017 May; 6(5): 655–

[8]. Cohen SL, Einarsson JI, Wang KC, Brown D, Boruta D, Scheib SA, Fader AN, Shibley T. Contained power morcellation within an insufflated isolation bag. Obstet Gynecol. 2014;124:491–497. doi:10.1097/AOG.0000000000000421. [PubMed] [CrossRef] [Google Scholar

[9]. Ekweani JC, Oguntaya OA, Kolawale A, et al. Huge cervical fibroid. Port Harcourt Med J 10 (2016): 135-138

[10]. Kavitha B, et al. Cervical fibroid with "Lantern on top of St Paul "appearance. Int J Res Dev Health 2 (2014):

[11]. Sumanlata Mendiratta1*, Soumya Dash1, Rajni Mittal1, Suman Dath1,Manisha Sharma1, Rajiv N. Sahai2 Cervical fibroid: an uncommon presentation11International Journal of Reproduction, Contraception, Obstetrics and Gynecology Mendiratta S et al. Int J Reprod Contracept Obstet Gynecol. 2017 Sep;6(9):4161-4163

Dr.Shivani,et.al. "Management of a Huge Cervical Fibroid by Laproscopy." *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 19(1), 2020, pp. 04-07.