

Two Rare Presentations of Huge Fibroid Polyps

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ABSTRACT

Uterine fibroids are the most common benign, monoclonal, smooth muscle cell tumors in women of reproductive age group. Here we present two rare cases of huge fibroid polyps. First is a 28 years old nulliparous woman with acute retention of urine. On examination, she had a large mass impacted into the vagina with necrotic areas. She underwent vaginal myomectomy followed by hysteroscopic D+C. Second is a 25 years old nulliparous woman with protrusion of mass from vagina for 1 month. Local examination revealed a large globular mass attached to the fundus of a totally inverted uterus. Vaginal myomectomy with repositioning of inverted uterus was done. Post op period of both the patients were uneventful. Thus prompt diagnosis and conservative surgery can help relieve acute symptoms and save uterus for future reproduction.

Introduction

The fibroids are the most common pelvic smooth muscle tumors in women of reproductive age group. They are classified according to their location into different grades as per Wamsteker classification system. Submucosal fibroid polyp is classified as grade 0. When large, it can protrude through gradually dilating cervix and ultimately prolapse through the vagina. The main complication of this condition is pain, necrotic degeneration, hemorrhage and infection. They are also the most common factor for non-gravid uterine inversion. They represent a separate entity regarding their treatment. Though easily accessible vaginally these large fibroid polyp carry risk of severe uncontrollable hemorrhage and uterine inversion during myomectomy thereby requiring hysterectomy as a life saving measure.

CASE 1: Mrs. T, 25 years old nulliparous married for 4 months presented with c/o white discharge per vaginum x for 2-3 months and something coming out per vaginum x 1 month. Her general examination was normal. Per abdomen examination was soft. On local examination: a large 12 x 12 cm globular mass lying outside the vulva attached to the fundus of the uterus and the uterus was totally inverted. On per vaginal examination pedicle of polyp could not be felt. All blood investigations were within normal limits. On USG uterus was anteverted of 5.5x2.6x3.8cms. A big mass was seen outside the vagina with a pedicle arising from cervical canal, ET 7.7mm. On MRI a pedunculated mass lesion arising from uterine fundus and prolapsed through introitus, possibility of polyp with areas of degeneration was noted. She had vaginal myomectomy followed by repositioning of inverted uterus under general anesthesia. Post op period was uneventful. She was followed up after 1 week and the uterus was nicely repositioned, the cervix had become absolutely normal. USG pelvis was done which showed uterus anteverted, 6.4x 4.1 x 5.0 cms, ET 9 mm B/L ovaries normal

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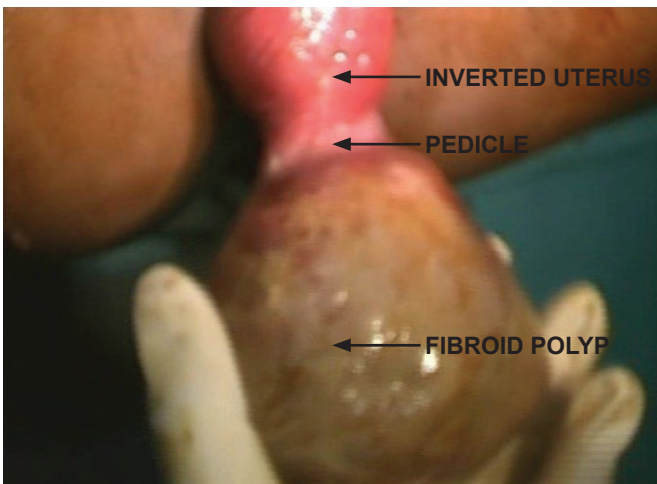


Fig 1. Prolapsed Fibroid Polyp with Inverted Uterus

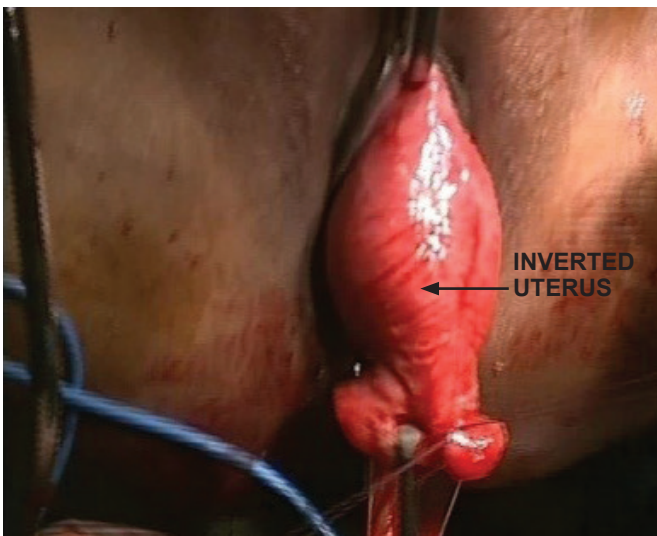


Fig 2. Polypectomy Done

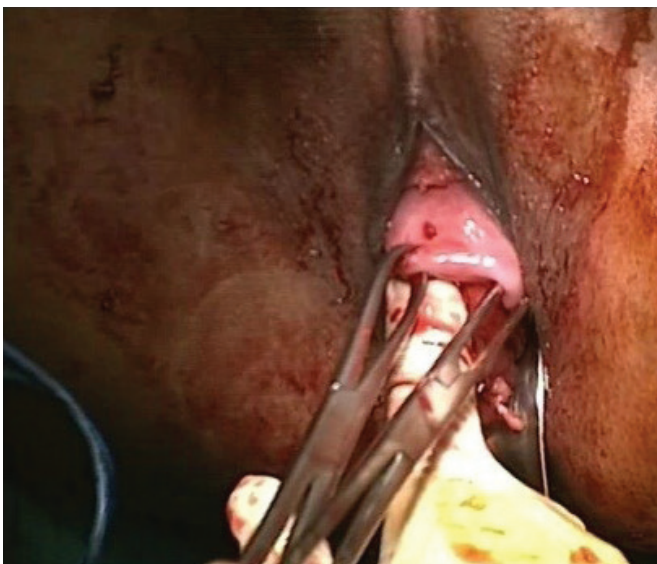


Fig 3. Uterus Repositioning

CASE 2: Mrs S, 28 years old nulliparous, married for 2 months presented to the casualty with c/o acute

retention of urine for 4 days, continuous bleeding P/V for 17 days. Her general examination was normal. Per abdomen examination was soft. On per speculum examination a large mass 12x 12 cm was seen impacted into the vagina with areas of necrosis and bleeding with foul smell. On per vaginal examination a 12x12 cm mass was felt impacted in the vagina, though the pedicle could not be felt nicely. The cervical canal was distended and thinned out over the vaginal mass, uterus was anteverted, bulky. All blood investigations were within normal limits. USG done showed a heterogenous predominantly echogenic mass 12.2x 12.6 cms distending the cervical canal. The lesion appeared to be arising from the endometrial cavity with internal vascularity continuous with that of endometrial cavity. Both ovaries were normal. MRI done showed a large pedunculated endometrial polyp prolapsed into the endocervical canal with areas of hemorrhage and necrosis into it. She had vaginal myomectomy followed by hysteroscopy D+C under general anesthesia. Post op period was uneventful.

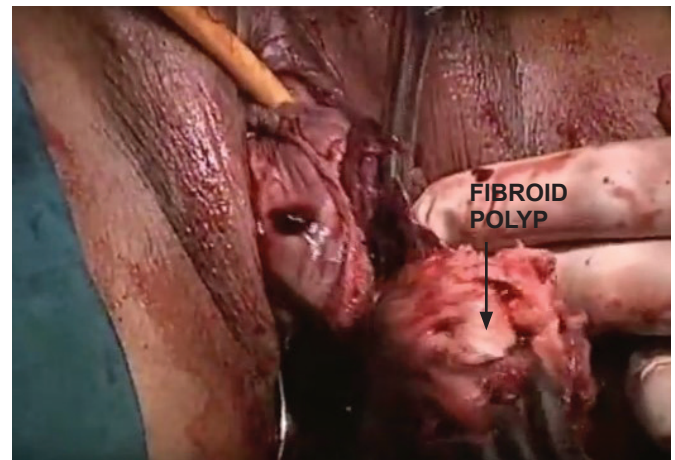


Fig 4 Prolapsed Fibroid Polyp

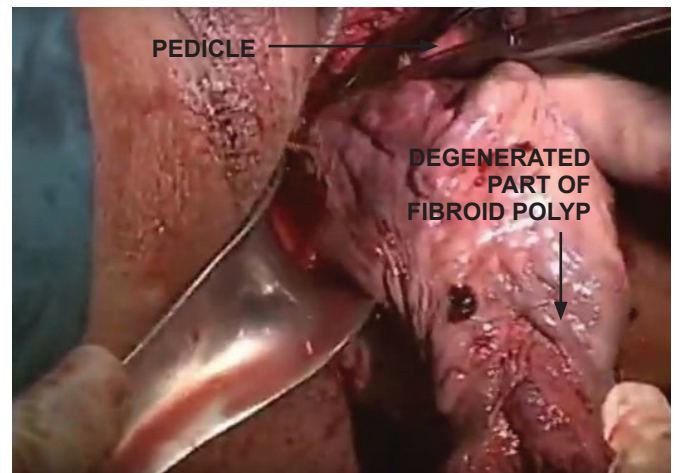


Fig 5 Clamped Pedicle

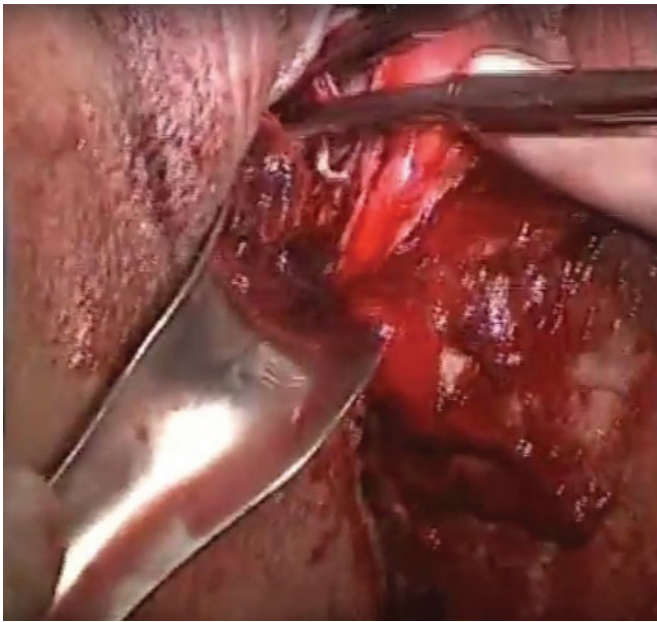


Fig 6 Polypectomy Done

Discussion

Uterine fibroids (myomas or leiomyomas) are the most common benign, monoclonal, smooth muscle cell tumors of the human uterus. Their etiology is multifactorial, and the incidence ranges from 5 to 77% in women of reproductive age¹. There are no data regarding the incidence or risk factors of prolapsed uterine leiomyomas in particular. Submucosal fibroids account for approximately 15 to 20 percent of these and an unknown proportion of submucosal leiomyomas prolapse through the cervix¹. Majority of women with uterine fibroid are asymptomatic. Symptomatic women typically complain of heavy and prolonged bleeding. Women with a fibroid that has prolapsed through the cervix may present with vaginal bleeding, watery discharge, vaginal pressure or rarely urinary retention.

Uterine fibroids (myomas, leiomyomas) are an extremely rare cause of acute urinary retention with only a few case reports and series documented in literature²⁻⁵. Various mechanisms have been postulated by which acute urinary retention may occur due to a leiomyoma. The commonest theory is that the proximal urethra and bladder neck compression may be caused by anterior and superior displacement of the cervix due to the impacted fibroid. In normal voiding, the cervix is rotated away from the urethra/bladder neck; this movement is hindered by the impacted uterine fibroid⁶⁻⁸.

Uterine inversion is an extremely rare condition of submucosal fibroid polyps. There are two types of uterine inversions- puerperal and non puerperal or gynnaeciological⁹. Inversion can also be classified as acute and chronic. Uterine inversion can be classified into four stages as Stage 1: The inverted uterus remains in the uterine cavity, Stage 2: Complete inversion of the fundus through the cervix, Stage 3: The inverted fundus protrudes through vulva, and Stage 4: Inversion of the uterus and vaginal wall through the vulva.³ Gomez-Lobo et al. reported only 150 cases of non puerperal uterine inversion from 1887 to 2006 with Only four cases having been reported in women less than 45 years¹⁰.

The underlying cause of uterine inversion in 80%-85% of cases is uterine leiomyoma making it the most common cause. The proposed factors thought to contribute to uterine inversion are (a) a uterus previously distended by a tumor undergoing sudden emptying; (b) Intra uterine tumor causing thinning of uterus; and (c) dilatation of the cervix⁹.

The main symptoms of non-puerperal uterine inversions are anaemia caused by irregular vaginal bleeding, vaginal discharge, lower abdominal and/or pelvic pain, a protruding mass in the vagina, and in some cases obstruction of the urethra⁹.

As nonpuerperal uterine inversion is rarely encountered by the gynecologist its diagnosis and management could be challenging¹¹. In our case, on clinical examination, the diagnosis was not clear, so detailed ultrasound of abdomen and pelvis was done to confirm the diagnosis. On ultrasound, it can be diagnosed by visualization of an indentation at the fundus on longitudinal section¹². However, in our case, ultrasound did not pick up the inversion. Magnetic resonance imaging can prove to be a useful imaging modality for preoperative diagnosis of uterine inversion. A “V-shaped” uterine cavity and a thick, inverted fundus in a sagittal section and section through the upper level show layers of the inverted uterus with “bull’s-eye” configuration in T2-weighted images¹³. Unfortunately, because of the rare nature of the disorder, uterine inversion frequently goes undetected until surgery unless a high index of suspicion is maintained.

The condition is treated surgically. A fertility sparing surgical treatment is the ideal in this condition⁹.

With regard to the type of operation that should be performed for prolapsed pedunculated fibroids, Philpott states that vaginal myomectomy 'is particularly indicated when the tumour is necrotic and infected'. Tumours attached to the interior of the uterus by a stalk and then expelled into the vagina may produce inversion of the uterus. 'The patient's symptoms are those of the polyps and the associated inversion may be missed unless the possibility is kept in mind. If it is overlooked, the result can be disastrous because, in dividing what is regarded as the pedicle of the polyps, the surgeon cuts across the fundus of the uterus and opens into the peritoneal cavity. Vaginal myomectomy is a relatively straightforward procedure with low postoperative morbidity.

There is no current consensus on the management of urinary retention in patients with uterine leiomyomas¹⁴. Wu et al., have proposed an algorithm for the management of patients with acute urinary

retention due to leiomyoma¹⁵. They suggest that short term management of acute urinary retention due to uterine leiomyoma (size \geq 5-6 cm) is bladder decompression by catheterization, while long term management is based on either uterus preserving options (in whom fertility is desired) or hysterectomy in those who are menopausal. Pre/perimenopausal women may be tried with hysterectomy or GnRH agonists, aromatase inhibitors or ulipristal acetate.

Conclusion

Fibroids are usually asymptomatic. Patients can present with a range of symptoms depending on its size and location. In the above cases the patient presented with acute symptoms and prompt diagnosis and conservative surgery helped us to relieve them of the acute symptoms and save the uterus for future reproduction.

REFERENCES

- Rice K E, Secrist J R, Woodrow E L. et al. Etiology, diagnosis, and management of uterine leiomyomas. *J Midwifery Womens Health*. 2012;57:241–247
- Wu CQ, Lefebvre G, Frecker H, Husslein H. Urinary retention and uterine leiomyomas: a case series and review of literature. *Int Urogynecol J*. 2015;26(9):1277–84
- Mavromatidis G, Dinas K, Mamopoulos A, Delkos D, Rouso D. Acute urinary retention due to a uterine fibroid in a non-pregnant woman. *Clin Exp Obstet Gynaecol*. 2009;36:62–63
- Novi JM, Shaunik A, Mulvihill BH, Morgan MA. Acute urinary retention caused by a uterine leiomyoma: a case report. *J Reprod Med*. 2004;49:131–32
- Hosokawa Y, Kishino T, Ono T, Oyama N, Momose H. Two cases of female acute urinary retention caused by an impacted pelvic mass. *Int J Urol*. 2005;12:1069–70
- Barnacle S, Muir T. Intermittent urinary retention secondary to a uterine leiomyoma. *Int Urogynaecol J Pelvic Floor Dysfunct*. 2007;18:339–41
- Yang JM, Huang WC. Sonographic findings of acute urinary retention secondary to an impacted pelvic mass. *J Ultrasound Med*. 2002;21:1165–69
- Ding DC, Hwang KS. Female acute urinary retention caused by anterior deflection of the cervix which was augmented by an uterine myoma. *Taiwan J Obstet Gynaecol*. 2008;47:350–51
- Non-puerperal uterine inversion due to submucous myoma in a young woman: a case report Marjolijn de Vries, Denise Arlette Maria Perquin*de Vries and Perquin *Journal of Medical Case Reports* 2010, 4:21
- Gomez-Lobo V, Burch W, Khanna PC: Non-puerperal uterine inversion associated with an immature teratoma of the uterus in an adolescent. *Obstet Gynecol* 2007, 110:491-493
- Omololu OM, Rabiou KA, Quadri MA, Oyedeko MO, Fatogun YM. Non puerperal uterine inversion due to Submucous fibroid: A case report. *Niger Postgrad Med J* 2011;18:158-60
- Chhabra S, Agrawal V. Inversion of uterus – Vagaries of presentation. *J Obstet Gynecol India*. 2009;59:162–4
- Mihmanli V, Kilic F, Pul S, Kilinc A, Kilickaya A. Magnetic resonance imaging of non-puerperal complete uterine inversion. *Iran J Radiol*. 2015;12:e9878
- Wu CQ, Lefebvre G, Frecker H, Husslein H. Urinary retention and uterine leiomyomas: a case series and review of literature. *Int Urogynecol J*. 2015;26(9):1277–84
- Lefebvre G, Vilos G, Allaire C, Jeffrey J, Arneja J, Birch C, et al. Clinical Practice Gynaecology Committee, Society for Obstetricians and Gynaecologists of Canada. The management of uterine leiomyomas. *J Obstet Gynaecol Can*. 2003;25:396–418. quiz 419-22