A CASE OF LARGE CERVICAL FIBROID

THE CHALLENGING HYSTERECTOMY!

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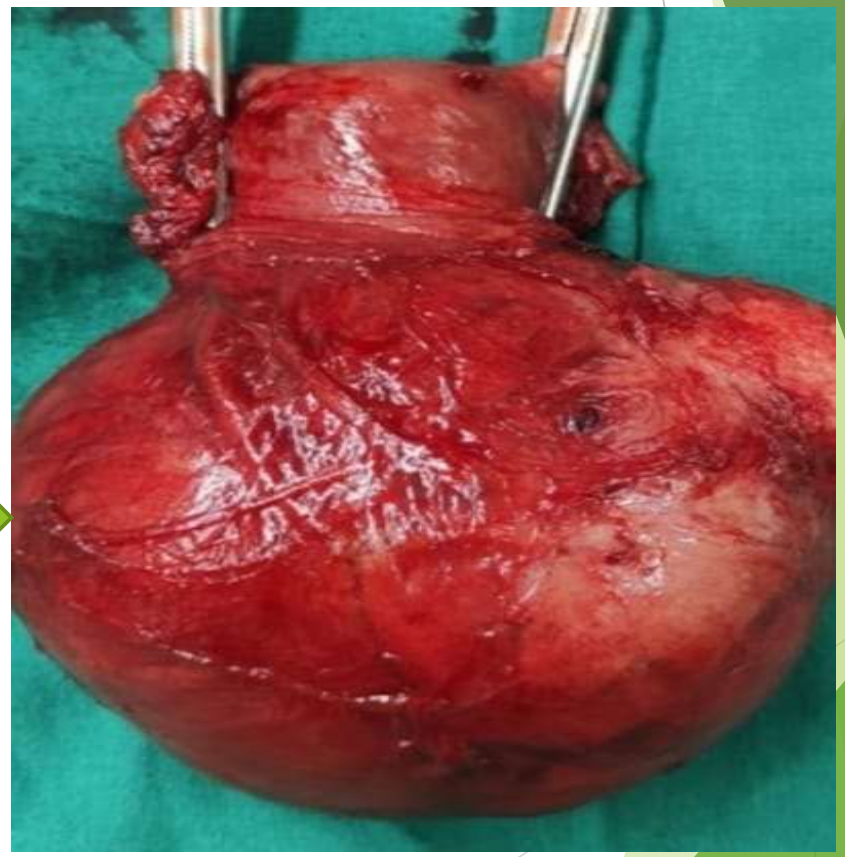
LANTERN ON THE DOME OF ST.PAUL'S CATHEDRAL ,LONDON



CASE HISTORY

- Mrs. XYZ, 45 years old ,female P2L2
- Previous 2 normal vaginal deliveries
- Married since 25 years came with complaints of-
- Heaviness with dragging sensation in lower abdomen
- Repeated episodes of retention of urine
- Burning micturition on and off and since last 1 year.

- No complaints of Pain bdomen
- No C/O PV Bleed,
- No C/O PV Spotting,
- No C/O Menstrual Irregularities

MENSTRUAL HISTORY

- LMP-21/9/2023.
- Previous Menstrual Cycle-Regular, Moderate flow, No Dysmenorrhea.

OBSTETRIC HISTORY

- Married since 25 years.
- 1ST CHILD: FEMALE/ 20 YEARS/ FTNVD
- 2ND CHILD: MALE/ 18 YEARS/ FTNVD

PAST HISTORY

- H/O Lap TL done 17 years back.
- No H/O any significant medical or surgical illness in the past.

PERSONAL HISTORY

- Bowel- Regular
- Bladder-Complaint of difficulty in complete passage of urine and weak stream of urine.
- Sleep- Disturbed due to increased urine frequency and burning micturation

FAMILY HISTORY

- No history of similar complaints in the family.

ON EXAMINATION

- Patient was average built and well nourished
- Height: 154 cm
- Weight : 50 kg ,BMI=22.7 Kg/m2.
- No Pallor , Icterus, edema, clubbing, cyanosis
- Afebrile
- Pulse: 88 bpm
- BP: 118/ 78 mm of hg
- CNS: patient was well oriented to time place and person.
- CVS: S1S2 heard
- RS: Air entry bilaterally equal

PER ABDOMINAL EXAMINATION:

- Single, large, non tender, globular mass was palpable in lower abdomen
- Approx 14-16 weeks size
- Fundus could not be palpated
- Smooth surface, Firm in consistency
- Restricted mobility from side to side
- Lower border of margin could not be reached
- No Ascites

PER SPECULUM EXAMINTION

- Cervix appeared normal
- No erosions
- No bleeding
- No discharge

BIMANUAL EXAMINATION

- Single, large, globular ,firm mass in pelvis of 14-16 weeks size.
- Restricted mobility
- Nontender
- B/L forniceal fullness present

PER RECTAL EXAMINATION

- Firm mass was palpable

PROVISIONAL DIAGNOSIS

45 years female, with previous 2 full term normal vaginal delivery with central cervical fibroid

MANAGEMENT

- Investigations:
- Hemogram
- Urine routine microscopy
- Renal function test
- Blood grouping and Rh typing
- USG (A+P) .

USG FINDINGS

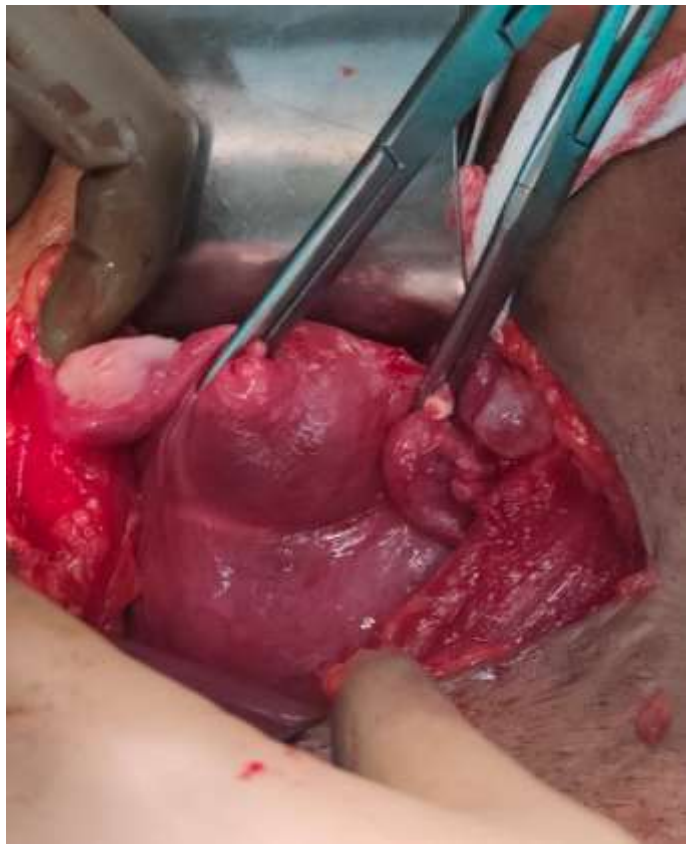
- A well defined
- Heterogenously hypoechoic lesion
- Size 10x10x11cm
- Arising from anterior uterine wall in lower uterine region and anterior wall of cervix
- Colour Doppler-mild internal vascularity
- Suggestive of fibroid
- Intending urinary bladder with mild left sided hydroureter

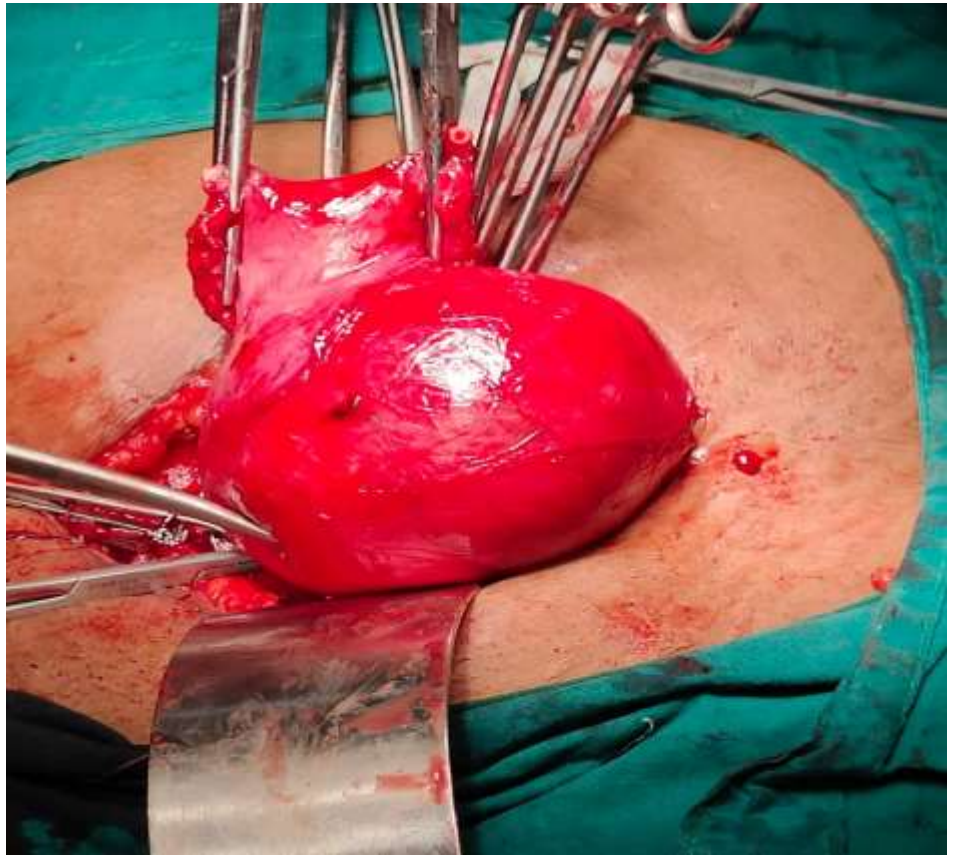
TREATMENT:

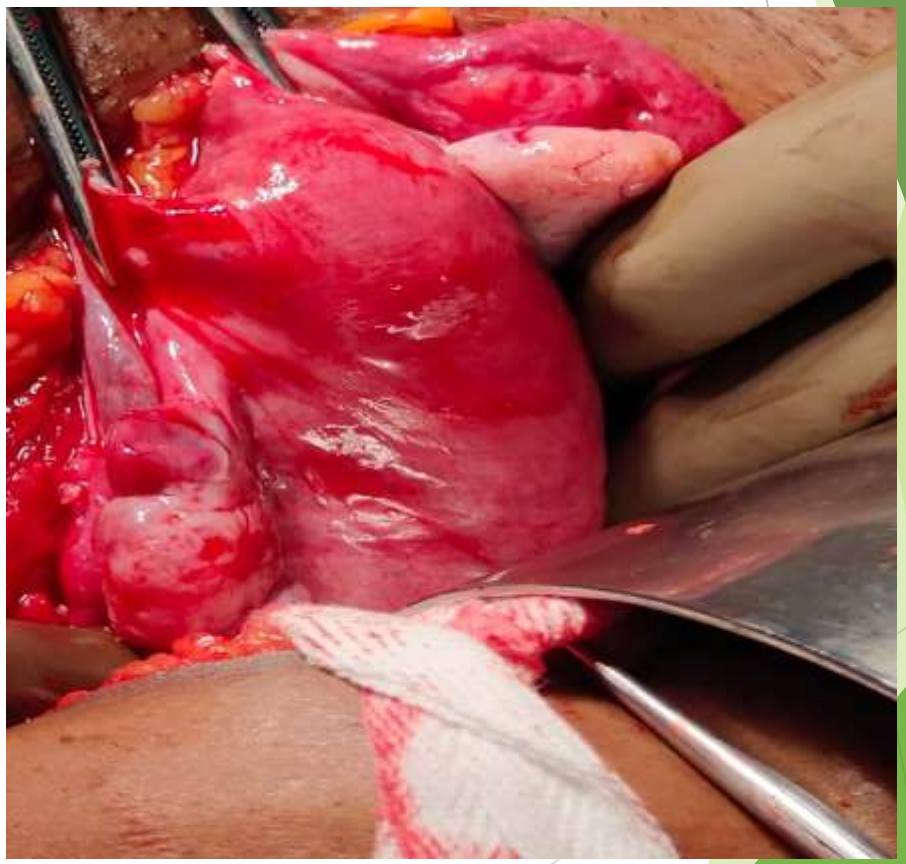
After all investigations and written informed consent, a decision of

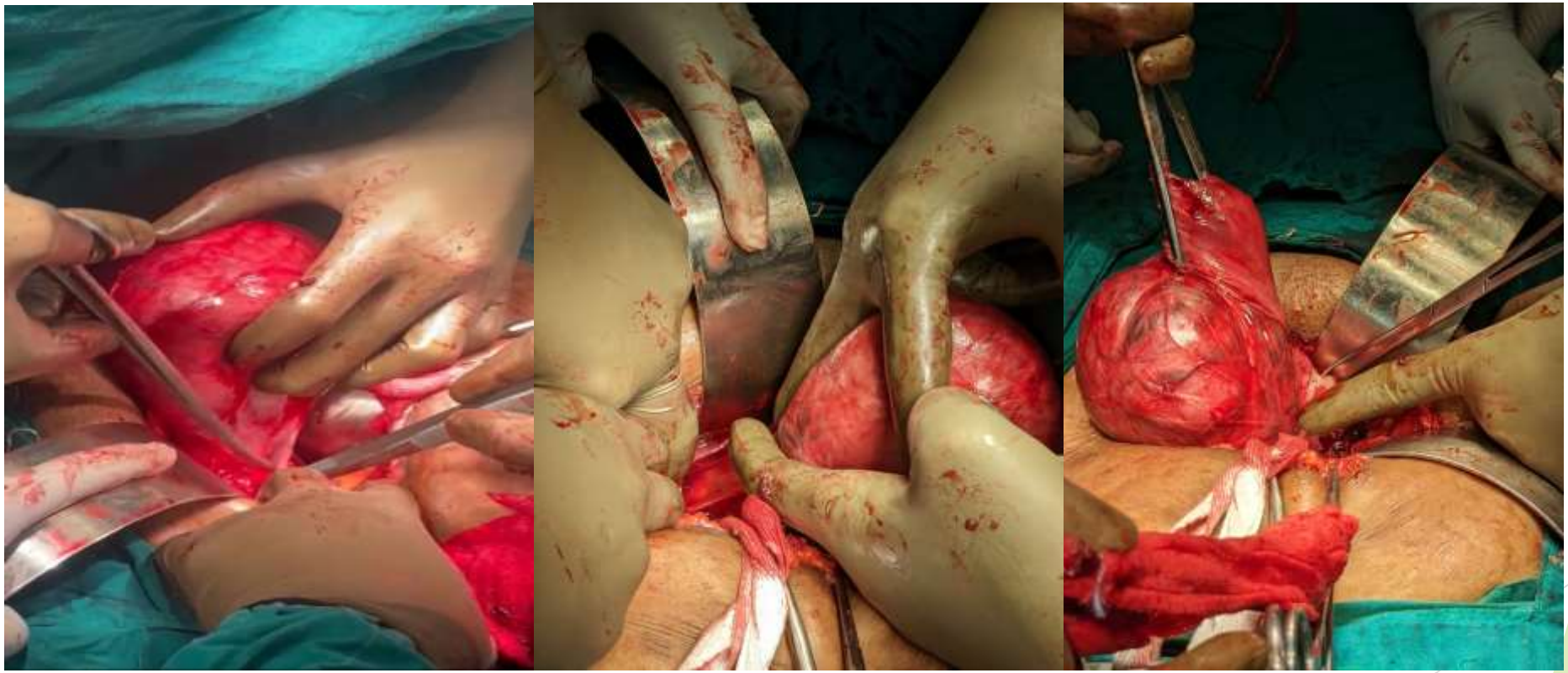
Total Abdominal Hysterectomy with Bilateral Salpingectomy was taken.

Intra operative findings: FIBROID WAS FOUND TO BE ARISING FROM CERVIX OF SIZE 10x12x12 CM









DIFFICULTY ENCOUNTERED IN CASE OF CERVICAL FIBROID:

- They give rise to greater surgical difficulty by virtue of relative inaccessibility and close proximity to bladder, ureter and uterine vessels
- Space and exposure
- Bladder mobilization
- Clamp placement
- Finding of apex of vagina.

OVERCOMING CHALLENGS

- Knowing the anatomy
- Pushing the bladder downwards.
- Retropritoneal dissection
- Debulking myomectomy

REMOVED SPECIMEN

- Entire fibroid along with uterus was removed in entielty.

POST OP

- There was no post operative complications
- Foleys catheter was removed after 24 hours after surgery
- Patient was discharged on post op day 7 of surgery

DISCUSSION ON CERVICAL FIBROID:

- Fibroids are most common benign tumors of female in reproductive age out of which cervical fibroid is unique and rare.
- Incidence of cervical fibroid: 1-2%(less than 5%)

HISTORY

- The term fibroid was introduced by ROKITANSKY in 1860 and KLOB in 1963.
- German pathologist RUDOLF VIRCHOW demonstrated that these tumors originated from uterine smooth muscle cells and introduced the term MYOMA.

TYPES OF CERVICAL FIBROID

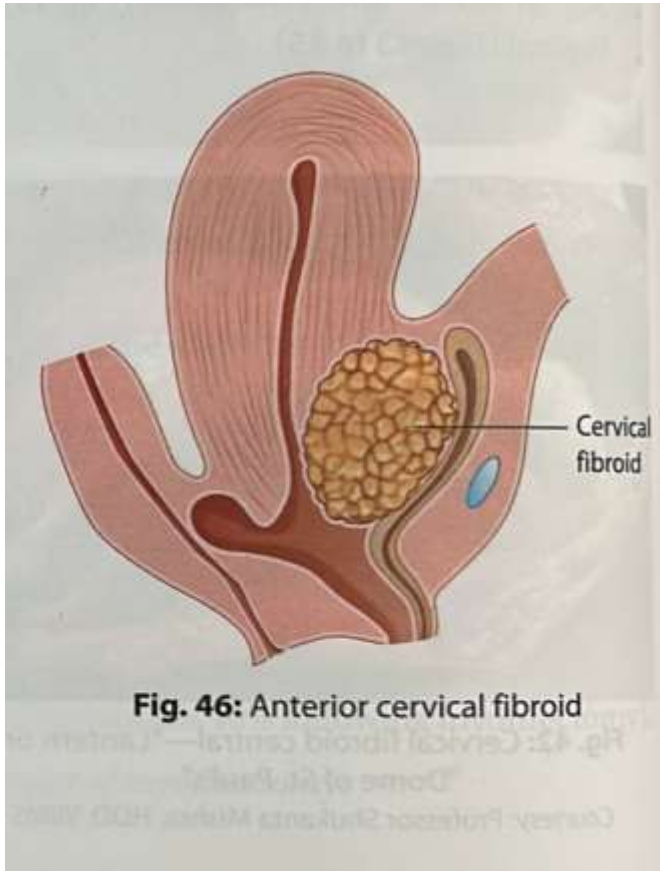


Fig. 46: Anterior cervical fibroid

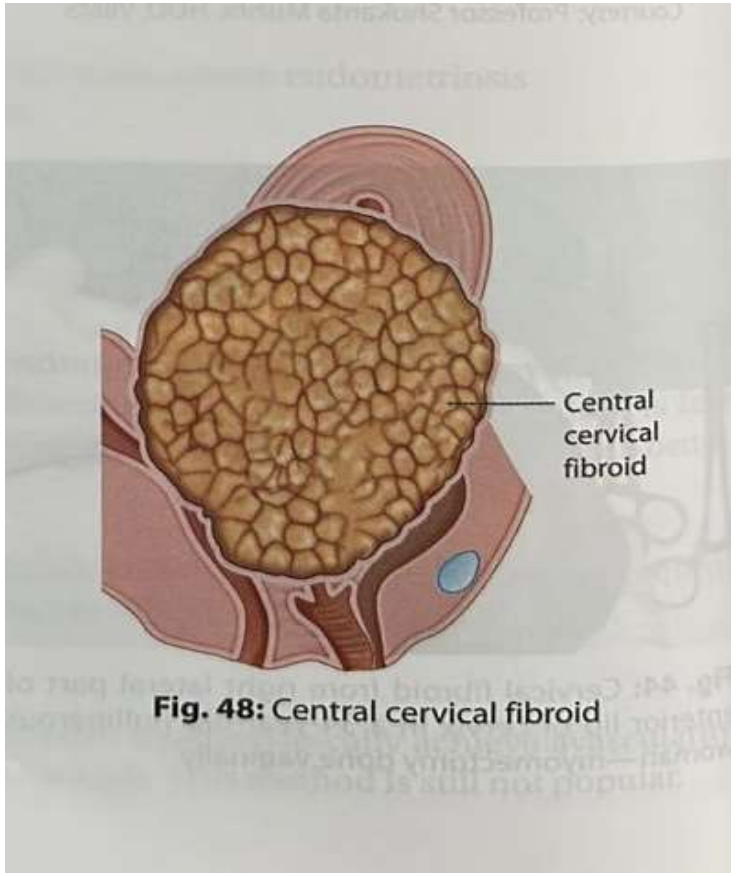


Fig. 48: Central cervical fibroid

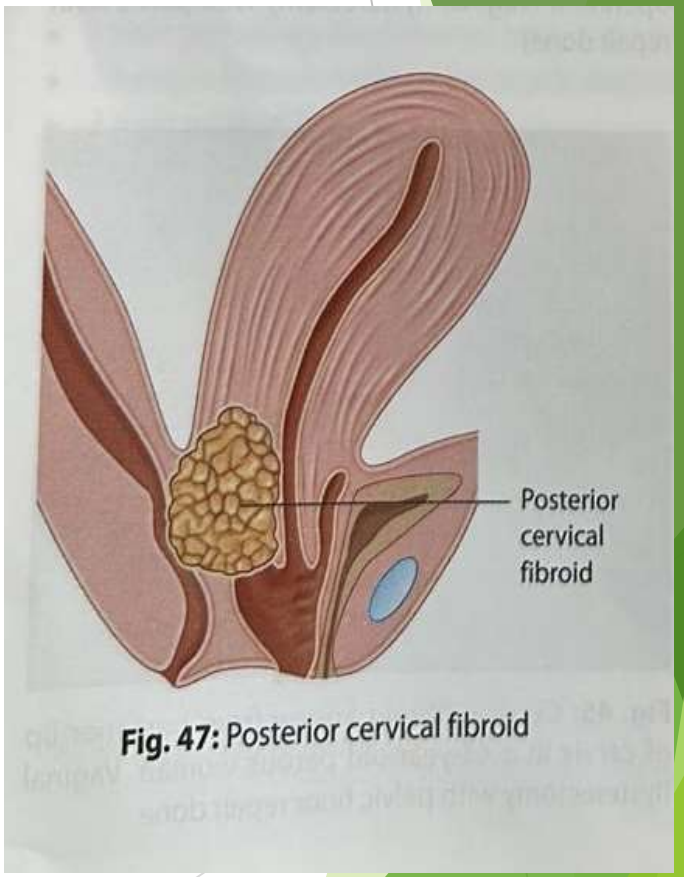
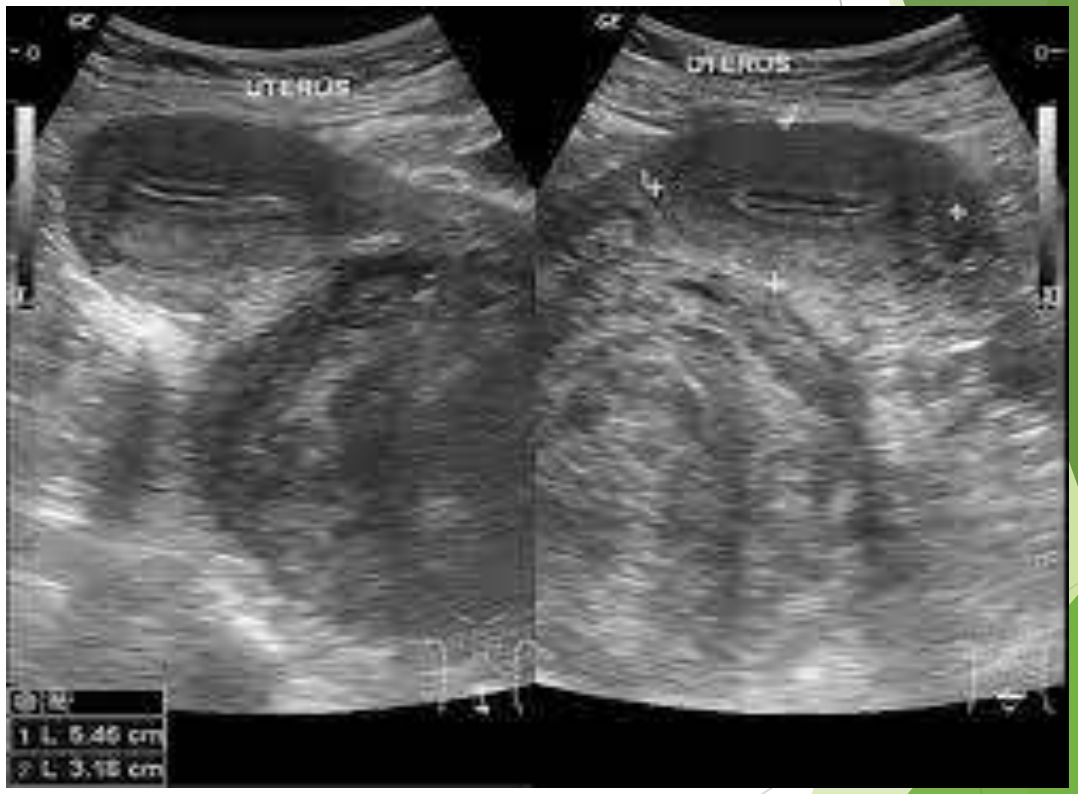


Fig. 47: Posterior cervical fibroid

ROLE OF USG?

- USG is most readily available and least costly imaging technique to diffrentiate fibroids from other pelvic pathology

- It is reasonably reliable for uterine volume of 375cc and 4 or fewer fibroids.



USG helps to detect :

- Size
- Site
- Number of fibroid
- Location

3D USG helps in fibroid mapping

ROLE OF MRI?

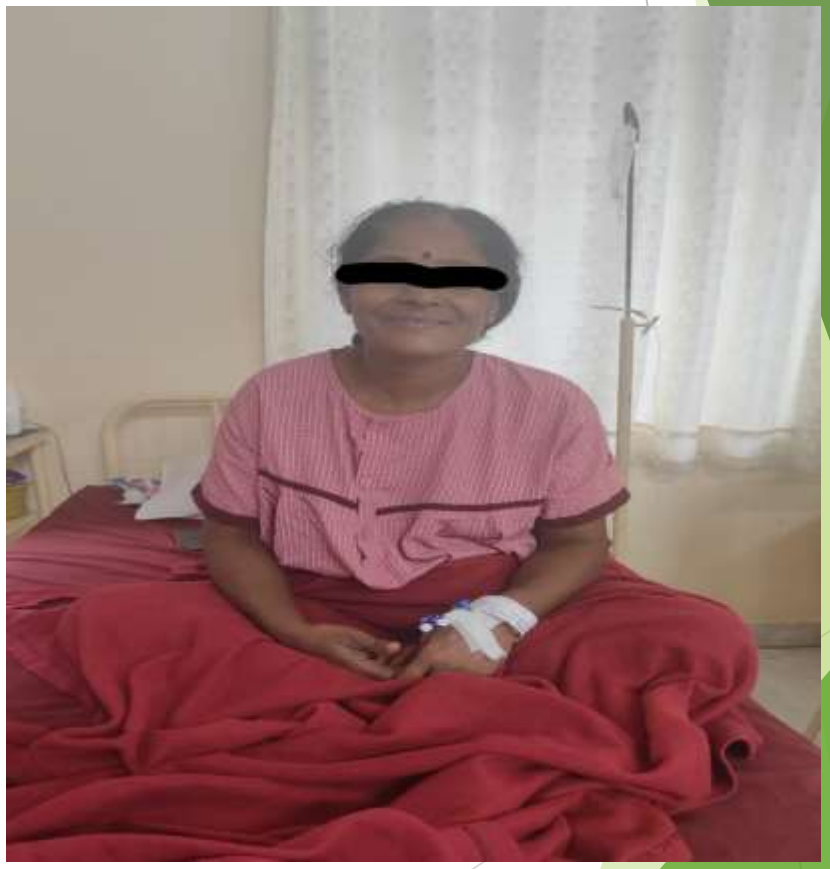
- MRI is not technique dependant and has low inter-observer variability for diagnosis of sub mucosal , intramural fibroids and other fibroids as compared to USG.
- MRI allows evaluation of number ,size and position of fibroids .Also it can evaluate their proximity to bladder, rectum and endometrial cavity .

- MRI helps define what can be expected at surgery and may help surgeon avoid missing fibroids during surgery .
- For women who wish to preserve fertility, MRI helps to document location, position relative to endometrium and is very helpful prior to hysteroscopic, laparoscopic and abdominal myomectomy.

CONCLUSION:

- Inspite of fibroid being huge ,vascular and deeply impacted in pelvis there was no injury to ureter or any other adjacent structures which was great advantage to the patient.
- Thus we conclude that proper preoperative evaluation , preparation and knowledge of altered anatomical structures are important for surgical treatment of cervical fibroid and MRI should be considered pre operatively for proper evaluation of anatomy.

- Patient was completely relieved from her urinary complaints post operatively.



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THANK YOU