Inadvertent prolapse of a huge cervical fibroid mimicking acute uterine inversion: A case report

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Abstract

Prolapse of cervical fibroid is a rare but life threatening occurrence. This complication may occur early in some patients while in others it may follow complications like constipation, difficulty in micturition to mention a few. A 47 year old Para o^{+o} lady presented to the Accident and Emergency Unit of our hospital with a two(2) day history of a huge mass protruding per vagina and a history of significant bleeding per vagina. Packed Cell Volume was 19% on admission and she had Four(4) units of blood transfused. She subsequently had examination under general anaesthesia and cervical myomectomy was done. Her Post Operative clinical state was satisfactory.

Prolaps inadvertent d'un énorme fibrôme cervical imitant une inversion utérin aiguë; un rapport de cas

Résumé

Le prolapsus du fibrome cervical est un phénomène rare mais potentiellement mortel. Cette complication peut survenir tôt chez certains patients tandis que chez d'autres, elle peut faire suite à des complications telles que la constipation, des difficultés de miction, pour n'en citer que quelques-unes. Une dame Para o $^{+o}$ de 47 ans s'est présentée à l'unité des accidents et des urgences de notre hôpital avec des antécédents de deux (2) jours d'une énorme masse dépassant par vagin et d'antécédents de saignements importants par vagin. Le volume de cellules concentrées était de 19 % à l'admission et quatre (4) unités de sang lui ont été transfusées. Elle a ensuite été examinée sous anesthésie générale et une myomectomie cervicale a été pratiquée. Son état clinique postopératoire était satisfaisant.
Mots-clés : Prolapsus, fibrome cervical, inversion utérine, myomectomie cervicale

INTRODUCTION

Cervical fibroids are rare and are usually asymptomatic because of their small sizes. However when they become large they cause pressure symptoms like urinary retention and constipation due to the proximity to the bladder, ureter, urethra and rectum. It may also cause retrograde menstrual blood flow and difficulty during labour and delivery.(1-4) Occasionally, cervical fibroid or submucous fibroid may outgrow its blood supply and become necrotic, this may lead to some patient presenting with offensive vaginal discharge,(5) there may be cramps during menstruation.(6) The case presented below is rare and unique because the history and clinical findings show how dramatic these cases could present and if not promptly managed could be life threatening.

CASE REPORT

Mrs PA, a 47 year old Para o+° woman presented to the Accident and Emergency Unit of our hospital with a two day history of a huge mass protruding per vagina and a history of significant bleeding per vagina. The protrusion occurred following an attempt to bear down on defaecation in the toilet. This was followed by significant bleeding per vagina associated with passage of blood clots. There was no observed passage of fleshy materials nor vesicles. Her last menstrual period was three weeks prior to onset of complaint. There was no history of abdominal distension, there was a prior history of constipation and occasional difficulty in micturition before this period. There was a history suggestive of deep dyspareunia, no history of weight loss, no history suggestive of her involvement in strenuous activities prior to her presentation in our facility. She had been advised on the need to have a surgical intervention to remove a suspected mass in the pelvic region. The patient had a previous exploratory laparotomy for gastrointestinal complication in the past.

On examination at admission she was anxious, pale, not cyanosed, no finger clubbing and no pedal edema. Her Pulse rate was 116 beats per minute and her Blood Pressure was 95/60 mmHg. The abdomen was flat with a midline infraumbilical hypertrophic scar, it moved with respiration. No area of significant tenderness, no palpably enlarged organs and bowel sounds were essentially normal. Vaginal examination revealed a huge mass protruding per vagina and beyond the introital opening with areas of haemorrhages on the protruding mass. Digital rectal examination was essentially normal.

Blood samples was taken immediately for investigations. Her Packed cell volume was 19%, blood was grouped and crossmatched and transfusion commenced immediately. Urethral catheter was passed to monitor urine output and intranasal oxygen supplementation was administered. The serum electrolytes, urea and creatinine were essentially normal. The protruding mass was wrapped with sufratule covered with warm saline gauze to reduce the risk of abrasion injury to the mass. She eventually had four units of blood transfused over 24 hours and 10 millilitres of Calcium Gluconate was administered. Informed consent was obtained and she had Examination Under General Anaesthesia and Vaginal myomectomy done. Findings at surgery revealed a large protruding mass that measured 16 by 18 by 20 centimeters with three centimeters stalk attaching to the anterior lip of the cervix, the cervical os was about six centimeters dilated (Figures 1and 2). The uterus was palpated intact and of a normal size. The mass was excised at the base of the stalk and the end was suture ligated using vicryl 2 suture. Haemostasis was ensured and the vagina was packed with guaze for 6 hours following the procedure. The excised mass weighed 1.8 kilograms.

Her postoperative recovery was satisfactory and she was discharged home on the third post operative day. Histopathologic result of the mass was confirmatory of a cervical leiomyoma.

DISCUSSION

Cervical fibroid is a differential diagnosis of a non-puerperal uterine inversion in a gynecological patient, and usually leads to diagnostic dilemma.(7) In case of prolapsed fibroid vaginally, as in the case of Mrs PA, the treatment modality is vaginal myomectomy with or without hysteroscopy.(8,9) It has been postulated that these prolapse per vagina may occur due to uterine contractions which may make the fibroid mass protrude through the cervix.(8)

The symptoms were initially not suggestive of a gynaecological condition, but with time patient was advised on the need for evaluation and possibility of a pelvic surgical intervention. Nevertheless, her symptoms progressed and eventually she had a prolapse which was followed with significant bleeding per vagina. In cases of acute uterine inversion the symptoms usually involves neurogenic shock

which doesn't occur with prolapsed cervical fibroid.(10)

The sudden nature of the clinical presentation prompted the need for a quick surgical intervention after prompt resuscitation.(9) Her post transfusion packed cell volume was 25%. It is important to have a suspicion of a malignant change considering the history of presenting complaint in this particular case but that fear was allayed by the report of the histology which was suggestive of a benign lesion.

The clinical presentation of Mrs PA was initially atypical and this raised the importance of detailed history, physical examination and investigations before diagnosis was made. If the steps were promptly taken by patient, the resultant complication could have been averted.

Conflict of interest: The authors declare no conflict of interest

Ethical clearance: Ethical clearance was sought and obtained from the Bowen University Teaching Hospital Ethical Research Committee.

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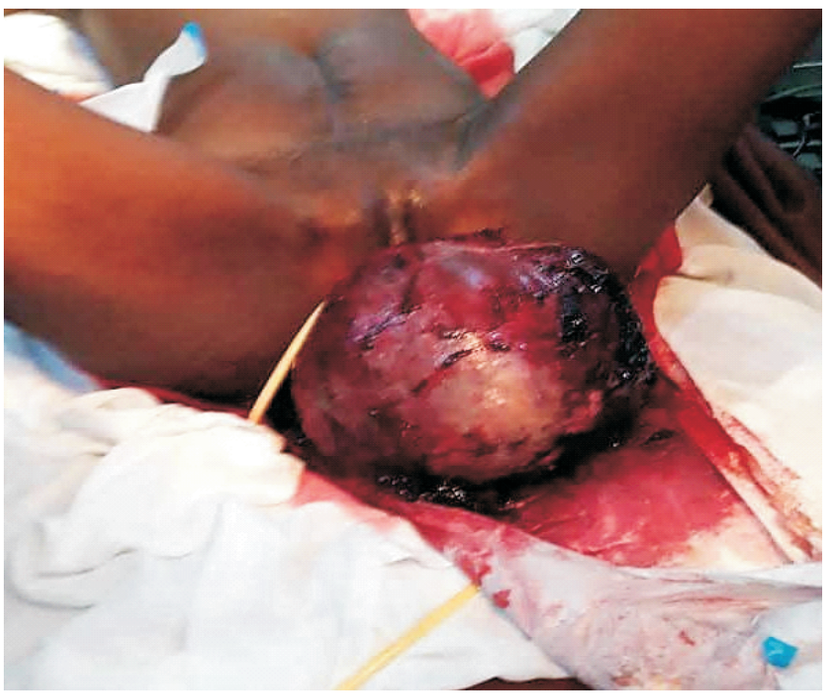

Figure 1. Huge prolapsed cervical fibroid mimicking Acute Uterine Inversion

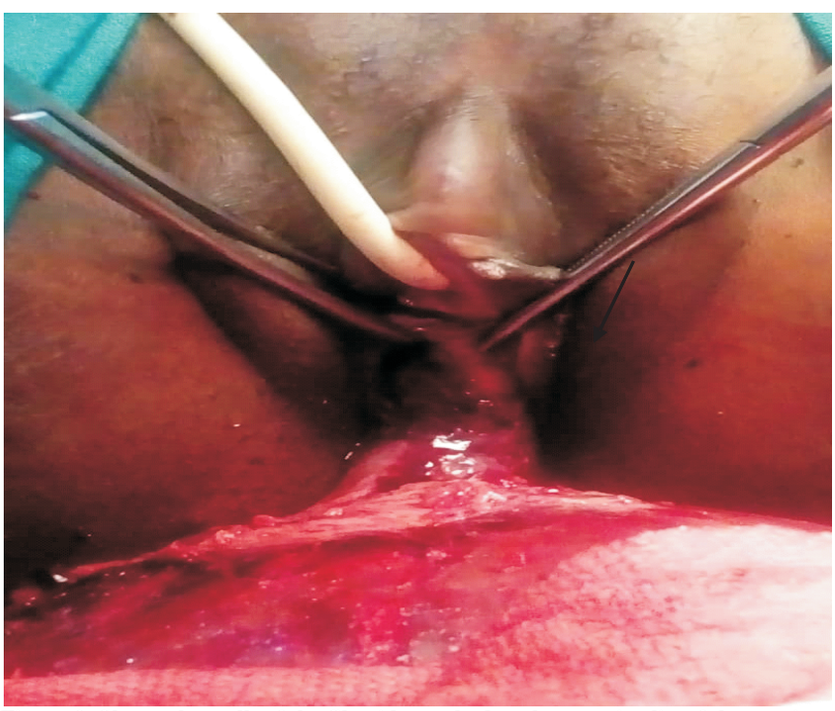

Figure 2. Shows the stalk of the fibroid attached to the anterior lip of the cervix (indicated by the arrow)

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