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GIANT UTERINE LEIOMYOMA: A CASE REPORT AND LITERATURE REVIEW

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ABSTRACT

Background: Uterine leiomyoma are the most common uterine pathology among all female pelvic pathologies. The location of a uterine fibroid plays an important factor in symptoms presentation. Submucous fibroids and intramural fibroids could present at early stages with PV bleeding, recurrent miscarriages, or dysmenorrhea. However subserosal fibroids will go unnoticed for a long time until they become big enough to cause pressure effect or an obvious mass. Huge leiomyomas can grow to enormous sizes, and giant leiomyomas are the ones that weigh >11.4 kg. With many cases published regarding that. **Case:** We report a case of a 43 years old nulliparous lady who presented for a regular medical checkPup after developing a huge abdominal mass extending from below the symphysis pubis reaching up to the xiphisternum. That was ignored for more than 3 years for personal issues, She was fully investigated and councilled regarding methods of management and prognosis. Patient underwent Laparotomy Myomectomy of around was 35x13x18cm myoma that weighs 11.802 kg. Histopathology report gave the diagnosis of Leiomyoma with hyaline degeneration with no sarcomatous changes. She had uneveventful post operative period and was dishcraged home stable. **Conclusion:** Most subserosal fibroids will go unnoticed for a long time until they become big enough to cause pressure effect or an obvious mass. Huge abdominal masses could originate from many organs, the most common diagnosis in females of reproductive age is a benign uterine fibroid. Management of uterine fibroids depends on many factor and surgical excision could be very challenging especially with large masses adherent to other organs. PrePop, intraPop and postP op care are all of extreme significance in preventing adverse outcomes in such cases.

KEYWORDS: Giant Uterine Leiomyoma, Myoma.

INTRODUCTION

Pelvic Uterine fibroid is also known as leiomyoma as it arises from uterine smooth muscle. It is considered to be the most common benign gynecological tumor of the female pelvis, believed to be related to etsrogen effect. As it is more prevalent among females in reproductive age group, it decreases after menopause and almost very rare among adolescnets. Clinically, these leiomyomas are diagnosed in approximately 25% of population.[1]

According to their location, uterine leiomyomas are classified into subserosal, intramural and submucosal. In addition to uterine leiomyoma, there are also extrauterine leiomyomas. Subserosal uterine leiomyomas are often relatively asymptomatic, therefore, they sometimes become very large even before the patient becomes aware of them. In comparison, intramural and submucosal uterine leiomyomas are usually symptomatic, even in small sizes. Most common presenting symptoms of uterine leiomyomas are menorrhagia, infertility, severe dysmenorrhea, abdominal distension. Added to that other non specific symptoms as frequent urination, Difficulty emptying the bladder, Constipation, vague Backache or leg pains Huge leiomyomas can grow to enormous sizes, and giant leiomyomas are the ones that weigh >11.4 kg according to many published studies and case reports.[2-6]

CASE REPORT

A 43PyearPold Nulliparous Bahraini lady, Married since 4 years, visited our Obstetrics and Gynecology outpatient clinic for routine checkup. She was having regular menstrual history with fair amount of bleeding, No abdominal pain or PV discharge, away from complain of increase in her abdominal girth.

Patient was anxious a radiological imaging that was done in private hospital and disclosed a mass most likely originating from the uterus. According to the patient she has been noticing this significant increase in abdominal girth since 3 years but ignored it due to being busy with her husband who was recently diagnosed to have renal cell carcinoma required surgical excision and with chemotherapy and had just completed his treatment course. Then she decided to undergo a medical consultation. Patient denied any weight loss, night sweats, hematuria, flank pain, appetite changes or sleep disturbances.

Her last health service visit was 5 years back when she visited assisted reproductive clinic

throughout her previous marriage that lasted for 2 years for primary infertility.

On examination, abdomen was soft and lax, no tenderness or rigidity but was distended with a large mass around 30 weeks in size midway between umbilicus and xiphisternum. The external genitalia were normal as well as speculum examination. It was not possible to discriminate the origin of the tumor on pelvic examination. Routine labarotory test results were normal as well as tumor markers. MRI pelvis was reported as, a 30cm x 20cm mass looks of uterine in origin with no sarcomatous changes, other two fibroids were also present. A small hemorragic cyst in the right ovary as well and left ovary was normal So underwent Laparotomy through a vertical midline incision from the xiphoid process till the symphysis pubis, a large tumor originating from the uterus occupying the whole abdomen was identified, looks like pedunculated subserosal fibroid that was filling the entire lower abdomen (Figure 1), initially appeared to be retroperitoneal as it was severely adherent to the bowel that required dissection. Uterus was spared.

Myomectomy was done and homeostasis secured.

The postoperative period was uneventful, and the patient was discharged five days after the operation in excellent condition. The removed specimen was 35x13x18cm size and 11.802 kg in weight (figure 2).

Microscopic examination revealed a leiomyoma with hyaline degeneration. The Peritoneal fluid was Negative for malignancy. All together made up the final diagnosis of uterine leiomyoma with no sarcomatous changes.

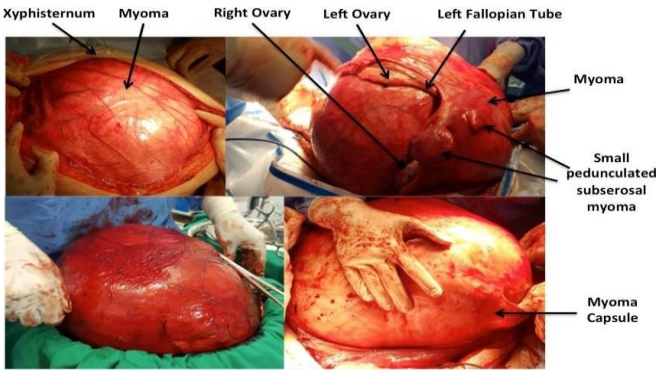

Figure 1: Myoma in correlation to size of a the hand. Rotated uterus and fallopian tube demonstrated. Small pedunculated myoma.

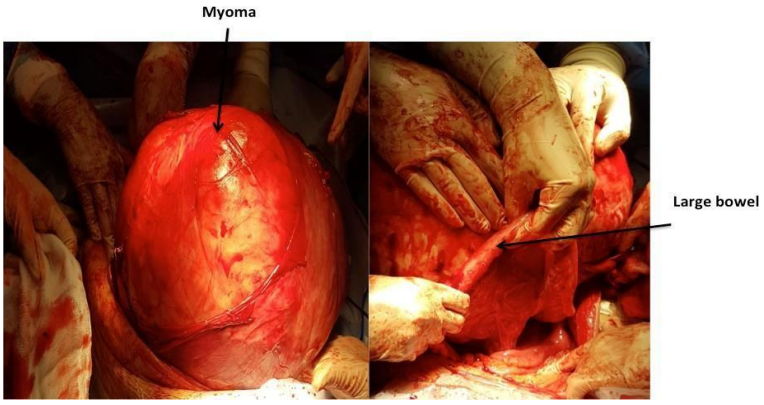

Figure 2: Myoma and segment of adherent large bowel loop.

DISCUSSION

Only few cases of giant uterine tumors have been reported in the recent literature. The reporting of large uterine leiomyomas dates back to as old as 1888 after postPmortem resection of a leiomyoma weighing 63.3kg, this was ever the largest documented giant leiomyoma in literatures.[7] The largest leiomyoma resected in a patient that survived the procedure was weighing 45.4kg.[8] Masterson reported a 60.7Pkg myoma that was removed from a patient in 1930, but she died of pneumonia 48 hours later.[9]

The main factor that plays an important factor for early diagnosis of the myoma in the early symptoms that patient may experience and accordingly will seek medical attention for, That maily depends on the location of a uterine fibroid. For example, Submucousal fibroids and intramural fibroids could present at early stages with PV bleeding, recurrent miscarriages, or dysmenorrhea.[10] On the other hand, most subserosal fibroids will go unnoticed for a long time until they become big enough to cause pressure effect or an obvious mass. This was the case with our patient, in which she only presented for a medical checkPup when she already developed a huge abdominal mass from below the symphysis pubis reaching up to the xiphisternum. Other risk factor that may predispose her to develop such a huge mass was personal stressful, by itself could have been a risk factor for fibroid formation[11,12] in addition to other risk factors like nulliparity and ethnic group.[13]

Management of uterine leiomyomas vary from conservative to surgical based on many factors that are taken into consideration including the size, location and number of myomas.[14] In our case, the patient was diagnosed to have a large myoma occupying most of the abdominal and pelvic cavity. This left us with only one option of myomectomy through an open approach, she was also coucniled about the propability to proceed for hysterectomy

in case myomectomy was not possible. Added to that, she was aware that in case of sarcomatous changes evidenced on the histology then a second surgery will be needed which will include a hysterectomy and bilateral adnexectomy. Patient was also aware that even an MRI cant be diagnostic of sarcomas.

The combined preoperative and postoperative mortality of giant leiomyomas back in 1979 reached up to 15%.[7] Indeed, challenges few decades back could be due to prePop patient preparation, lack of some surgical instruments, duration of surgery, lack of variety of agents and methods to manage hemorrhage and secure hemostasis, infection control, and postPoperative care like DVT prophylaxis. In a review of ten years from 1999 to 2008 in a teaching hospital, studying 248 patients, no mortality rates were detected.[15] This sheds the light on the importance of prePop evaluation maintaining adequate hemoglobin levels as well as appropriate anesthesia review. In addition, intra Pop management with newly introduced instruments, hemostasis achievement and shorter duration of surgery all play an important role in reducing morbidity and mortality. PostPop patients' care with early mobilization and DVT prophylaxis with TED stocking and clexane injections as well as preventing infection with antibiotics coverage also effects the end result.

CONCLUSION

Huge abdominal masses could originate from many organs, the most common diagnosis in females of reproductive age is a benign uterine fibroid. Management of uterine fibroids depends on many factors and surgical excision could be very challenging especially with large masses adherent to other organs. PrePop, intraPop and postPop care are all of extreme significance in preventing adverse outcomes in such cases.

The treatment should be individualized according to both the symptoms severity and the patient's desire to preserve fertility are very important. The final diagnosis can be made either intraoperative or histologically. Also imaging technique can in some cases miss some associated pathologies due to the size of the giant myoma. The patients should be informed about this possibility and about the need for adapting or changing the planned surgery to attempt a complete recovery.

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