



AN UNCOMMON CASE OF PROLAPSED PEDUNCULATED SUB MUCOUS FIBROID

Keeranmayee Mishra*, Tushar M Shah, Pallavi Ninama, Chirag Parikh

B.J.Medical College, Asarwa, Ahmedabad-380016, Gujarat, India.

Corresponding Author: - **Keeranmayee Mishra**
E-mail: keeran.subham@gmail.com

<p>Article Info Received 17/08/2014 Revised 06/09/2014 Accepted 12/09/2014</p> <p>Key words: Submucous fibroids, Menorrhagia, Forceps.</p>	<p>ABSTRACT 5-20% women in their reproductive age are reported to have fibroid. Pedunculated submucous prolapsed fibroids are uncommon tumours. The patient in this case presented with menorrhagia and severe anaemia. Abdominal hysterectomy was done but fibroid was removed by an episiotomy and application of obstetric forceps.</p>
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INTRODUCTION

Pedunculated prolapsed submucous fibroids are uncommon if not exceedingly rare tumors of uterus. Incidence is low accounting for only 05 % of all occurrences of fibroid among women. Though least common variety it produces the maximum symptoms. Management options can range from polpectomy to hysterectomy [1].

CASE REPORT

A 38 years old female P1 A0 L0 patient presented to the outpatient department with complaints of menorrhagia since 3 months. She was extremely pale, cachexic owing to excessive bleeding. Her general condition was conscious, oriented to time, place and person, pulse rate 122/min, Blood pressure 100/70 mmhg, Temperature normal, respiratory and cardiovascular auscultation was normal. On examination-per abdomen-soft, no other abnormality. Per speculum-cervix not visualized, excessive bleeding present, clots passed, globular structure with smooth surface, bulging in vaginal cavity which did not bleed on touch seen. Per Vaginum-mass of size nearly 12*10 cm felt protruding out from os, Cervix and uterus not delineated. Investigations on day of admission-Hb-4.74gm/dl, rest all investigations within

normal limits. Ultrasonography (Abdomen + Pelvis)-10 x 7 cm well differentiated heterogeneous echo texture lesion noted in lower segment of uterus/cervix with internal vascularity s/o- lower uterine segment/cervical fibroid, b/L adnexa normal, no other abnormality detected, USG + KUB-within normal limits

Blood transfusion with 3 PCV was given to patient over 2 days to revive the hemoglobin count. Decision for hysterectomy (abdominal) was taken as menorrhagia was not controlled.

Perop

On opening the peritoneal cavity, a small size uterus with cervix was seen.

A large mass was noted bulging below the plane of the bladder.

Routine steps of hysterectomy were done. 1st round ligament, then tubo-ovarian, the uterine vessels, then uterosacral clamps successively applied. Till then the origin of the fibroid could not be made out. Finally a transverse incision was kept at level of uterine isthmus

A pedunculated large sub mucous fibroid was discovered hanging from posterior wall of uterus about 0.5 cm above the incision.



Figure 1. Pedicle clamped



Figure 2. Cut and ligated



Figure 3. Vaginal view of prolapsed pedunculated fibroid



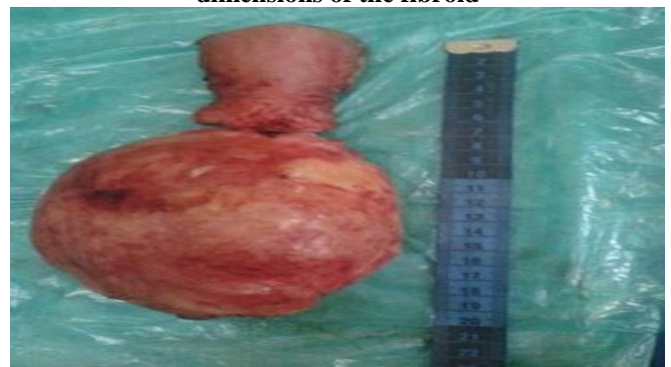
Figure 4. Outlet forceps applied



Figure 5. Fibroid delivered out



Figure 6. Post hysterectomy specimen showing dimensions of the fibroid



Now a pair of clamps was applied to the peduncle, it was cut and ligated.

The mass was now hanging freely in the vagina. Owing to the large size, a decision to deliver out the mass vaginally was taken.

A mediolateral right episiotomy was given.

Outlet forceps were applied on both sides of the mass and it was successfully delivered out 2 PCV were given perop. Clamps were applied below cervix at the vault. Uterus and cervix removed, sent for HPE. The vault was now closed in continuous, nonlocking manner with vicryl. Hemostasis was checked and achieved. Abdomen closed in layers. Episiotomy was also sutured. Post operatively patient was stable and discharged on 9th post-operative day. Histopathologic report was s/o. Leiomyoma of dimensions 13 x 10 x 6 cm³ with cut surface- solid, white, whorled pattern. Rest all normal.

DISCUSSION

Pedunculated prolapsed submucous fibroids are uncommon if not exceedingly rare tumours of the uterus. Mostly present in women of reproductive age group. The presenting symptoms include menorrhagia, infertility, pain, excessive leucorrhoea, the mass may get infected or ulcerated leading to foul smelling discharge, sometimes twisting of the stalk of fibroid may lead to severe pain, dysparenia and rarely uterine inversion. Management options include correction of symptoms medically, vaginal / hysteroscopic myomectomy. But myomectomy carries a recurrence rate of 2-3%. Further large size makes vaginal application of clamps difficult and application of clamp without visualisation of stalk could lead to severe hemorrhage in an already anaemic patient. So a decision of abdominal hysterectomy was made as patient was 38 years old and did not want preservation of uterus [2,3].



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