A CASE REPORT OF AN ENORMOUS PROLAPSED PEDUNCULATED SUBMUCOUS MYOMA

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ABSTRACT

We report the case of a patient with a large spontaneous prolapse of a pedunculated uterine submucosal leiomyoma expelled from the introitus. After the vaginal myomectomy, we performed a total abdominal hysterectomy, because of the enormous size of the myomatous uterus. The final histopathological report revealed a benign submucous leiomyoma and the postoperative recovery was quick without any complications.

Key words: submucous myoma, pedunculated, uterus

INTRODUCTION

Uterine fibromyomas are the most common tumours of the female genital tract and are classified as submucosal, intramural, or subserosal. Myomas are usually associated with abnormal vaginal bleeding, lower abdominal pain, threatened abortion, recurrent miscarriage, intrauterine growth retardation, abruptio placentae, preterm labor, infertility (1). Some of the submucous myomas may be pedunculated and eventually can protrude through the cervical canal and into the vagina (4,7). Even very large myomas can prolapse into the vagina and outside (8). After that, the myoma usually becomes necrotic and sometimes infected (2). Myomectomy for submucous leiomyomas can be accomplished by open, laparoscopic, hysteroscopic, and vaginal approaches (5,9).

Case presentation

A 49-year-old nulliparous woman was hospitalized in the gynecological department with abnormal vaginal bleeding. Pelvic examination revealed the presence of a large tumour mass measuring 38 cm in diameter and prolapsed from the vagina (figure 1). The ultrasound examination demonstrated several fibroids as focal masses with a heterogeneous texture and determined one more submucosal and two intramural myomas. The biggest intramural fibroids measured 85.4 x 84.7 mm and are visualized on figure 2. Laboratory tests showed low haemoglobin level of 72 g/l; hematocrit 0.26 L/L; MCV - 70.6 FL; MCH - 20.6 pg; RDW - 30.2 %; WBC - 7.3 G/L.

With these clinical findings, we interpreted the mass as a prolapsed pedunculated submucous myoma. After the intensive reanimation a vaginal myomectomy was planned.

Fig. 1. A view of a prolapsed pedunculated submucous myoma.

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The final histopathological report revealed a benign submucous pedunculated leiomyoma and myomatous uterus. Venous thrombosis and congestion with interstitial hemorrhage are responsible for the color of a leiomyoma undergoing red (carneous) degeneration.

DISCUSSION

On the first clinical step, after the gynecological and ultrasound examination, we rejected uterine inversion, which is possible after sudden expulsion of the large tumour (3). The main symptoms of non-puerperal uterine inversions are anaemia caused by irregular vaginal bleeding, vaginal discharge, lower abdominal pain, a protruding mass in the

CONCLUSION

Vaginal myomectomy can be chosen as a method of treatment for prolapsed pedunculated submucous myomas. In other cases, when the myoma is not very large a hysteroscopic resection is planned.

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