



ISSN: 0975-833X

Available online at <http://www.journalcra.com>

International Journal of Current Research
Vol. 10, Issue, 09, pp.73747-73748, September, 2018

DOI: <https://doi.org/10.24941/ijcr.32132.09.2018>

**INTERNATIONAL JOURNAL
OF CURRENT RESEARCH**

RESEARCH ARTICLE

A HUGE CERVICAL FIBROID WITH INFERTILITY: CASE REPORT

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ARTICLE INFO

Article History:

Received 17th June, 2018
Received in revised form
20th July, 2018
Accepted 25th August, 2018
Published online 30th September, 2018

Key Words:

Cervical Fibroid, Infertility.

ABSTRACT

Leiomyomas are the most common uterine and pelvic tumors. Cervical fibroids are uncommon (1-2%) and their presentation as huge abdominal mass is even rarer. We present here a case of a 30 year old female who presented with abdominal mass and primary infertility. Abdominal examination revealed a nontender, solid mass of 24 weeks size filling the abdominal cavity with restricted mobility. Lower border of the mass could not be felt. Laprotomy was planned. Laprotomy revealed fibroid arising from supravaginal portion of the cervix displacing the normal sized uterus superiorly. Myomectomy was done with reconstruction of cervical canal. Postoperative period was uneventful. Patient resumed her menses after 1 month.

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Citation: Neena Gupta, Uruj Jahan and Fatima Usmani, 2018. "A huge cervical fibroid with infertility: Case report", *International Journal of Current Research*, 10, (09), 73747-73748.

INTRODUCTION

Fibroids are present in approximately 5-10% of patients with infertility, and are the only abnormality seen in 1-2.4% of patients with infertility (Kaur et al., 2002). Clinical pregnancy, implantation and live birth rates are significantly impaired in women with any location of fibroid. Submucosal fibroids have a relative risk of 0.36 of achieving clinical pregnancy, and a relative risk of 0.32 of having live birth when compared to non fibroid controls. The effect of intramural fibroids on infertility remains unclear. Subserosal fibroids are thought to have little to no effect on fertility. Cervical fibroids are uncommon (1-2%) and usually arise from supravaginal portion of the cervix. The symptoms most commonly presented are retention of urine, menstrual abnormalities, constipation, and sometimes can present only as an abdominal mass without any other symptoms and may mimic an ovarian tumor. The possible mechanisms by which the cause infertility could be Cervical fibroids may compress the cervical canal; when large, they alter the position of the cervix in relation to the vagina and the seminal pool. Cervical myomas may aggravate a retroversion, resulting in fixation of the uterus and hyperemia of the endometrium. Large cervical fibroids are rare and can present with surgical difficulties at the time of either myomectomy or hysterectomy and have an increased risk of urinary tract injuries and intraoperative bleeding.

We present here a case of large cervical fibroid where myomectomy was done successfully.

Case report: A 30 year old female patient attended the outpatient clinic at GSVM Medical College for the first time with complaints of infertility since 10 years for which she has not taken treatment. Since 2 years she complained of abdominal mass for which she reported to a private hospital along with her infertility complaint. Her menses were regular, 2-3days, normal flow. Number of pads used per day was 2-3. Per abdomen examination showed firm, regular, nontender mobile abdominal mass of 24 weeks size. On per speculum examination, Cervix was pulled up. On per vaginal examination, a mass of 24 weeks size with smooth surface, regular, nontender and seemed to be originating from cervix, bilateral adnexa could not be assessed. On ultrasound examination, uterus was enlarged with intramural fibroid of size 17*13cm seen in the anterior wall with anechoic areas seen in it. Endometrial echocomplex was centrally placed and thickness 9.1mm. Bilateral ovaries normal with no evidence of free fluid seen in the cul-de-sac. Her Husband seminogram was normal. Hormonal profile showed raised TSH and prolactin for which she was taking eltroxin 25 microgram and tab cabergoline. Uterine sound was passed through the cervical canal but resistance was felt in the cervical canal. HSG and SIS was tried but could not be done.



Fig.1. Uterus at top of fibroid



Fig. 2. Open cervical canal after removal of fibroid

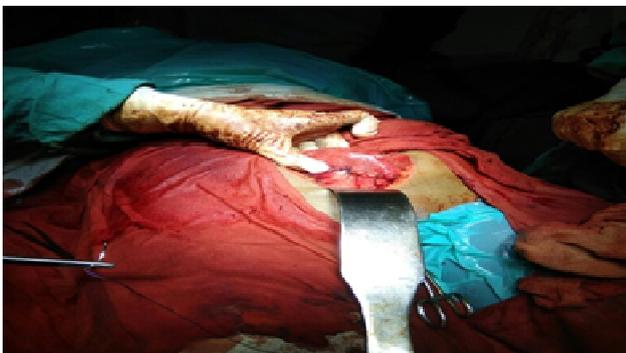


Fig. 3. Reconstructed uterus and cervical canal

Laprotomy was planned. Per operative findings were fibroid of size 18*20 cm arising from the lower segment and cervix extending to the left broad ligament. Uterus was sitting on the top of right side of mass. Uterovesical fold of peritoneum was stretched all over the mass on the anterior side (Figure1).

On opening the uterovesical fold of peritoneum the mass was seen. Transverse incision was given on the capsule and myoma was enucleated. Enucleation was done with blunt dissection of fingers and hemostasis of fibroid bed. After enucleation ant cervical wall was deficient so a catheter was passed through the cervical canal and anterior cervical canal was reconstructed (Figure 2, 3). Hemostasis was achieved. Endometrial cavity opened and was repaired with vicryl 2-0. Both the tubes and ovary are normal. Perop patency of the tube was checked by introducing dye through the catheter placed in the cervical canal. Bilateral spillage of the dye was seen.

DISCUSSION

The paucity of smooth muscles in the cervix uteri makes the incidence of leiomyomas in this region a rare finding in clinical practice. The incidence is about 1%–2%, and the uterine corpus leiomyoma/cervical leiomyoma ratio is about 12:1. Its growth depends on oestrogen-like fibroids located in the corpus, and hence its incidence is commoner among women in their reproductive age group making it less common in premenarcheal and post-menopausal females. It is also commoner among Africans compared to their Caucasian counterparts. Genetic contribution has been demonstrated. Cervical fibroids alter the shape of the cervix or may lengthen it. They may grow large enough to obstruct the cervical canal causing cryptomenorrhoea or may obstruct contiguous structures such as the ureters, bladder and rectum leading to urinary retention, increased frequency of micturition, feeling of incomplete voiding and constipation. It may also lead to menstrual abnormalities, dyspareunia and post-coital bleeding. Imaging techniques such as ultrasound and intravenous urograms may demonstrate the cervical mass with or without calcifications and show back-pressure changes to the urinary system. Treatment options will be dictated by the presentation, patient's desires and the skills of the attending physician and can include resection which can be hysteroscopic or via open abdominal surgery, uterine artery embolisation/ligation, abdominal myomectomy or hysterectomy. If large, the patient may benefit from GnRH analogues to shrink it and thereby making it operable. This will reduce the chances of damage to contiguous structures such as the ureters and urinary bladder². The place of histology cannot be overemphasised as some other cervical masses can mimic it such as cervical polyps, cancer and leiomyosarcomas. In the face of malignancy, such patients can still benefit from adjuvant cytotoxic chemotherapy.

Conclusion

To operate on a big cervical fibroid was a big challenge. Patient could land up into hysterectomy or there could be ureteric injury. During operation cervical canal was opened which was reconstructed and the patient resumed her menses.

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