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Case Study

Prolapsed Myoma: Case Presentation

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Abstract

The prolapsed or abortive myoma is a rare entity and incidental finding in patients who report abnormal uterine bleeding, metrorrhagia type or during sexual intercourse. Its clinical and ultrasound diagnosis is usually very easy, however, it can be subject to medical errors in underestimating its origin and confused with cervical carcinoma or cervical inflammation in obstetricians who are not well trained. In the presentation of this case of a myoma proceeding in a patient who underwent caesarean section and 6 months later began to present persistent spotting-type bleeding, without other concomitants, without an adequate clinical evaluation of it. Therefore, we seek that, with this case, we learn a little more in our professional practice.

Keywords: *Prolapsed Myoma; Uterine Bleeding; Metrorrhagia*

Introduction

Uterine leiomyomatosis are the most frequent benign tumors of the myometrium and one of the main causes of hysterectomies in the world. Most are diagnosed incidentally by ultrasound during gynecological evaluations. Its significance lies in its organic association with uterine hemorrhages, mainly due to its capacity for vascular autonomy and hypertrophic proliferation of myometrial smooth muscle, its easy activation of protein and gene epitopes of estrogen receptors, which favor the stimulation of growth factors cells similar to insulin, which means that these fibroids can grow and be very self-sufficient and independent.

Submucous fibroids, classified as 0, 1 and 2, both by transvaginal pelvic ultrasound and by hysteroscopy, are strongly related to uterine bleeding, due to their intimate relationship with the cycle of endometrial proliferation and desquamation, coupled with the deforming effect it generates on its surface, making it very brittle and prone to bleeding.

In the case of cervical fibroids, they are type 0, characterized by being pediculates, whose thickness will depend on the weight of the overall mass of the fibroid and the progressive tension it may exert on the fibrolaxus tissue of the pedicle. That is why it is very important to determine how large the exposed fibroid is in the vagina, its stem or pedicle and its length, locating it within the uterine cavity. This is relevant when deciding whether the fibroid can be removed on an outpatient basis or, on the contrary, an abdominal or laparoscopic hysterectomy should be performed [1-3].

Vaginal extraction of the fibroid should be avoided if the stem is thick or if the mass looks friable, foul-smelling and is accompanied by other alterations that may suspect a carcinoma [4].

Finally, great importance should be given to post-extraction hysteroscopy of these masses, to locate the base of the stem, scrape it or perform electrofulguration of the area or take biopsy samples if necessary.

Although the transcervical fibroid may be an incidental finding, it should always be properly evaluated and not underestimated as an important cause of abnormal uterine bleeding and also of the possibility of carcinoma. Undoubtedly, these samples should receive histopathological evaluation to help us relate the clinic and the final result.

Clinical Presentation

This is a 34-year-old patient, G4p3c1, with the last caesarean section 6 months ago due to spontaneous obstetric bleeding, when she was at 38 weeks' gestation, without fetal compromise, fundus-located placenta, and fetal ultrasound that indicated a fetus in adequate fetal health. intact membranes, ruling out vasa previa. The treating obstetrician decides to perform an abdominal caesarean section due to possible placental abruption, even when the ultrasound did not report it, taking advantage of the same procedure to perform surgical sterilization due to the maternal desire for irreversible contraception. In the intraoperative period, the surgeon did not report the presence of tumor masses or intracavitary or intramural fibroids with submucosal extension, or internal structural defects. The patient is discharged from her postoperative period at 48 hours, without complications and with outpatient management.

The postoperative and puerperal follow-up up to 3 months, evolves without apparent alterations in terms of the report of uterine hemorrhages, infections, with adequate urination, defecation and general conditions. Amenorrhea course with active lactation.

The patient, 3 months after her last puerperal control, begins to present irregular and intermittent uterine bleeding for a month, of low volume and sometimes a little more abundant, without bad smell, but uncomfortable, which weakens the patient, for which go to a private consultation with an obstetrician.

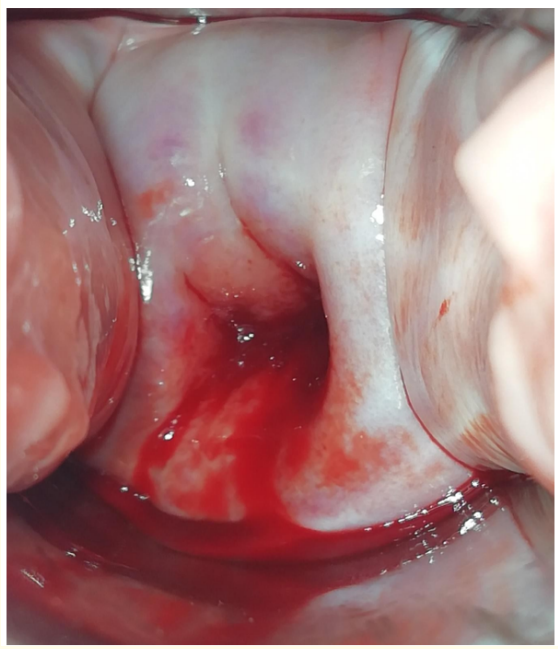
He performs a pelvic ultrasound without showing pathologies and the speculoscopy reports that the cervix appears without alterations, only signs of acute cervicitis, for which he indicates vaginal cream at 20% daily for 7 days based on triticum vulgare (Gynoderain, Lab. Leti).

However, the patient went to the emergency department of our service, 72 hours later, due to intense abnormal uterine bleeding that pierced her clothes, pale and sweaty. In the clinical check-up, despite her bleeding, hemodynamic status was stable, BP 100/60 mmHg, HR 110 bpm, depressible abdomen, slightly painful in the hypogastrium, vulva without abnormalities, speculoscopy, the presence of a rounded mass protruding from the endocervical canal was observed. and it exceeds the external cervical orifice of approximately 4 x 4 x 3 cm to direct vision and vaginal touch, hard consistency, poorly vascularized, whitish in color and not friable, supported by a very thin pedicle from the uterine cavity. Ultrasound revealed an echogenic mass protruding from the cervix, with a visible isthmic echogenic-hypoechogenic pedicle that crossed the endocervical canal, about 8 cm long and approximately 4 mm thick, with faint positive Doppler. Paraclinical: hb of 10gr, normal leukocyte differential count, normal coagulation times, normal fibrinogen and normal transaminases.

It was decided to perform pedicle torsion of the fibroid, grasping it with a hoop clamp, with gentle counterclockwise movements, with local infiltrative anesthesia for the uterus at 3 and 9 o'clock from the cervicovaginal junction, together with the application of 60 mg of sublingual ketorolac for 15 minutes prior to the procedure, extracting said mass without complications and with minimal bleeding. Subsequently, an isthmic curettage is performed with a very soft No.2 sims curette. Hysteroscopy could not be performed due to the lack of said technological resource at that time. The patient was discharged 6 hours after the procedure, with genital staining and prescription of prophylactic antibiotics for 5 days, analgesics, tranexamic acid and oral contraceptives.

The histopathological result of the surgical piece confirmed the diagnosis of leiomyoma, without evidence of malignancy.

Photograph 1: *Prolapsed myoma with the characteristics already described can be seen.*



Photograph 2: *The result is observed, after the mechanical extraction of the fibroid.*

Discussion and Conclusion

In our case, we must highlight several situations to analyze. In the first place, how was it possible that the obstetric surgeon did not observe the presence of this fibroid during the revision of the uterine cavity after delivery? Secondly, that the obstetrician consulted in the private clinic treated it as an acute cervicitis?

The possible explanation is that the patient, at the time of performing her cesarean section due to obstetric bleeding due to her lower segment decompression, descended due to her weight, having a soft and partially dilated cervix, but sufficient to become forward. Therefore, when exploring the lower segment, the surgeon did not detect it and even the pedicle or the latter was very lateralized and was confused with the decidualized endometrial epithelium. If the opposite was the case and he observed it, but did not report it in the story, it should be reprehensible and criticizable.

The second point of the question is as serious as the first, as it confuses a different mass with the anatomy of the cervix, its texture and color. As a clinician, we could infer that the obstetrician lightly observed the cervix, perhaps because part of the fibroid was not yet protruding when the study was performed, perhaps interpreting it as a product of previous cervical deformation from previous deliveries, with friable ectropion resulting from cervical inflammation.

In these situations, it is clear that the important thing is to carry out methodical evaluations, to suspect the presence of transcervical fibroids in the presence of a generally rounded mass that expands the edges of the cervix and that may or may not appear friable, depending on time and the presence of infections.

Likewise, avoid the temptation to extract the fibroid from the origin, without an adequate combined ultrasound evaluation or a pelvic Tomography or MRI, according to the wishes and costs of each service or country. As well as keeping in mind the possibility of intense uterine bleeding, with the risk of hemodynamic complications and with the possibility of performing a secondary hysterectomy. The use of hysteroscopy is essential after the torsion of these fibroids, which avoids the possibility of profuse or persistent bleeding, which may end in a hysterectomy.

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