

CASE REPORT

Rare Case of Asymptomatic Large Intramural Uterine Leiomyoma (Fibroid) in a Patient on Anticoagulants after Double Valve Replacement

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ABSTRACT

Introduction: A leiomyoma or a fibroid is a benign tumour composed mainly of smooth muscle cells with varying amounts of fibrous connective tissue. Most leiomyomas are asymptomatic. Uterine fibroids can be intramural, subserous and submucous.

Case report: In the present case, we are reporting an incidence of asymptomatic, intramural large uterine fibroid in a 52-year-old perimenopausal woman who is on anticoagulants. Ultrasonography of her abdomen showed enlarged uterus with focal lesion noted in the posterior myometrium measuring 11.7cm x 10cm noted with multiple cystic areas and septations within suggestive of degenerative areas. After counselling and obtaining consent, the patient was taken up for total abdominal hysterectomy with bilateral salpingo-oophorectomy. Intraoperatively, the uterus is found to be enlarged to 20 weeks gestation size weighing about 1000 grams. There was a posterior fundal fibroid measuring about 12cm x 10cm, soft and highly vascular. The histopathological reports showed an intramural uterine leiomyoma (fibroid) with hyaline degeneration, cystic change and haemorrhage. Diagnosis was made as a case of an asymptomatic, intramural uterine fibroid.

Conclusion: Large intramural uterine fibroid in a patient on anticoagulants after double valve replacement is very rare. When large asymptomatic leiomyomata occur in premenopausal women who have completed the family or who do not consider further childbearing, a recommendation for removal of fibroid may be made as it is almost impossible to predict which and when the patient will become symptomatic.

Keywords: Pelvic Tumours, Ultrasonography, Benign Tumours, Abdominal Hysterectomy

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INTRODUCTION

A leiomyoma or a fibroid is a benign tumour composed mainly of smooth muscle cells with varying amounts of fibrous connective tissue. Generally, the growth of leiomyomata is dependent on oestrogen production. In multiparous woman, the relative risk of formation of a leiomyoma decreases with each pregnancy. Most leiomyomas are asymptomatic.¹

As far as uterine fibroids are concerned, they are classified as body fibroids and cervical fibroids; based on their anatomical location. Uterine body fibroids are further sub-classified as intramural, subserous and submucous. Among the three, sub-mucous variety is known to show maximum symptoms. However, the sub-serous is least symptomatic.² In the present case, we are reporting an incidence of asymptomatic, intramural large uterine fibroid in a perimenopausal woman who is on anticoagulants.

CASE REPORT

A 52-year-old woman, who is a known rheumatic heart disease patient, had undergone double valve replacement two years ago. As part of preoperative evaluation, an ultrasonography showed a uterine fibroid measuring 11.6x9.8 cm in the posterior uterine wall and the patient was presented to the outpatient clinic of department of gynaecology at Sree Mookambika Institute of Medical Sciences, Kulasekaram, Tamil Nadu, India, with the ultrasonographic report.

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Patient had neither complaints of abdominal pain and nor did she have any menstrual irregularities. She was a P2L2 who was menstruating regularly with normal flow.

On examination, her vitals were stable. Respiratory system examination was normal. During cardiovascular system examination prosthetic click was noted to be present. On abdominal examination, uterus was found to be enlarged to 20 weeks gestation size with smooth surface, firm consistency and transverse mobility.

On local examination, vulva was normal. Her uterine cervix and vagina were also normal. Bimanual examination showed bossing over the posterior uterine wall and in the region of right fornix.

A repeated ultrasonography of the abdomen showed enlarged uterus with focal lesion noted in the posterior myometrium measuring 11.7cm x 10cm noted with multiple cystic areas and septations within suggestive of degenerative areas. Bilateral ovaries were normal, seen posterior to uterus below the fibroid. There was no indication of ascites or pleural effusion. Report indicated a case of degenerative uterine myoma.

Her other routine investigation, reports were as follows: Hemoglobin-12.3g/dl; total blood count- 8,200 cells/mm³; differential count-N59% L31% E9% M1%; ESR - 11mm/hr; Blood group- B positive; RBS - 89mg/dl; Blood urea - 30mg/dl; Serum creatinine - 1mg/dl; Serum uric acid - 5.4mg/dl; Sodium - 139mmol/L; Potassium-9 mmol/L; Chloride - 102mmol/L; HIV, HBSAg, VDRL - Negative; Thyroid profile - Normal; ECG- Normal; Cardiac ECHO - Normally functioning mitral and aortic prosthetic valve. Trivial MREF- 62%; INR (at the time of admission) - 2.16; Prothrombin time - 25.9 seconds; INR (before surgery) - 0.90. The patient was on oral anticoagulants- Tab. ACITROM (ACENOCOUMAROL) 4mg OD.

After counselling and obtaining consent, the patient was taken up for total abdominal hysterectomy with bilateral salpingo-oophorectomy. Prior to the surgery, she was changed over to Inj. HEPARIN 5000 units intravenously, 6th hourly. After obtaining a normal INR (0.90), the surgery was performed. Intraoperatively the uterus is found to be enlarged to 20 weeks gestation size weighing about 1000 grams. There was a posterior fundal fibroid measuring about 12cm x 10cm, soft, highly vascular [Figure-1]. Both the uterine tubes with ovaries were below the level of the fibroid and grossly appeared normal. Postoperative period was uneventful.

The gross cut section of the fibroid showed a large amount of blood clot in side with lots of fibromuscular tissue [Figure-2]. The histopathological

reports showed an intramural uterine leiomyoma (fibroid) with hyaline degeneration, cystic change and haemorrhage [Figure-3 and Figure-4]. A cervical intraepithelial neoplasia type I with nabothian cyst and chronic cervicitis was also observed. Otherwise, uterus was reported to be in weakly proliferative phase with normal uterine tubes and ovaries. However, there was also report of a paratubal simple cyst on right side.

Ultrasonographic, gross and histopathological observations of the mass confirmed the case as an intramural uterine fibroid.

DISCUSSION

Leiomyoma or fibroids are one of the most common tumours of the uterus and female pelvis. Its true incidence is almost impossible to determine accurately. During post-mortem examinations, its frequency is quoted to be 50% which can be considered as reasonable.² Generally, most of the fibroids are asymptomatic. However, there are instances where the fibroids can lead to some symptoms like menstrual menorrhagia, metrorrhagia, abdominal pain and abdominal swelling.²

Though most fibroids are asymptomatic and are discovered accidentally during pelvic examination and during ultrasonography ordered for some other reasons, there is a recommendation to remove asymptomatic large leiomyomata as it is impossible to predict which and when the patient will start developing symptoms. Hence, it is better to remove them when the patient has less operative risk and when the size usually is 12-14 weeks gestational size.

In the present case, the removal of fibroid was even more vital as the patient had undergone double (aortic and mitral) valve replacement and was on oral anticoagulants since last 2 years with an international normalised ratio (INR) of 2.16 with a fibroid of 18-20 weeks gravid uterus size. It is interesting to note here that in spite of being on anticoagulants for last 2 years, the patient with such a huge fibroid was totally asymptomatic. Although the INR value of this patient was less than that required for patient with double valve replacement (3-3.5 is considered normal), it was much higher than what is considered normal. It is one such rare case where an intramural uterine fibroid of size 12cm x10cm remained to be asymptomatic for more than 2 years.

As far as the management of asymptomatic fibroid is concerned, there is currently no evidence to substantiate performing hysterectomy for an asymptomatic leiomyoma for the sole purpose of alleviating the concern that it may become malignant.³ Recent guidelines suggest that cases of asymptomatic women

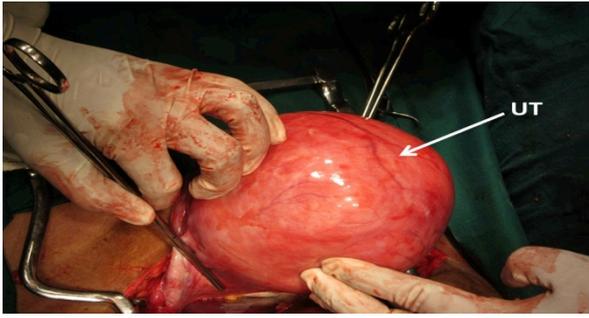


Figure-1: Enlarged uterus (UT) with fibroid pulled out of the abdominal cavity. High vascularity of the uterus can also be seen.

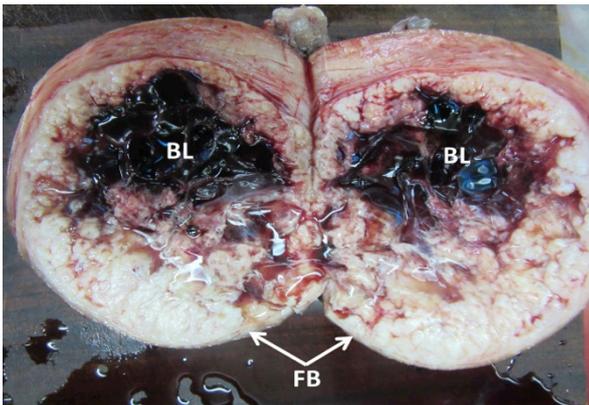


Figure-2: The fibroid [FB] cut open to show the blood clot [BL] and fibromuscular tissue inside.

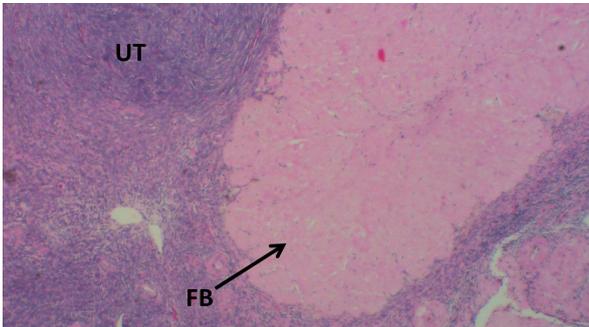


Figure 3: Photomicrograph of haematoxylin and eosin stained section of the uterine wall [UT] with section of fibroid [FB].

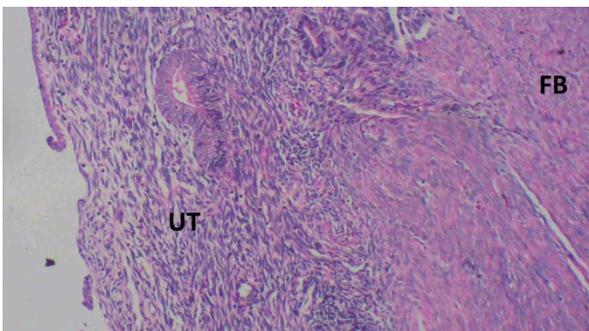


Figure-4: Photomicrograph of haematoxylin and eosin stained section of the uterine wall showing its endometrium [UT] and a part of intramural fibroid [FB].

with fibroids of size more than 16 weeks should be referred to specialists to discuss the options including observation. It also states that any subsequent intervention should be clinically justified.⁴ It is also suggested to leave asymptomatic fibroids to grow and to become symptomatic. But, there are others who consider that it is wise to treat fibroids before they grow to a size when they become symptomatic, as treatment might become more challenging at a later stage.⁵ However, in the present case, the patient was in the perimenopausal age group, considering the fact that she was on 2 anticoagulant drugs requiring a very high level of anticoagulation for a lifetime, definite therapy in the form of hysterectomy was the best management option for her which in this case was executed safely.

CONCLUSION

Uterine fibroids are common and are generally asymptomatic. However, large intramural uterine fibroid in a patient on anticoagulants after double valve replacement is a rare case. When large asymptomatic leiomyomata occur in premenopausal women who have completed the family or who do not consider further childbearing, a recommendation for removal of fibroid may be made as it is almost impossible to predict which and when the patient will become symptomatic.

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