



## A rare case of vaginal fibroid presenting as ovarian tumor

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### Introduction

Although uterine fibroids are common, vaginal fibroids are very rare. We report a case of large vaginal fibroid which could not be diagnosed before surgery.

### Case report

A 55 years old para 2 belonging to upper middle socio-economic status came complaining of pain in abdomen off and on since 1 month. Pain was tolerable and did not radiate anywhere. It increased on exertion and became less after rest. Both her deliveries were by cesarean section, the last being 29 years back. She had tubal ligation done. She attained menopause 12 years back. There was history of laparotomy 15 years back for some tumor, probably uterine or ovarian. Operation record was not available. She was obese and also a known case of hypertension and coronary heart disease taking regular treatment. Her mother had died of hypertension and heart disease. On abdominal examination, a midline infraumbilical scar was seen. A suprapubic lump was felt reaching upto the umbilicus. It was irregular in shape, having variable consistency and had restricted mobility. On vaginal examination, the cervix was high up and flushed with vagina. The same lump was felt and could not be made out separately from the uterus and ovaries. Her hemoglobin was 14.4 dL, lucocyte count  $7.290/m^3$ , differential count – P-64 L-33 E-03, ESR 12 mm first /hour, blood group O Rh +ve, random blood sugar

82 mg/dL, serum creatinine 0.8 mg/dL, blood urea 8 mg/dL, bleeding time 2 minutes 40 seconds, clotting time 4 minutes 10 seconds, serum sodium 137 mEq /dL, and serum potassium 4.09 mmol/L. Mantoux test was 22x25 mm, Elisa for tuberculosis was negative and CA 125 was 7.69 IU/mL. Her ECG showed normal sinus rhythm with T wave abnormalities and chest x-ray revealed cardiomegaly. Echocardiography showed concentric left ventricular hypertrophy, and mild anterior region hypokinetic and diastolic dysfunction. Sonography revealed a large predominantly hypoechoic mass in the pelvis measuring 13.8 x 11.9 x 9.4 cm extending upto the umbilicus but more towards right side and anterior to iliac vessels. Uterus and ovaries could not be defined separately. Besides, sonography also revealed cholelithiasis. MRI of pelvis was suggestive of a 17.8 x 17.4 x 8.8 cm solid mass in relation to posterior wall of the uterus. It had cystic area with hypokinetic contents suggestive of blood. Since ovaries could not be visualized, it was difficult even on MRI to ascertain whether the mass was arising from the ovaries or the uterus.

Abdomen was opened by midline incision through the previous scar. The incision was extended above the umbilicus to facilitate removal of the gall bladder. A mass with soft consistency was seen arising from the posterior vaginal wall and going upwards. There were no adhesions between the mass and the posterior surface of the uterus. The uterus and both the ovaries were normal in appearance, (Figure 1). There were adhesions between the mass and the rectum and the great vessels of the pelvis. The adhesions were carefully separated. Adhesions between the uterus and the bladder were separated. Total abdominal hysterectomy with bilateral salpingo-oophorectomy and removal of the vaginal cuff with the mass were done. This was followed by cholecystectomy. Total operative time was 2 hours and 30 minutes. Blood loss was minimal.

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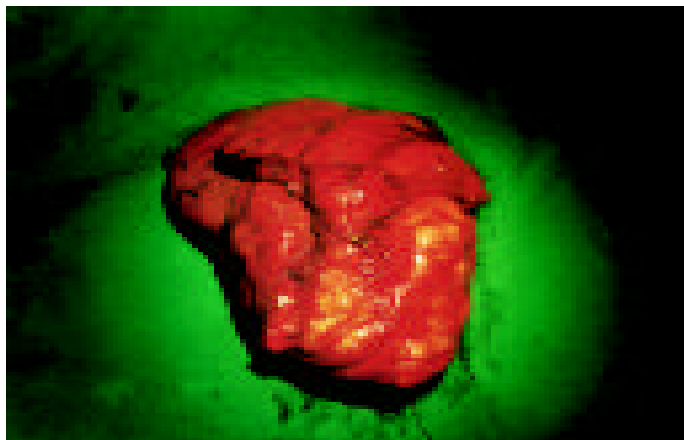
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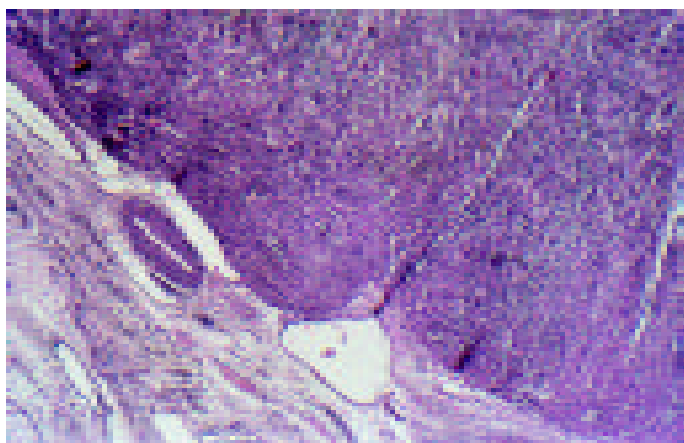
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**Figure 1.** Normal uterus, tubes and ovaries on top of the mass

The patient stood the procedure well and her postoperative period was uneventful. Alternate stitches were removed on 9<sup>th</sup> and 10<sup>th</sup> postoperative day and she was discharged in good condition. Histopathological examination of the specimen revealed chronic cervicitis, and leiomyoma with secondary changes arising from posterior part of the vagina (Figure 2). Endometrium, ovaries, and tubes were unremarkable. Gall bladder showed chronic cholecystitis and cholelithiasis.



**Figure 2.** Microphotograph showing vagina in left lower part and leiomyoma in the right upper part.

## Discussion

This case is interesting because of the many risk factors she had, both surgical and medical. Presentation was like an ovarian tumor. But at laparotomy and after

histopathological examination, it was found to be a vaginal fibroid which itself is rarely seen in this manner and age group.

Uterine leiomyomata are common benign pelvic tumors occurring in at least 20% of women aged 30 years<sup>1</sup>. The majority of myomas arise in the uterus but they may also arise from the round ligament, uteroovarian and uterosacral ligaments, the vagina, and the vulva. In only 1-4% cases, the myoma grows primarily in the cervix<sup>2</sup>. Primary vaginal fibroids are even rarer. The earliest reference made of such a tumor is attributed to De Leyden in 1773, and the first review of literature concerning such tumors was published in 1882<sup>3</sup>. Approximately 330 vaginal leiomyomas have been reported in the world literature. In the initial stages, the vaginal leiomyomas may be asymptomatic<sup>4</sup>. Symptoms arise with the growth of the tumor mainly due to compression. There may be variable clinical presentation and a broad differential diagnosis that can lead to pre-operative misdiagnosis<sup>5</sup>. Leron and Stanton<sup>5</sup> reported a case of vaginal leiomyoma with a symptom complex of prolapse with urinary urgency and urge incontinence. Gowri et al<sup>6</sup> reported a case of leiomyoma arising from the lateral vaginal wall presenting as a gluteal swelling with pus discharging vaginally, creating clinical dilemma in diagnosis<sup>6</sup>. Treatment is always surgical. Enucleation and excision is the treatment of choice in young patients. The obvious problem is the most effective approach. This is either by the abdominal or vaginal route, depending on the location of the tumour<sup>7</sup>. In perimenopausal age group, hysterectomy should be done as was done in our case.

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