



Case Report

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Puerperal vaginal prolapse of a huge pedunculated submucosal uterine fibroid that was initially intramural - A case report

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Abstract

Puerperal vaginal prolapse of a huge pedunculated submucosal uterine fibroid is a rare event in a woman who delivered vaginally recently. The authors hereby present a case of a 10 cm uterine fibroid that prolapsed through the cervix five weeks after vaginal delivery. After 48h of intravenous administration of broad spectrum antibiotics, the myoma was successfully twisted under general anesthesia. The authors recommend that women carrying a huge uterine fibroid should be well observed during the postpartum period to diagnose an eventual uterine fibroid vaginal prolapse early, so as to prevent fibroid superinfection, obstructive complications and postpartum hemorrhage as well.

Keywords: Huge intramural uterine fibroid, Puerperium, Submucosal uterine fibroid, Vaginal prolapse.

INTRODUCTION

Vaginal prolapse of submucosal uterine fibroids is a rare event that usually occur outside pregnancy, delivery or puerperium^{[1], [2]}. The prolapse is preceded by uterine contractions that are necessary to dilate the cervix and expel the fibroid. Low situated uterine fibroids measuring 5 cm or more are usually responsible for previa obstacle, with consequently an emergency cesarean section as the only safe mode of delivery^{[3], [4]}. Vaginal prolapse of huge uterine fibroids is rare during the puerperium in women who delivered vaginally because the fibroid would have obstructed the labor. The authors report here on a case of puerperal vaginal prolapse of a huge pedunculated uterine fibroid in a woman who delivered vaginally.

CASE REPORT

A 25 year old single student, gravida 1 para 1, was received on 15/05/2015 with a five days history of cramp-like lower abdominal pain radiating to the lower back. This was associated with a foul-smelling hydrorrhoea, difficult micturition and partial urinary retention that occurred two days ago.

She had a term vaginal delivery five weeks earlier in the same health facility of a baby girl who weighed 3000g. There were neither maternal nor neonatal complications. She had a past history of menorrhagia. She had known intramural uterine fibroids confirmed by ultrasound scan two years earlier during work-up for menorrhagia.

On physical examination, her temperature was 38.5°C. There was hypogastric tenderness. She had a myomatous uterus with a symphysis-fundal height of 16 cm. There was a malodorous vaginal discharge. On speculum and digital vaginal examinations, a fleshy mass of about 10 cm in diameter was present in the vagina, rendering difficult the examination of the cervix.

The diagnosis of an infected prolapsed pedunculated uterine fibroid associated with urinary retention was made. An indwelling urinary catheter was set up, but with a little difficulty because the fibroid was compressing the urethra, as well as an IV line. An antibiotic therapy was started intravenously with ceftriaxone (Rocephine[®], Roche, Neuilly-sur-Seine, France) (500 mg thrice daily).

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Two days later, under general anesthesia, the fibroid was successfully twisted off per vaginal route. A speculum examination found a normal cervix, which was 4 cm dilated and the base of the fibroid's pedicle was located in the posterior uterine wall at 3 cm from the external cervical os. The fibroid was sent for pathology, which later confirmed uterine leiomyoma.

DISCUSSION

Uterine fibroid, also called leiomyoma or myoma, is the commonest benign tumor of the female genital tract. The locations can be subserosal, interstitial (intramural) or submucosal. Submucosal fibroids, which can be sessile or pedunculated, give more symptoms (menorrhagia, pain due to prolapse process, to red degeneration or when the stalk of the pedunculated type is twisted, intermenstrual bleeding and hydrorrhea) [5].

Complications of uterine fibroids include anemia (from menorrhagia) and infertility. During pregnancy, fibroids may be responsible for spontaneous abortion, preterm labor, placental abruption, postpartum hemorrhage and abnormal presentation or mechanical dystocia (previa mass) requiring cesarean delivery [6]. Except menorrhagia, none of these signs was observed in our patient.

Other complications are vaginal prolapse with compression of the bladder neck and resulting urinary retention, as in our case. Vaginal prolapse of a fibroid can also occur following uterine artery embolization for uterine fibroids [7]. Uterine fibroids may also favor uterine inversion during the prolapse, especially the non-pedunculated submucosal fibroids [8]. Prolapsed pedunculated uterine fibroids are most likely to be infected, especially when they are necrotic as in our case, as a result of spontaneous twisting of the stalk or as a result of uterine artery embolisation.

A huge submucosal uterine fibroid, low situated in the uterine cavity, is frequently responsible for previa obstacle [4]. Prolapsed fibroid after vaginal delivery, as observed in our patient, is favored by uterine contractions necessary for uterine involution.

The absence of obstacle in our case is explained by the fact that this fibroid was initially intramural with no obstacle to delivery and became pedunculated submucosal post partally, which then prolapsed easily, as this phenomenon has been described by some authors [9]. We think that during the uterine involution process, the intramural fibroid was expelled through the probably thinner (therefore easily breakable) myometrial layer lining between the endometrium and the intramural fibroid and thereafter through the endometrium. This phenomenon might have been favored by strong uterine contractions.

The question that remains unanswered is if there were any possibility of puerperal uterine rupture during this process if this woman was delivered by cesarean section.

Pervaginal twisting of a prolapsed pedunculated submucosal uterine fibroid is a simple treatment option^{[10],[11]}, that can be achieved even in a low resource setting as in our case. The anesthetic requirements are minimal as well as surgical morbidity, the surgery duration and hospital stay are shorter when compared to laparotomy^[12]. Women should be put on broad spectrum antibiotics^[13], as in our case.

CONCLUSION

This case report shows that a huge intramural uterine fibroid might prolapse vaginally during the puerperium. Therefore, women carrying such huge fibroid should be well observed during the postpartum period to diagnose an eventual vaginal prolapse of the fibroid early, so as to prevent hemorrhagic, infectious or obstructive complications.

Conflict of interests

The authors have none to declare

Informed consent: Was obtained from the patient.

Author contributions: Case management – E.N., Patient follow-up – C.E.E.; Literature Search – N.N.A.; Writing – E.N.; Critical Reviews – E.N., C.E.E., N.N.A. All authors approved the final version of the manuscript.

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