A Rare Case of Giant Broad Ligament Fibroid with Cervical Fibroid Mimicking Ovarian Tumour: Interesting Case Report

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Case Report

Abstract: Our reported case was a 48yr old lady with complaints of mass per abdomen and menstrual irregularities with associated bowel and bladder complaints. The data was collected by history-taking, clinical examination, laboratory investigations, transabdominal ultrasonographic examination, and by histopathological study of the excised surgical specimen. Exploratory laparotomy proceed abdominal panhysterectomy was done. Intraoperatively a huge 15 x 16 cm left sided broad ligament fibroid attached to lateral wall of body of uterus near isthmus buried deeply in left broad ligament was present. Another 5 x 5 cm cervical fibroid was also seen. Postoperative period was uneventful and patient was discharged after 7 days. Histopathological report confirmed fibroid of cervical and broad ligament origin.

Keywords: broad ligament fibroid, cervical fibroid.

Introduction

Leiomyoma/ fibroma/fibroid is the most common benign tumour of the uterus and most common female genital neoplasm. It is the most common solid tumour of the broad ligament. It affects 30% of all the women of reproductive age but incidence of broad ligament fibroid is less than 1%. Cervical fibroid account for 3% to 8% of uterine leiomyoma and is commonly single and is either interstitial or subserous. Rarely it becomes submucous and polypoidal. Here we present a rare case of huge broad ligament fibroid with cervical fibroid mimicking ovarian tumour creating diagnostic difficulties in differentiating both.

Case Report

Our reported case was a 48yr old lady admitted on 23.10.13 with complaints of mass per abdomen and abdominal discomfort since one year. It was gradual in onset and progressive in nature with history of rapid increase in size since one month to present size. Associated with heaviness in lower abdomen and bladder and bowel disturbances like incomplete voiding and constipation. Menstrual history: irregular menses/ 4-5 days/ 1-2 months/ moderate flow/pain in abdomen since one year LMP 7 days back Obstetric history: P3 L3 normal deliveries T/L done 24 years back. On physical examination patient was afebrile and haemodynamically stable. On per abdominal examination a uniform mass of 26-28 weeks size gravid uterus which appears to be arising from the pelvis. No dilated/engorged veins and visible peristalsis. On palpation tumour is of varying consistency[soft to hard], non tender, mobile and with regular margins. Lower pole could not be reached. Fluid thrill and shifting dullness elicited. On per speculum examination cervix and vagina appears healthy and pushed towards left. No abnormal discharge. On per vaginum examination cervix was firm, deviated to left. Uterus was bulky, mobile and firm. And mass moves with cervical movement. Right and posterior fornical fullness present.
Investigations
Trans abdominal ultrasonography dated 11.10.13 showed large right ovarian cyst of 7.18 x 7.27cm without septations within it. Left ovary showed large ovarian cyst of 15.1 x 6.7cm with multiple septations within it with high index of peripheral vascularity. Free fluid in peritoneal cavity S/O ascites. The patient underwent some laboratory investigations including full blood picture, serum biochemistry, cancer antigen (Ca-125) which were all within normal limits.

Treatment
Exploratory laparotomy proceed abdominal panhysterectomy was done on 24.10.2013. Intraoperatively 15 x 16 cm left broad ligament fibroid attached to lateral wall of body of uterus near isthmus buried deeply in left broad ligament. 5 x 5 cm cervical fibroid present. Left tube with hydrosalphix seen. omental adhesions with parietal peritoneum seen. one pint whole blood given intra operatively. Postoperative period was uneventful and patient was discharged after 7 days.

Histopathological report confirmed fibroid of cervical and broad ligament origin. Microscopic examination of the surgically removed specimen found in the left broad ligament demonstrates interlacing bundles of smooth muscle cells, scattered thick walled blood vessels, and evidence of cystic, myxoid, and hyaline degeneration.

Discussion
Giant fibroids are known to arise from the uterus, although very rarely from extra-uterine sites. Among extra-uterine fibroids, broad ligament fibroids generally achieve enormous size and generally present with pressure symptom like bladder and bowel dysfunction. We report a case of true broad ligament fibroid measured about 15 x 16 cm with cervical fibroid of 5 x 5cm. This case is reported for its rarity and the diagnostic difficulties in differentiating ovarian tumor and giant fibroid. Most common presentation of fibroid is menstrual disturbances and dysmenorrhoea. But broad ligament and cervical fibroids generally presents with pressure symptom like bladder and bowel dysfunction. Most common secondary changes in fibroids are degenerations, infections, haemorrhage, necrosis and sarcomatous changes. Myxoid degeneration is a rare complication of benign fibroid, where presence of cystic changes mimics the metastatic malignant ovarian tumor. They give rise to greater surgical difficulty by virtue of their relative inaccessibility and close proximity to the bladder and uterus. Enlargement causes upward displacement of the uterus and the fibroid may become impacted in the pelvis, causing urinary retention and ureteric obstruction. The present patient had fibroids which grew, not only to occupy the pelvic cavity, but became a huge abdominal mass pushing the uterus near umbilicus. The broad ligament benign tumour even though being uncommon can grow to a large size as exemplified in this case requiring hysterectomy.

References