

A case report of a large prolapsed submucous myoma with pelvic abscess

Juan Wang, Lili Qian, Zhen Shen, Jing Wang, Dabao Wu, Ying Zhou

Department of Obstetrics and Gynecology, Anhui Provincial Hospital, Anhui Medical University, Hefei, Anhui (China)

Summary

A patient with a large prolapsed submucous myoma is usually performed by vaginal myomectomy. Acute infection is a contraindication of surgery. This report describes a 25-year-old nulliparous woman who suffered from a large prolapsed submucosal myoma with pelvic abscess that was successfully removed through vaginal myomectomy, after anti-infection therapy and GnRH to cause the myoma to shrink. This study confirms the reliability, safety, and efficiency of transvaginal myomectomy in this special case.

Key words: Transvaginal myomectomy; Large prolapsed submucosal myoma; Pelvic abscess.

Introduction

Uterine myoma is one of the most common benign tumors in women of reproductive age [1]. Leiomyomas are classified as submucosal, intramural, or subserosal. Some of the submucous myomas may be pedunculated and eventually can protrude through the cervical canal and into the vagina. In symptomatic cases, a myomectomy is preferred for reproductive-aged women who desire to maintain their fertility [2]. This report describes a large prolapsed submucous myoma with pelvic abscess that was removed vaginally.

Case Report

A 25-year-old woman, gravida 0, para 0, was admitted to the clinic for lower abdominal pain, dysmenorrhea, and excessive menstruation for more than one year. Her medical history included exploratory laparotomy due to persistent lower abdominal pain 10 days previously. On gynecologic examination, a 10-cm pedunculated mass with pus protruding through the cervical canal into the vagina was noted. Transvaginal ultrasonography showed a 101×43mm heterogeneous echo in uterine cavity extends to the cervical canal and a 90×54×35-mm mass in the right adnexa. MRI examination confirmed a large prolapsed submucosal myoma of uterus (Figure 1) and right adnexa abscess. A neoplasm biopsy was performed that revealed the tendency of a benign tumor or tumor-like hyperplasia. White cell count on admission was $21.92 \times 10^9/L$ and temperature was $37.2^\circ C$. Based on the clinical pictures and laboratory results, a large submucosal myoma with pelvic abscess was suspected and the patient was treated with intravenous antibiotics (vancomycin and metronidazole). The patient also underwent a sonographically guided attempt for drainage of the suspected pelvic abscess and drainage of pus of 60 ml. Considering that emergency surgery may result in myometrium infection and the spread of uterine infection, the doctors firstly controlled the inflammation by antibiotics therapy for two

weeks. The patient was suggested GnRH to shrink the myoma after the temperature resumed normally and a decreased level of subphrenic drainage was achieved. Regular follow-up transvaginal ultrasonography showed a 65×36-mm heterogeneous echo in utero, a 66×49-mm high echo in cervical canal, and a 76×46-mm low echo in the right adnexa. During the second course of GnRH therapy, the patient suffered from acute abdominal pain again. Considering the persistent pelvic abscess and the consistent dilation of cervix, the patient was operated after admission. A severe adhesion between the intestine, uterus, bladder, and the omentum was found. The patient underwent abdominal adhesiolysis, right salpingectomy, and abscess incision, and then was submitted to transvaginal uterine submucosal myoma resection. The histopathology examination revealed the degeneration and necrosis of leiomyoma, right adnexal tubo-ovarian abscess associ-



Figure 1. — Computed tomographic scan showing a large submucosal myoma protrude through the cervical canal and into the vagina. Arrows show the myoma.

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ated with endometriosis. At follow-up eight months at the outpatient department, the patient was asymptomatic. Her blood routine examination was normal and transvaginal ultrasound showed no abnormality.

Discussion

Uterine fibroids are the most common benign tumor of all female pelvic tumors and more often in women between the ages of 30 and 50, but are now increasingly younger. Fibroids are made of muscle cells and other tissues that grow in and around the wall of the uterus, or womb. The cause of fibroids is unknown. As the leiomyoma often occurs in the reproductive age and presents atrophy in a postmenopausal woman, which suggests that it may be related to female sex hormones.

Many women with fibroids have no symptoms. Some have symptoms such as abnormal bleeding, pelvic masses, pelvic pain, infertility, bulk symptoms, and obstetric complications [3]. The most common auxiliary examination is ultrasound [4], which uses sound waves to form the picture. Some patients may need hysteroscopy, CT, and MRI examination [5]. Strategy should be based on age, general health, the severity of symptoms, the location of the fibroids, the type and size of the fibroids, and fertility desire in the future [6]. Surgical treatments include hysterectomy by hysteroscopy or laparotomy or laparoscopy [6]. The use of GnRH agonist appears to be relevant and beneficial in patients with submucous fibroids [7]. Larger uterine fibroids usually become necrotic and sometimes infected, because lack of adequate blood supply and dilation of cervix [8]. Anti-inflammation therapy is recommended for this case with a large submucosal myoma and heavy pelvic abscess; the tumor can be decreased after with two to four courses of GnRH. However, we must realize that the consistent dilation of cervix can result in persistent infection, and the patient should be operated as soon as possible when the tumor has shrunk. Vaginal myomectomy is recommended as the most appropriate strategy for isolated prolapsed pedunculated submucous myoma, especially for fertility-desiring women [8, 9].

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Corresponding Author:

YING ZHOU, M.D.

Department of Obstetrics and Gynecology

Anhui Provincial Hospital, Anhui Medical University

No. 7 Lujiang Road, Luyang District

Hefei, Anhui (China)

e-mail: caddie1234@gmail.com