VAGINAL MYOMA

(A Case Report)

by

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Myoma arising from the vaginal wall is such a rare entity that for this reason, a case report should be made. But, despite its rarity, it is also of interest because it needs to be differentiated from much more common gynaecological lesions, such as cystocele, urethrocele, urethral diverticulum, rectocele, inclusion cysts, Wolffian duct remnants and carcinoma of the vaginal wall.

Case Report

Mrs. A. B., 30 year old, Hindu, para 4, was admitted to the Lokmanya Tilak Municipal General Hospital, Bombay, on 12-4-1968 with the complaint of a swelling coming out per vaginam for one year. Swelling at the vaginal introitus was small in the beginning and had gradually increased in size. At the onset, it was intravaginal and it prolapsed out only on coughing or straining. At the time of examination it had prolapsed out even at rest. There were no urinary complaints. Menstrual cycles were 3/30, regular, moderate and painless. Her last delivery was 10 years ago.

General examination showed that she was of average build and well nourished. A moderate degree of anaemia was present. Pulse was 72 per minute and blood pressure was 110/70 mms. of Hg. Systemic examination findings were normal.

Per speculum examination, a round, firm swelling, 3″ in diameter, arising from the anterior vaginal wall, ½″ below the external urethral meatus was seen. The vaginal mucosa over the swelling was ulcerated at one place. This ulcerated area was covered with reddish granulation tissue which bled on touch.

On vaginal examination, it was clear that the swelling was distinctly separate from the cervix. The uterus was retroverted, normal in size, smooth, firm and mobile. Adnexae were normal.

Investigations

Haemoglobin was 8 gm. per cent. Urine examination was normal and screening chest revealed normal appearance. Kahn test was negative. Cystographic study showed normal bladder and urethra. The tumour was not projecting inside the bladder lumen. A biopsy taken from the edge of the ulcerated area showed changes of chronic inflammation without any evidence of malignancy.

Treatment

The patient was operated upon under spinal anaesthesia. A self-retaining catheter was passed. The tumour was enucleated from its capsule. The edges of the capsule and vaginal wall were sutured with interrupted catgut stitches.

Macroscopically, on enucleation the

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tumour was 4" x 3", oval in shape, lobulated and firm in consistency. The cut surface was pinkish white in colour with whorled appearance.

Postoperatively, the patient had haematuria for two days. The self-retaining catheter was kept in for 10 days. The patient came for follow-up. The vaginal wound had healed well.

Microscopically the tumour showed the structure of a myoma.

Discussion

The first description of a myoma of the vaginal wall was given by Denys de Leyden in 1733. It is a rare tumour. Benett and Ehrilich in 1941 estimated that approximately 200 cases had been reported in the world literature (Farell and Abrams, 1956). These tumours are more common in parous women between the age of 30 and 50 years. The aetiology of myoma of the vaginal wall is as uncertain as that of uterine myoma. Immature muscle cells and adventitia of arterial walls are possible origins of the tumour. Its aetiology may be different from that of uterine myoma because these two growths seldom occur simultaneously (Marcus 1966).

The majority of vaginal myomas are situated in the midline of the anterior vaginal wall (Kettle *et al* 1965). The next common site is the posterior wall and the least common site is the lateral wall. The growth is usually single and sessile but may be pedunculated. The overlying vaginal mucosa is usually intact but may be ulcerated, as in this case, and the growth then simulates a malignant neoplasm.

Complete lack of symptoms is characteristic with the small tumours. There will be bleeding and discharge if the overlying vaginal mucosa is ulcerated. Joseff (1965) has mentioned that frequency of micturition and stress incontinence may occur with the anteriorly situated tumours. Constipation and rectal pressure symptoms can occur with the posteriorly situated tumours.

Surgical enucleation is usually easy. In removing anteriorly placed myoma, injury to the urethra should be prevented.

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