ROUND LIGAMENT FIBROMYOMA

(A case report)

by

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Though fibromyoma of the uterus is a common gynaecological lesion, round ligament fibroid is relatively rare. The diagnosis is not very easy and the surgical treatment may at times be very difficult. Almost all authorities have noted this condition but very little discussion is made so far.

Case Report

Mrs. T., 38 years of age was admitted on 28-9-1971 with the history of swelling of the lower abdomen for 6 months and occasional lower abdominal pain aggravated on stress and strain for 3 months.

Past history, family history and personal history nothing suggestive. Menstrual history—Normal, last menstrual period being one month back. Obstetrical history—Married for 22 years, 6 FTNL, last child 15 years.

Clinical Examination: Average build of poor nutrition, slightly anaemic. Blood pressure 160/100 mm of Hg. No other abnormality was detected in general examination.

Per abdomen: Liver was one finger palpable, soft and tender. Colon—loaded. A suprapubic firm lump of about 18 weeks pregnancy size was felt. It was not tender, well defined and relatively mobile.

Heart and lungs were found to be normal.

Vaginal Examination: Uterus slightly bulky, deviated to the left side and mobile. Cervix—Cervical erosion and a cervical polyp was present. Through the right fornix a firm lump was felt which was continuous with the lump felt per abdomen, separate from the uterus with rather restricted mobility.

Rectal Examination: Nothing suggestive.

Investigations: Routine laboratory investigations including chest X-ray and liver function tests were carried out E.C.G. showed normal tracing, X-ray of the abdomen soft tissue mass in the lower abdomen.

Her hypertension and hepatic condition were treated with consultation of visiting physician and when she was fit medically, surgical treatment was carried out.

Treatment: On 25-10-1971, operation was performed and findings are as follows:

Examination Under Anaesthesia—per abdomen—restricted mobility of the swelling, per vaginum—the firm swelling appears to be closed to the uterus.

Pedunculated uterine fibroid or Ovarian tumour with adhesion.

Dilatation and Currettage, polypectomy, cervical biopsy and electrocoagulation were done. Laparotomy findings—A solid tumour of about 15 cm diam. arising from the right round ligament in the middle part of its intraabdominal course was noted. It was firm without adresion. Uterus was slightly bulky no other pathology was noted in the pelvis.

The tumour was removal and bilateral partial tubectomy (as the patient wanted sterilization) done.

Post operative period: In the following morning the patient developed hypotensive syndrome which responded to the usual

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resussitative measures. After that her recovery was uneventful. The following tissues were sent for histopathological examination—cervical tissue, cervical polyp, endometrium and the tumour.

Histopathological reports were as follows (No. 2816/71) Cerix—Structure of chronic cervicit s. Endometrium—Post menstrual proliferative phase without secretory activity. Polyp—Structure of fibromyomatous polyp. Tumour—Structure of fibroleiomyoma.

Discussion

According to R. Virchow, J. C. Walthar recorded the first case of round ligament Myoma in 1863. Heyomemann in 1895 and A. P. Clark in 1900 described this condition. The diagnosis is sometimes difficult and may be confused with both ovarian cyst or pedunculated uterine fibroid as happened in our case. The final diagnosis was only in laparotomy. There was no associated fibroid of uterus except the cervical fibromyomatous polyp.

Her symptom was swelling of the lower abdomen and occasionally lower abdominal pain. There may not be any symptom or swelling in the lower abdomen and/or pressure symptoms. Menstruation is not effected as in this case. The anatomy of this tumour makes them clinically important, the characteristic being confusing situation grossly distorting occassionally replacing the normal ligament or dissecting under the blood vessels. In our case the diagnosis following laparotomy was easy and in surgical removal no difficulty was encountered. The operator has to keep within the capsule to avoid damage to the neighbouring structures.

The subdivision of this tumour are intraperitoneal, intraacanalicular and extraperitoneal. In our case it was intraperitoneal as an intraabdominal growth a condition first described in 1875. The round ligament fibromyoma may be bilateral as was described by K. M. Masani originally described by V. N. Purandare.

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References

1. Breen, J. I. and Neubecker, R. D.: J. Obst. & Gynec. 19: 771, 1962.
2. Jeffcoate, T. N. A.: Text book of Gynec. Ed. 3. London, 1971. Butterworth & Co. Ltd., P. 55, 167, 572.
3. Masani, K. M.: A text book of Gynec. Ed. 6, Bombay 1971. Popular Prakashan, P. 319.
4. Novak, E. R., Jones, G. S. and Jones, H. W.: Novak's Text book of Gynec. Ed. 7. Calcutta, 1965. Scientific Book Agency, P. 400.
5. Recci, James, V.: One hundred years of Gynec. Ed. 1. New York, 1945. The Bhakeston Co. P. 358.