

A CASE OF LEIOMYOMA UTERUS WITH ASCITES

by

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Leiomyoma is the most common benign neoplasm of the uterus. Yet its association with ascites and hydrothorax is extremely rare. Meigs in 1954 reported 5 cases of leiomyoma uterus with such effusions and classified them as pseudo-Meigs' syndrome. Williamson *et al* in 1972 reported 11 cases of uterine leiomyoma from the world literature but in every case there was hydrothorax with or without ascites. We are reporting a case of multiple leiomyomas of the uterus with the unusual association of ascites. A careful search of the literature has revealed only 5 cases of uterine leiomyoma associated with ascites. (Kelly and Cullen 1909—have reported 4 cases while Calmenson, 1947—only one case). In the absence of hydrothorax the present case cannot be included under the pseudo-Meigs' syndrome even though removal of the tumour cured the patient.

CASE REPORT

In October 1976, a 35 years old multiparous patient was admitted in this hospital with the complaints of a lump in the abdomen and gradual distension of the abdomen for 1 year.

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She had loss of appetite and weight for 6 months. There was no disturbance of menstruation. She was a middle aged woman of small build and poor nutrition. There was no lymphadenopathy or oedema. Her abdomen was grossly distended. A solid lump about 5" × 5" was present in the right side of lower abdomen. It was relatively mobile from side to side. On pelvic examination the uterus appeared pushed to the left side. A solid fixed mass could be felt through the right fornix which appeared continuous with the tumour felt per abdomen. There were irregular nodular masses of hard consistency felt continuous with the uterus on left side. The posterior fornix appeared free. A provisional diagnosis of bilateral malignant ovarian tumour with ascites was made.

Investigations

Hb. 9 gms%, TLC 9400/cmm., DLC. P₈₀, L₁₄, E₁, ESR 30 mm 1st hr., Urine—negative for albumin and sugar and no pus cells seen. Fasting blood sugar 55 gms%, blood urea—18 mgs%, X-ray chest—normal, ECG—within normal limit, X-ray abdomen, soft tissue shadow in the pelvic and lower abdomen, IVP—both kidneys and ureters normal in function. Right ureter slightly dilated in upper part. Left ureter not seen in lower part. Urinary bladder showed pressure effect on right side, Barium meal follow through was also normal. Ascitic fluid revealed suspicious looking malignant cells.

At laparotomy 2 litres of yellow coloured peritoneal fluid were drained. A growth 6" × 6", soft in feel, was seen arising with a short thick pedicle from the right side of the uterine fundus. This growth had a parasitic vascular attachment on its posterior surface with the omentum and

small bowel. The uterus showed multiple fibroids. One of the fibroids was burrowing in the right broad ligament. Both the tubes and ovaries appeared healthy. The fundal fibroid was separated from the intestines and omentum. A panhysterectomy was done in view of the suspicious looking fundal fibroid and report of ascitic fluid. Microscopic cut section of the specimen revealed multiple leiomyoma uterus with no evidence of malignancy.

The patient has been followed up and at the time of reporting this case i.e. 6 months after the operation, she is doing well with no recurrence of ascites. She has put on weight.

Discussion

The aetiology of accumulation of fluid in the abdominal cavity with leiomyoma of the uterus is not clear. Various views have been put forward. It is thought that intermittent torsion of the pedicle may result in stagnant anoxia associated with reduced blood flow and release of toxin increases tissue permeability (Williamson *et al* 1972). In the myoma with a long parasitic pedicle, the unsupported lymph vessels and veins can lose fluid when subjected to increased pressure resulting in ascites (Calmenson *et al* 1947 and Meigs' 1954). The degeneration and necrosis of the myoma or irritation of the peritoneum could be responsible for fluid in the abdomen. Various other possible factors discussed are that accumulation of fluid depends upon a balance between secretion and reabsorption. In health fluid is rapidly absorbed from the peritoneal cavity (Meigs' 1959). The rate of exudation may be increased by acute or subacute inflammation, but chronic inflammation occludes the under-

lying lymphatics and may thus reduce reabsorption. Additional factors to be considered are falling osmolarity resulting from anoxia or low plasma protein levels.

In the case reported, probably the big sized subperitoneal fibroid and peritoneal irritation by its parasitic attachment could be held responsible for the presence of ascites.

The clinical features of the case on admission suggested malignant ovarian tumour with ascites. The fact that a patient has fluid even bloody fluid in the chest or abdomen or both does not necessarily mean she has a malignant lesion.

This has an importance as a knowledge of this disease can cure the patient. Otherwise, the mistake of labelling the case as inoperable can leave the patient suffering.

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