LEIOMYOMA VAGINA

(Report of Two Cases)

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Leiomyoma is the most commonly seen uterine tumour but as far as vaginal leiomyoma is concerned, it is of rare occurrence and imposes considerable diagnostic problems. The rarity of the condition prompted us to report the following 2 cases.

Case 1:

Mrs. C., aged 40 years, was admitted on 20th October 1976 with history of menorrhagia for 1 year. She had burning micturition and dysuria for 3 months. She had no other complaints like metrorrhagia, discharge or any mass protruding from vagina.

Menstrual and Obstetric History: Menarche at 13, Cycle $\frac{5-6}{28-30}$ days regular before one year. Present $\frac{10-15}{25-30}$ days regular with excessive flow. She had 5 FTND, last delivery being 8 years ago.

On physical examination, except for pallor there was no other abnormality. Pelvic examination revealed a firm mass 4" x 3½" arising from anterior vaginal wall. Cervix was pushed high up towards the left side. Uterus was anteverted, multiparous size. No adnexal mass felt. On speculum examination cervix could not be visualized.

Investigations: Hb. 6.4 G% PBF diamorphic anemia. T.L.C., D.L.C., blood sugar, blood urea, bleeding time, clotting time, screening chest and ECG were essentially normal. I.V.P. showed normal anatomy and function of urinary system.

A clinical diagnosis of vaginal leiomyoma was made and patient was put on hematinics and supportive therapy. On 28-11-76 under epidural anaesthesia, in lithotomy position a vertical midline incision was made over anterior vaginal wall after leaving a catheter in the bladder. Tumour was separated from vaginal wall and almost whole of tumour was removed easily although it got morcellated. Tumour appeared necrotic at places and cervix was still high up. In view of necrotic appearance of the tumour, and possibility of malignancy, abdominal hysterectomy was performed. Abdomen opened by a midline infraumblical incision. Uterus was bulky and appendages were normal. No evidence of tumour in abdominal cavity. Postoperative period was uneventful except for urinary tract infection due to E. coli, sensitive to streptomycin. Patient was discharged on 11th post-operative day.

Gross: Tumour was nearly grape fruit in size, firm.

H.P.: Leiomyoma. Chronic cervicitis. Adenomyosis uterus with endometrium in proliferative phase.

Follow up 6 months later on 25-5-77, revealed no abnormality.

Case 2:

Mrs. L.W. 23 years P 3 + 0 was admitted on 14-2-75 with complaints of dyspareunia for 1 year, more so for the past 3 months. She had continuous bleeding per vaginum for 1 month. Her menstrual cycles had been regular 6-7/30 days before. She had 2 full term nor-

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mal deliveries, the third being 8 months ago by LSCS with tubectomy because of a vaginal tumour.

Physical examination revealed no abnormality. Pelvic examination revealed a mass of firm to hard in consistency size of grape fruit arising from right lateral pelvic wall, cervix could not be reached. Body of uterus was not made out separately. Blood hemogram, urine analysis, blood urea, blood sugar, X-ray chest and IVP were essentially normal. A clinical diagnosis of cervical fibromyoma was made. At laparotomy, there was difficulty in removing the tumour as it was very low down in the pelvis and could not be reached. Abdominal total hysterectomy was done so as to have an access to the tumour. However, the tumour could not be enucleated and biopsy was taken and abdomen closed. Histopathology of the tumour was diagnostic of vaginal leiomyoma. Uterus was normal. Cervix showed cervicitis. Patient had uneventful recovery except she continued to have purulent discharge per vaginum. She was discharged in good condition after 4 weeks.

Follow up after one year revealed no evidence of tumour in vagina and pelvis was clear.

Comments

Benette and Ehrlich (1941) estimated about 200 such cases reported in world literature adding 12 cases of their own. Quan and Birbhaum (1961) reviewed the literature and found less than 250 cases. Several cases have been reported by Indian authors.

Most of the cases have been reported in parous women between 35 and 55 years of age, but an occasional case has been reported in younger patients. Tumour may be asymptomatic. Symptoms are usually due to site and size. Patients usually present with dyspareunia, discharge, discomfort, swelling or mass in vagina. Some patients have retention urine, frequency or burning micturition. Our first patient had difficulty in micturition and she had menorrhagia which might have been due to associated adenomyosis. Second patient had dyspareunia along with discharge per vaginum and dystocia due to tumour and had to undergo LSCS. A case of obstructed labour leading to rupture uterus due to vaginal leiomyoma has been reported by Colarado (1905). Anterior vaginal wall is the commonest site for the leiomyoma, the next being posterior and least common being lateral vaginal walls. First patient had anterior vaginal wall leiomyoma and in second, tumour originated from lateral vaginal wall. The tumour is usually single and varies in size from 3-4 cm to 20 cm and in the present cases too the tumour was 10 cm x 8 cm in each case.

The diagnosis of anterior vaginal wall leiomyoma may be confused with Gartner's cyst, cystocele, sub urethral cyst, Skene's duct abscess or diverticulum of urethra. When it is in the posterior vaginal wall, it has got to be distinguished from rectocele, cervical fibroid, inclusion cyst.

Treatment for vaginal leiomyoma is enucleation but total hysterectomy was done in both our cases, in first case in addition enucleation of tumour was done which could not be achieved in the second case. Interestingly the tumour disappeared completely in second case within one year of hysterectomy.

Summary

Two cases of vaginal leiomyoma are presented.

References

1. Benett, H. G. and Ehrlich, M. M.: Am. J. Obstet. & Gynec. 42: 314, 1941.
2. Colarado, V.: Zbi Gynec. 1: 762, 1905. Quoted by Marcus, 1966.
3. Marcus, J. L.: J. Obstet. & Gynec. Brit. C'wealth. 73: 1013, 1966.
4. Quan, A. and Birbhaum, S.: J. Obstet. & Gynec. India. 18: 360, 1961.