UNUSUAL PRESENTATION OF CARCINOMA CERVIX WITH CERVICAL FIBROID

(A Case Report)

by

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Introduction

The coexistence of cervical fibroid with carcinoma cervix is uncommon. It is known that corporeal cancer is much higher in myomatous uteri; this may be because of oestrogen, the common aetiological agent suggested for both (ER Novak, 1975). But this is not so in the case of cervical cancer.

CASE REPORT

A 65 years old women, para 6, menopausal for 15 years, was hospitalised on 21 July 1981 for a gradually rising lower abdominal mass of 3 months duration and recurrent attacks of colicky lower abdominal pain.

General examination did not reveal any abnormality. P/A examination revealed a regular round, nontender, smooth mass arising from pelvis and about 14 weeks' size uterus. It was mobile from side to side.

Extreme vaginal stenosis with marked senile atrophy precluded any vaginal examination. P/R examination showed the mass to be regular, smooth and projecting on to the anterior rectal wall.

All laboratory investigations were within normality. X-ray of lower abdomen and pelvis was normal.

Laparotomy

Exploratory laparotomy was done on 24 July 1981. Abdomen was opened through a Pfannenstiel's incision. The mass that was felt clinically per abdomen was the enlarged uterus (10 cms x 10 cms); it was sitting on top of another mass of about the same size with a well-defined constriction separating the two, thus giving a dumb-bell appearance. The urinary bladder had been pulled up and covered the anterior surface of the lower mass. Dense adhesions were present laterally and posteriorly.

The uterus and lower mass felt soft and fluctuant and it was possible to squeeze the contents from one to the other side, fairly easily. At this stage it was impossible to identify the nature of the lower mass. We decided to proceed on with a hysterectomy along with removal of the mass. The adenexae with the upper part of broad ligaments were clamped, cut and ligated. While attempting to separate the adhesions in the pouch of Douglas, a small part of the wall of the lower mass, that was held in the left hand for traction, gave in causing sudden entry of the index finger in to the cavity of the mass. An immediate gush of about 200 ml of dark, fluid blood filled the pelvis and with that the uterus and the mass collapsed becoming a thin baggy structure. After clearing the blood, further separation of adhesions was attempted by holding the mass in the left hand and applying firm traction to it. Now the mass started peeling-off the pelvic floor, cleanly and easily, leaving a clean, dry bowel-shaped pelvic floor. There was no indication of the presence of cervix or its canal on the pelvic floor.

The specimen showed the dilated, stretched uterine body sitting on a globular mass. The mass was the cervix, dilated because of a lateral cervical fibroid (9 cm X 9 cm). This fibroid had pushed the external os and the cervical canal so much that the os had turned upward and the lower part of the canal closed due to compression. The cavity here was produced partly by the upper dilated cervical canal and

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partly by the degenerated fibroid. The endometrial cavity was smooth, thin and atrophic The cause of the haemetometra was not apparent then (Figs. 1 and 2).

The abdomen was closed with a drain and the patient had an uneventful post-operative recovery.

Histopathological report of the specimen:

(a) Epidermoid carcinoma of the cervix.

(b) Degenerating (hyaline) myoma of cervix.

(c) Atrophic endometrium without any features of malignancy (Fig. 3).

It is noteworthy that even at operation there were no features to suggest a cervical malignancy.

After receiving the histopathology report, the patient was given a full course of pelvic irradiation.

See Figs. on Art Paper V