

VAGINAL MANAGEMENT OF UTEROCERVICAL MYOMAS

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SUMMARY

Uterine myomas usually behold their presence in the uterine cavity by causing excessive blood loss during menstruation or bleeding in between menstruation. Sometimes submucous leiomyomas are gradually pushed down towards dilating cervix due to uterine contractions and now these pedunculated myomata may remain in the cervical canal or get prolapsed through cervix, partially or completely. This may make a silent tumour symptomatic. Sometimes they do arise from cervical wall either remaining inside the cervix or growing in the wall or protruding through the cervix in the vagina changing the symptomatology completely.

MATERIAL & METHOD

Present study was done in the department of Obstetrics and Gynaecology of Mahatma Gandhi Institute of Medical Sciences, Sevagram. It includes 100 cases of utero-cervical myomas which presented with variable symptoms and mostly were managed vaginally primarily. These myomas were completely or partially protruding from cervix, though many of them were

not arising from cervix. Small cervical polyps up to 2 cms were not included in the study.

OBSERVATIONS

Youngest patient was 21 and eldest 60 yrs.; only 2 were between 20 to 29 years, 76 between 30 to 45 and 22 above 45 years. There were nullipara as well as grandmultiparas; most were multiparous (Table I). Commonest mode of presentation was abnormal uterine bleeding, but many women did come with something

Table I
PARITY OF WOMEN PRESENTING WITH
UTERO CERVICAL MYOMAS

Parity	No. and %
Nullipara	5
P1	13
P2	15
P3	32
P4	25
P5	10
Total	100

Table II
SYMPTOMATOLOGY OF WOMEN PRESENTATION
WITH UTERO-CERVICAL MYOMAS

Symptomatology *	No. and %
1. Intermittent bleeding	42
2. Cyclical excessive bleeding	35
3. Pain in abdomen	26
4. Frequent heavy cycles	20
5. Something coming out of vagina	20
6. Backache	20
7. Vaginal white discharge	
- foul smelling	8
- odourless	15
8. Post coital bleeding	15
9. Infrequent heavy cycles	4
10. Lump in abdomen	2

There were some with multiple symptoms.

coming out of introitus. However many women came with multiple complaints (Table II). Largest tumour was around 17-18 cms in diameter. 53 tumours were cervical and 47 uterine, 31 tumours were sessile and 69 pedunculated. However out of 53 cervical tumours 11 (20.75%) were sessile and out of 47 uterine tumours 20 (42.55%) were sessile (statistically significant difference (P value > 0.05)). None of the women planned for vaginal procedure ended up in abdominal procedure because of technical problem. However because of anticipated technical difficulty in operating vaginally 10% women were primarily planned for abdominal procedure and 40% women had hysterectomy later as they continued to have symptoms due to enlarged uterus or because they had other myomas making a total of 50% abdominal procedures.

DISCUSSION

Leiomyoma may occur in uterus or cervix. General incidence reported is 98-99% uterine and 1-2% cervical (Tindall 1994). In the present study of 100 cases mostly managed vaginally 53% were cervical. This does not represent the incidence of cervical tumours as it is a selective study. Almost double were sessile in case of uterine tumours compared to cervical. They are rare before the age of 20 years, most being symptomatic between 35-45 years (Tindall 1994). In our study most of the women (76%) were between 30-45 yrs. They are believed to be common in nulliparous or relatively infertile women but in this series most were multiparous only 10% being below second parity.

Those tumours which grow in uterine

cavity cause increased uterine activity resulting in uterine contractions, dilatation and effacement of the cervix (Brooks et al 1975). Benuch et al (1988) have reported 46 women with pedunculated submucous myomas treated by vaginal myomectomy. 13% of them had necrotic infected myomas and presented with systemic signs of infections. In 5.9% of their patients vaginal procedure failed because the tumours were large. Some have utilized laminaria tent to dilate the cervix in preparation for vaginal myomectomy (Gokdrath 1992). Vaginal myomectomy can stop haemorrhage and help to control infection. Subsequent hysterectomy to remove other symptomatic myomas is needed for more than 50% of cases (Ranney and Frederick 1979) as happened in our series also. A fibroid as such also does not cause pain unless it is complicated by either degenerative change or is trying extrusion from the uterus as a polyp. In such cases the pain is caused by uterine colic which is aborting the myomas.

In our series some women did come with necrotic infected myomas (5%) but none with systemic infection. In one case almost complete autoamputation occurred. Other had partial (size was 12 cms) autoamputation without having any excessive bleeding. In none of the cases the procedure failed. However 40% cases had hysterectomy for either enlarged uterus or another myomas in the wall later and we did plan abdominal procedure as primary procedure in 10%. So total abdominal procedure were done in 50% of cases. Leiomyomas are believed to be oestrogen dependent tumour. The hyperoestrogenic state can cause myohyperplasia and endometrial hyperplasia. So these women are

not relieved completely by removal of myoma vaginally.

Though oestrogens seem to support active growth of these common uterine tumours, growth does not always coincide with increasing oestrogens and they may sometimes continue after climacteric (Ranney & Fredarick 1979). 18% of our women were post menopausal. Further malignancy must always be kept in mind. Many a times the look, because of inflammation and infection is malignant but the tumour is not malignant. However the reverse is also true. In one case (1%) Wertheim's hysterectomy was done later as the histopathology after excision of central cervical tumour of 6 cms X 6 cms, with cautery, turned out to be adenocarcinoma.

Further when the tumours presenting at or through vaginal cervix are removed vaginally, care has to be taken to exclude inversion.

Occasionally, pedunculated/sessile submucous myomata are found to have prolapsed through the cervix. Prolapsed pedunculated leiomyomas of the uterus may be managed by simple vaginal myomectomy. It is safe, may be easily performed and may not require prolonged anaesthesia. The risk of complications during and after a major abdominal surgical procedure in the case of infection and anaemia is eliminated. Interval hysterectomy if indicated, may be done and may turn out to be easy and clean.

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