A Case of huge posterior cervical Myoma - treated by vaginal myomectomy

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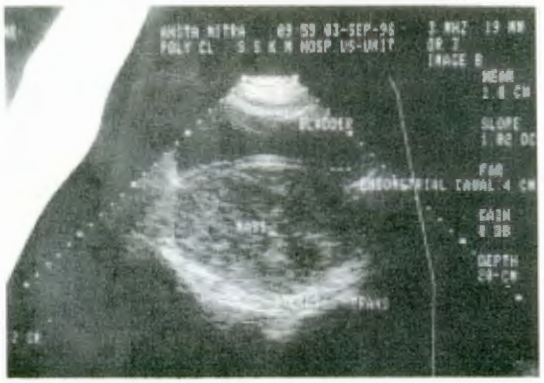
Mrs. A. M., 30 years H.F, P1+1, housewife, was admitted at SSKM Hospital, Calcutta with C/o frequency of micturition with a sense of incomplete evacuation of urine for 6-7 months and Irregular bleeding per vagina for 2 wks. She had an acute attack of retention of urine relieved by catheterisation 3 months back. Her bowel habit was normal. M/H : Menarche at 13 years. present menstrual cycle, 28±2 days, duration 4-5 days, average flow, accompanied with lower abdominal pain during d1 to d3, no clots. LMP- bleeding since last two weeks, O/H: Gravida-1, Para-1. FTND-5 yrs. back, 2nd conception - MTP at 12 wks gestation, 3 yrs back.



USG showing the large posterior cervical myoma.

General Examination - NAD, P.A - a midline intra-abdominal swelling arising from pelvis about 20 wks size of gravid uterus, firm irregular surface, well defined margin, with restricted mobility. It was dull on percussion, silent on auscultation, without any Braxton Hick's sign; no free fluid inside abdomen.

P/V exam - Vulva-NAD, a huge swelling coming from posterior aspect of vagina and occupying almost whole of vaginal cavity was visible. No anerior lip of cervix or external cervical os was seen or palpated properly. The anterior surface of the mass was covered by red epithelial lining of endocervix & was continous with streteched posterior vaginal wall extending below up to 2.5 cm above vaginal introitus and was firm in feel. The palpable mass was continous with the abdominal lump. P/R Exam - confirmed the P.V. findings. U.S.G. - Ut. bulky and occupied by a large heteroechoic mass (13.5 cm x 8.2 cm) displacing the midline endometrial echo anteriorly & rendering the cervical canal inaccessible. The large mass measured 13.2 cm x 8.2cm x8.2 cm (Fig. 1). Post voidal urine - 114 cc.

Laparotomy was done for myomectomy. Uterus was bulky with two small fibroids in anerior wall and also in posterior wall of body which was pushed high up in abdomen by a huge posterior cervical lump completely obliterating the pouch of Douglas. There were extensive adhensions between the tubes, ovaries, small intestine and also large gut posteriorly over the cervical mass. Removal of both anterior and posterior small fibroid was easily performed but posterior cervical myoma could not be approached without damaging of the gut. Hence keeping the abdominal wound covered, a vaginal approach was considered worth while. With lithotomy position and after proper antiseptic dressing & draping, a longitudinal incision (about 5 cm) was made on endocervical surface which was the anterior aspect of the posterior cervical lump. The mass was split open, fixed with myomascrew, initially sharp dissection and piece-meal removal by morcellation method was employed. When more space was available, enucleation on all sides of tumour was successfully attempted and removal of myoma, about the size of a foetal head at term was done with ligation of its newly formed pedicle. The residual potential space was closed with sutures per vagnum. Cervical canal was thus reconstructed with intact internal os. The abdomen was closed in layers as usual. Post operative period was uneventful. H.P. report confirmed benign leiomyoma. On follow up she had normal regular menstruation for 4 days.