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Central Cervical Myoma

Sanjay B. Rao, P.K. Shah, S.D. Shirodkar, G.A. Shinde

Department of Obstetrics & Gynaecology, L.T.M. Medical College and L.T. General Hospital, Sion, Mumbai 400 022.

Central cervical myomas are rare and occur in 1% to 2% of myoma cases. The tumour either of interstitial or of submucous origin expands the cervix equally in all directions. It occupies the cavity of the pelvis. The uterus located on it resembles a "lantern on the top of St. Pauls Cathedral". The operation for removal of cervical myoma can be difficult and at times, be an extremely formidable undertaking. We present here a challenging cases of a benign central cervical myoma with uncontrolled bleeding per vaginum not responding to medical therapy and necessitating hysterectomy on an emergency basis.

Mrs. L.M. a 45 year old retired staff nurse presented at Lokmanya Tilak Municipal Hospital on 24.11.99 with history of polymenorrhagia since 6 months. She was transferred from a Municipal Hospital at Vashi where she was admitted a day prior and given two units of blood transfusion for severe anaemia. The patient had a full term normal delivery 18 years ago and one spontaneous abortion a year later. She had undergone laparoscopic tubal ligation 16 years back. There was no past history of significant medical or surgical illness.

The patient had heavy menstrual bleeding every 15 days with severe dysmenorrhoea since the preceding 6 months. She had no bowel or bladder complaints. On admission her pulse was 100 beats per minute, BP 130/70mm Hg; She had severe pallor, RS: Clear, CVS: NAD. Per abdomen there was no guarding, rigidity or tenderness. A 16 weeks size firm mass was arising from the pelvis occupying the hypogastrium and right iliac fossa. On per speculum examination, the external os was patulous and a mass was distending the cervical canal and projecting towards the os. On per vaginal examination, there was a mass corresponding to 16 weeks, deviated towards the right side of the abdomen. Investigation revealed a Hb 6 gram%, total and differential counts within normal limits, coagulation profile was normal; liver and renal functions showed no abnormalities. Ultrasound examination showed a uterus just bulky, with a large central cervical fibroid 10 x 8 x 12cms. Both ovaries were normal. There was mild splitting of pelvicalyceal system in the right kidney with a hydroureter. The left kidney and ureter were normal.

The patient was transfused 2 more units of blood and given 2 intramuscular injections of testosterone 25mg 12 hourly and injection ethamsylate 250mgm 8

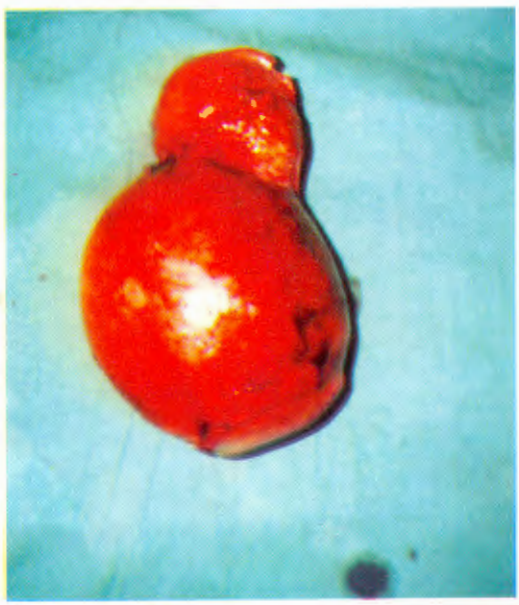

Fig. I

hourly. However within 12 hours of admission she had heavy bleeding per vaginum with passage of clots causing severe hypotension and tachycardia. She was rapidly infused with colloids with close monitoring of central venous pressure.

In view of uncontrolled bleeding per vaginum and deteriorating haemodynamic parameters, an emergency total abdominal hysterectomy had to be undertaken, under general anaesthesia. The abdomen was opened by right paramedian incision. The uterus was just bulky with a large central cervical myoma approximately 12 x 10 x 12cms occupying the pelvis. The ovaries were found healthy and therefore preserved. Both the corneal structures were clamped, cut and transfixed. The uterovesical fold of peritoneum was cut and the bladder retracted away. The posterior peritoneum was incised and both the ureters were identified before clamping the uterine vessels. The plane of cleavage between the cervix and vagina was found and the lower limit of vaginal edges were defined. Bilaterally uterosacrals were clamped, cut and transfixed. The uterus with central cervical myoma was delivered out (as shown in the picture). Vaginal edges were closed with continuous interlocking sutures. After confirming haemostasis, peritonization was completed. The patient required 4 more units of blood and 2 units of fresh frozen plasma. The urine output was clear and adequate in the post operative period. Histopathological findings were suggestive of a benign leiyomyoma with few areas of hyaline degeneration. The patient recovered well and was discharged 12 days later.