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Case Report

A Big Submucous Leiomyoma Mimicking A Hematoma After Myomectomy Surgery

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Abstract

Uterine fibroids are the most common tumors of uterus. Determination of the treatment options depend on the ability of imaging modalities to accurately detect fibroid tumors. Sexually inactive, 43 year-old woman was admitted, with a main complaint of heavy menstrual bleeding. Abdominopelvic ultrasound showed intramural myomas. Myomectomy was done. After the operation, the patient applied to our clinic with the complaint of vaginal bleeding. Abdominopelvic ultrasound showed a lesion on the anterior side of the uterus and was thought to be hematoma. The patient was hospitalized to perform a simple hysterectomy. After hysterectomy, a longitudinal anterior uterine incision was done and a submucousal myoma filling the whole cavity was seen. Transvaginal ultrasound seems to be the best way to determine the myomas. But if the patient is virgin, it is impossible to perform. Diagnostic tools, including transrectal ultrasound or magnetic resonance imaging may play significant roles in determining precise preoperative diagnosis.

Key Words:

Uterine fibroid, transrectal ultrasound, magnetic resonance imaging, virgin patient

Introduction

Uterine fibroids are the most common tumors of uterus which develop 20-40% of reproductive age women [1]. They are classified as subserosal, intramural and submucosal on the basis of their location in the uterus. Submucous fibroids are the most common structural cause of excessive menstrual bleeding in women of reproductive age and are also associated with dysmenorrhea and adverse reproductive outcomes [2]. Techniques used for presurgical evaluation are transvaginal ultrasound scanning, sonohysterography, office hysterescopy and magnetic resonance imaging (in case of large uterus with multiple fibroids, or if ultrasound scanning is technically difficult) [3]. Herein we present a huge submucosal myoma mimicking hematoma after myomectomy operation.

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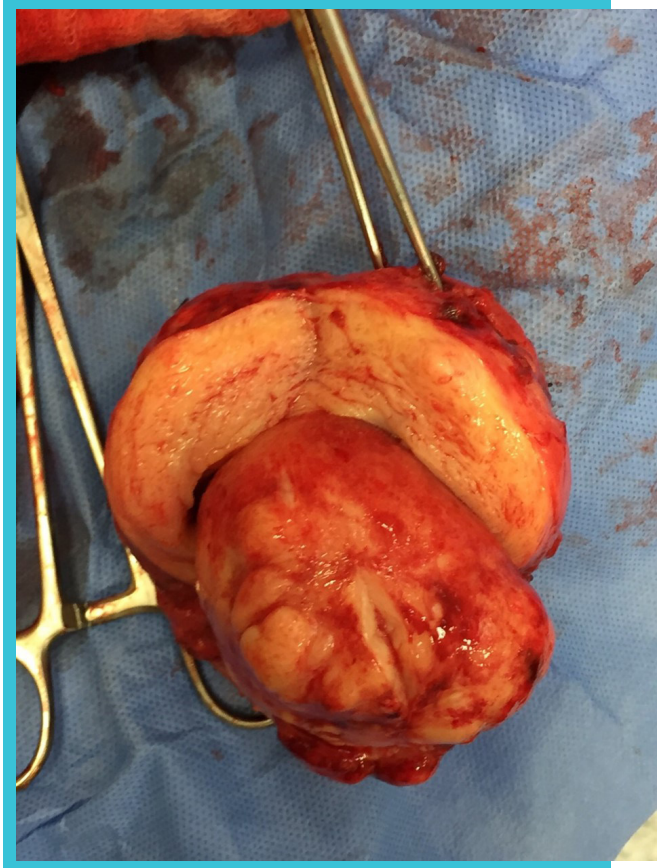
Case Presentation

A 43-year-old, sexually inactive woman was admitted to our obstetrics and gynaecology outpatient clinic, with a main complaint of heavy menstrual bleeding and lower abdominal pain continuing for a few months. Her physical examination showed a markedly pale woman. Her pulse rate was 100 beats per minute and blood pressure was 100/60 mmHg. The vulva pad was soaked with blood. Due to the patient was virgin, transvaginal ultrasound (TVUSG) could not be done. Abdominopelvic ultrasound revealed two intramural leiomyomas located at the fundal region of the uterus, measured 62*58 mm and 50*40mm. The sonologist thought that the patient was having vaginal bleeding because of intramural myomas and planned myomectomy. Because the patient was virgin, myomectomy was planned. Her hematocrit was 21% during hospitalization. The hepatitis B serology was positive. Before the operation, a blood transfusion was given with packed red blood cell suspensions. After preperation for the operation, myomectomy was done to the patient. Three intramural myomas were removed. Pathology reported

three leiomyomas measuring 8*8*5 cm, 4*2.5*1.5 cm and 1.5*1.2*1.2 cm respectively. The uterine cavity was not opened during the operation and no complication was seen. Twenty days after the operation, the patient applied to our clinic with the complaint of vaginal bleeding. Ultrasound examination showed an intramural hematoma measured 40*45 mm. The patient was hospitalized for observation. Her hematocrit was 23% and 2 packed red blood cell suspensions were transfused. Uterotonics were prescribed and the patient was discharged. Sixtyfive days after the operation the patient again applied to our clinic with the complaint of vaginal bleeding. Abdominopelvic ultrasound showed a lesion measured 76*63*53 mm located on the anterior side of the uterus deplating the endometrium and was thought to be hematoma or myoma. Her hematocrit was 27,4% and again packed red blood cell suspension transfusion was done. The patient was hospitalized for simple hysterectomy. Informed written consent was taken from the patient in order to proceed for abdominal hysterectomy. During her second operation both ovaries appeared normal, no intramural or subserosal myomas were seen. Uterine corpus and fundus were normal in appearance. Myomectomy scars on the uterus that was performed 2 months ago were totally normal. The surgery was completed and a longitudinal anterior uterine incision was done to see if there is a submucousal myoma or hematoma in the cavity after finishing hysterectomy. A submucousal myoma filling the whole cavity was seen macroscopically (Figure 1). The mass was sent for histology which confirmed it as benign submucousal myoma measuring 8*7*5 cm. There were no complications in the postoperative period and the patient was discharged on the third postoperative day.

Figure 1.



Giant submucous myoma filling the uterine cavity

Discussion

Determination of the treatment options and the appropriate clinical treatment of women with uterine fibroid tumors often depends on the ability of imaging modalities to accurately detect and localize fibroid tumors. Ultrasound examination is the first line imaging investigation [4,5]. Especially transvaginal ultrasound seems to be the best way to determine the number and the localization of the myomas. But if the patient is virgo, as in our case, it is impossible to perform a TVUSG. Diagnostic tools, including transrectal ultrasound (TRUS) or magnetic resonance imaging (MRI) may play significant roles in determining a precise preoperative diagnosis of the disease. If we could perform a TRUS to this patient, most probably we could see the submucous myoma preoperatively, but unfortunately it did not come to mind so we did not perform. The current established management of uterine fibroids may involve one of the following approaches or a combination thereof: expectant management, medical treatment, uterine artery embolization or surgical management, The chosen approach should be individualized depending on various factors, including age, type and severity of symptoms, suspicion

of malignancy, desire for future fertility and proximity to menopause. A surgical approach is most frequently preferred for management of giant or hardly symptomatic leiomyomas TRUS can be performed safely and easily especially for virgo patients, and may increase the likelihood of accurate diagnosis for myomas. The advantages of TRUS over MRI, besides cost, are its widespread availability, shorter scanning time, possibility of dynamic examination and use of doppler imaging. Ultrasound can also be used in cases in which MRI is contraindicated (e.g. presence of a pacemaker or metal implant, claustrophobic patient). In case TRUS, previous cleansing of the rectum should be done by simple rectal enema. Moreover TRUS is also a techique that may be used intraoperatively during hysterescopic metroplasty operations [6]. MRI has been considered the best noninvasive means of diagnosing anomalies of the reproductive tract. MRI provides excellent delineation of both internal and external uterine contour and enables measurement of intercornual diameter, visualization the endometrial contour. MRI has been quoted as having an accuracy of up to 100% in correctly identifying Mullerian anomalies [7]. MRI may give the most complete evaluation (sizes, positions, number) of submucous, intramural, and subserosal myomas and may help the gynecologist avoid missing fibroid tumors during surgery [8,9]. As a result, we report a case of huge submucosal myoma mimicking hematoma after myomectomy operation. If an operation is planned for a myoma, presurgical evaluation should be done meticulously to identify the localization and the number of the myomas. Especially for patients who are virgin, transrectal ultrasound or MRI may be good imaging modalities that should be evaluated.

Acknowledgement
None

Declaration of Interest
None

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