Huge Broad Ligament Fibroid : An Uncommon Presentation

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ABSTRACT

A 25 year-old unmarried female was operated for a large right broad ligament fibroid. Enucleation of fibroid with preservation of uterus and ovaries was done. Weight of the enucleated fibroid was found to be 5 kg. Fibroids are mostly situated in the body of the uterus which can be submucous, interstitial, and subserous. In few percent of cases it is found in cervical region. Although the above-mentioned locations have been frequently reported, broad ligament fibroid (a variety of subserous fibroid) is quite uncommon. This case is reported here to emphasize the importance of this location of fibroid and the diagnostic difficulties it can pose. JMS 2012;15(2):180-81

Key words: Fibroid, enucleation, uterus, broad ligament.

Fibroid is the commonest benign neoplasm of the uterus in females, composed of smooth muscle with variable amount of fibrous connective tissue, hence named as leiomyoma or fibromyoma. It is the commonest of all pelvic tumours in females, excluding pregnancy; being more common in nulliparous. It can be uterine or cervical. In uterus it can be interstitial / intramural, subserous / subperitoneal, and submucous. It can cause a variety of complications like degenerations, necrosis, infection, sarcomatous change, torsion, haemorrhage, and rarely polycythemia and hyperbilirubinemia. In addition to this, it can also cause pressure symptoms depending upon the location and size of the fibroid.

However, to the best of our knowledge, there have been less number of case reports of such a large broad ligament fibroid in the literature. This case is reported for its uncommonness and diagnostic difficulties.

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Case Report

A 25 year female, unmarried, normotensive, nondiabetic presented with menorrhagia for previous 3 months and swelling lower abdomen for previous 1½ months. The patient also had a history of dysmenorrhea with intermittent spotting with no history of pressure symptoms, decreased appetite, vomiting, loss of weight. Patient had attained her menarche at 16 years of age with regular cycles of 3 / 28-30 days, average flow till 3 months back when cycles became 4-5 / 25-30 days with increased flow, associated with dysmenorrhea.

Physical examination showed gross pallor with abdominal examination revealing firm, non tender swelling lower abdomen about 22-24 week pregnancy size, slightly mobile sideways. There was no other finding on her general and systemic examinations.

The patient was investigated. The hemogram showed hemoglobin of 7.5 g/dl. CA-125 level was 28 U/ml. Kidney function tests, liver function tests, chest X-ray, and Electrocardiogram (ECG) were normal. Ultrasonography (USG) revealed huge right adnexal mass. Contrast enhanced Computed tomography (CECT) scan of the abdomen and pelvis showed huge mass arising from pelvis which can be

Figure. Ultrasound picture of broad ligament fibroid and the specimen

right subserosal fibroid or right ovarian tumour. Uterus, left ovary and other structures appearing normal. The patient was given two units of blood transfusion preoperatively and was posted for surgery. On table, the diagnosis of huge broad ligament fibroid was made. Myoma was removed from broad ligament with preservation of uterus and bilateral ovaries and fallopian tubes. The patient was placed on intravenous fluids, intravenous antibiotics (cefoperazone sulbactam) and analgesics. Patient behaved well postoperatively. Orals were started after 12 hours, Foley's indwelling catheter was removed after 24 hours and patient discharged on 4th postoperative day in a stable condition. After one week, the patient presented for follow-up and was doing well. On further follow-up, her cycles became regular with average flow. Patient had a few counseling sittings with a medical social worker who after consultation with the gynaecologists assured her that she would conceive normally after she tied the nuptial knot. The patient got married 4 years later, conceived spontaneously 6 months after marriage and delivered a healthy baby by full term normal vaginal delivery with medio-lateral episiotomy.

Discussion

Fibroid (fibromyoma, leiomyoma, myoma) is the commonest benign neoplasm of the uterus in females, composed of smooth muscle with variable amount of fibrous connective tissue affecting 5-20% of women in the reproductive age group. A typical fibroid is a well circumscribed tumour with a pseudocapsule, firm in consistency, which in the body of uterus can be as intramural, submucous, subserous and rarely extruded one as parasitic. Majority of them can arise in the uterus but may also arise from the round ligament, uteroovarian/uterosacral ligaments, vagina and vulva; hence can be uterine and extrauterine, with uterine growth further divided into those which arise from the body and those which arise from the cervix. They are rarely found

before puberty and generally cease to grow after menopause. Association of fibroids in women with hyperoestrogenism is evidenced by endometrial hyperplasia, dysfunctional metropathia bleeding and endometrial carcinoma. Myomas increase in size during pregnancy, with oral contraceptives, while progesterone and GnRH cause its shrinkage. Unusual forms of leiomyomas include intravenous and intra-peritoneal leiomyomatosis.

Myomas in broad ligament are uncommon,¹ as compared to other locations. However, among the extrauterine myomas broad ligament myomas are common.² Fibroids in the broad ligament though not so common, are well known for achieving enormous size; which may mimic a malignancy of the pelvis thereby altering the course of treatment offered.³ Degenerative changes in the leiomyomas are considered to be due to inadequate blood supply and degenerative changes seem to depend on the degree and rapidity of the onset of vascular insufficiency. Bose *et al*, have reported a case of calcified broad ligament fibroid.⁴ There is no particular relationship between any symptom or group of symptoms and the incidence of degenerative changes.

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