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Case report

Massive cystic degeneration in uterine fibroid: Laparoscopic management

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ABSTRACT

A case of massive cystic degeneration in a uterine fibroid 21 cm × 16 cm × 12 cm mimicking malignant ovarian tumor. The 43 years, patient presented with lump abdomen with heavy periods and anemia. Ultrasonography (USG) and CT showed a large mass abutting the uterus extending into the abdomen. Mass was predominantly cystic with septations.

Treatment: Patient underwent laparoscopy. The mass was found to be arising from posterior fundal area more on the right involving the entire posterior surface and filling the abdomen. Both ovaries were normal. The mass was aspirated followed by total laparoscopic hysterectomy with bilateral salpingectomy. Histopathology showed cystic degeneration of leiomyoma. Postoperative period was uneventful.

Conclusion: Extensive cystic degeneration in fibroid result in unusual presentation and diagnostic dilemmas. Cystic degeneration of fibroid should be kept as differential diagnosis prior to surgical intervention in pelvic masses.

1. Introduction

Fibroids of uterus are one of the common gynecological tumors. Extensive degeneration within fibroids can cause diagnostic dilemmas. We report one such case of extensive cystic degeneration of fibroid.

2. Case report

A 43 year old presented with history of lump abdomen since two weeks with heavy periods since 7–8 months. The patient complained of heaviness in lower abdomen with no urinary/bowel complaints, no history of appetite/weight loss. She complained of heavy periods with clots but with no pain.

Her prior cycles were 3/30 day regular. Now she had bleeding for 5–6 days every 25–30 days. She was put on oral contraceptive pills for one year. Physical examination revealed pallor. Large abdominal mass arising from pelvis filling the abdomen till the epigastrium.

The mass was firm in consistency with restricted mobility because of the size.

On per speculum – cervix was not visualized, fullness of vaginal fornices was seen.

Per vaginum – cervix was felt high up anteriorly behind the symphysis pubis.

Uterocervical length was 18 cm, D & C was done, and curettage was sent for frozen section. **Investigations** – Hb – 7.3 g%, SLDH – 136 units, CA 125 – 37.4 units, rest of the blood investigations were within normal limits.

USG – huge (>20 cm long axis) abdominopelvic wall defined cystic mass extending up to supra umbilical level and paracolic of gutters showing septations inside (Ultrasound Figs. 1–5).

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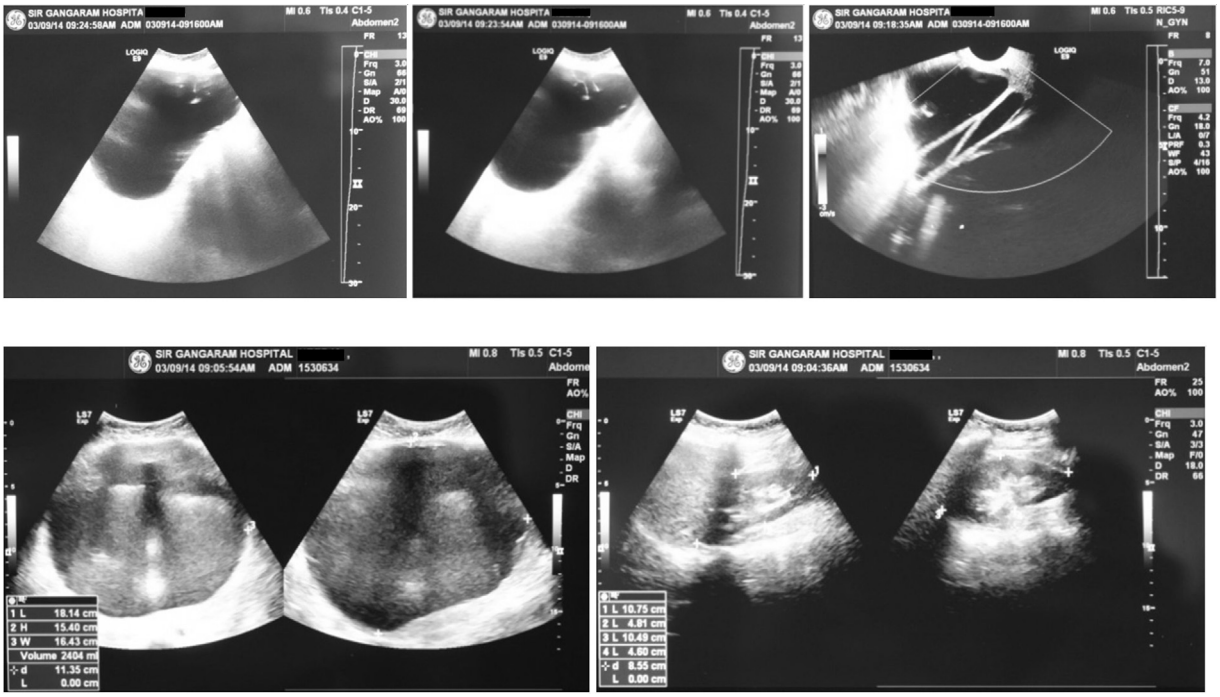
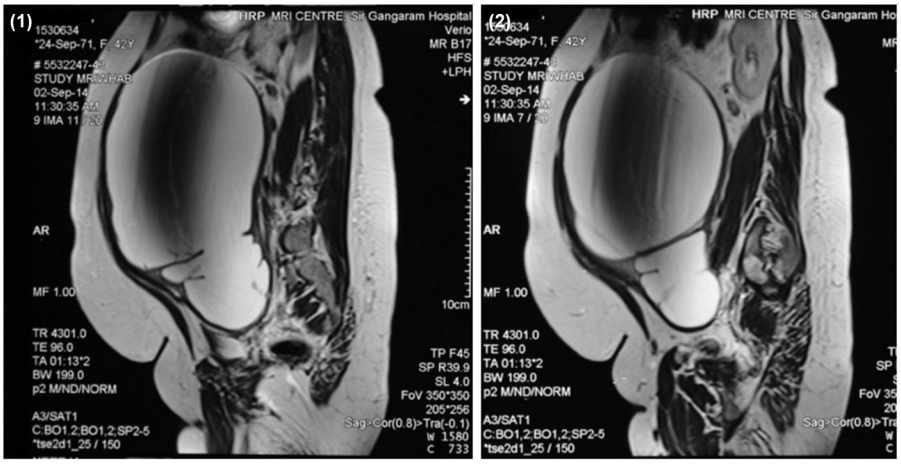


Ultrasound Figs. 1–5. Ultrasound pictures showing mass arising from the pelvis reaching the epigastrium.

MRI showed large multiseptated cystic mass $21 \times 16\ \text{cm} \times 12\ \text{cm}$ in the right posterolateral wall. After thorough counseling and consent she was taken up for surgery (2 units PRBC's were transfused preoperatively) (MRI Figs. 1, 2).



MRI Figs. 1, 2. (1) Large pelvic mass-fluid filled. (2) Large pelvic mass filling the abdomen.

Per abdomen examination – mass distending the whole abdomen.

While entering the abdomen the Veere's needle went into the cystic space, we aspirated 2.5 l of clear yellow fluids.

On laparoscopy through the Palmer's point – uterus enlarged to 16 weeks, large vascular pedicles seen bilaterally. Bilateral tubes and ovaries were apparently normal looking. Omentum was covering the whole of uterus. Sigmoid was adherent to the lateral pelvic wall on the left (Laparoscopic Figs. 1–6).