Primary parasitic myoma in a young virgin

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Received 25 February 2014; revised 8 May 2014; accepted 26 May 2014

Abstract The presented case is a primary parasitic myoma in a young virgin who worked as a resident in ICU of Benha university hospital. She came to my clinic with lower abdominal pain and swelling. MRI was done which revealed subserous anterior wall myoma 12 cm by 12 cm. The patient was operated upon and a large irregular myoma connected with the anterior uterine wall with a small pedicle. The interesting part in this case was the large nutritive vascular omental pedicle on the surface of the tumor.

The vessels in the omental pedicle were larger than the internal iliac vessels.

Keywords Parasitic myoma; Vascular omental pedicle

1. Introduction

Uterine leiomyomas are one of the most common tumors found in women of reproductive age. Uterine leiomyomas affect 20–30% of women older than 35 years, and their incidence may be on the rise since many women are postponing their reproductive careers (1).

Extrauterine leiomyomas are rare, benign, and may arise in any anatomic sites. Their unusual growth pattern may even mimic malignancy and can result in a clinical dilemma. Occasionally, uterine leiomyomas become adherent to surrounding structures.

They also develop an auxiliary blood supply, and lose their original attachment to the uterus, thus becoming ‘parasitic’.

Parasitic leiomyomas have been found in the remnants of a previous hysterectomy or laparoscopic myomectomy especially when morcellators were used for retrieval (2,3).

Parasitic myomas are rare but have been reported in the literature. These could be myomas detached from the uterus, which have taken blood supply from adjacent organs or could be retained myoma fragments.

2. History

A young virgin aged 24 years worked as a resident in ICU of Benha university hospital came to my clinic in Benha city complaining of lower abdominal pain and swelling. The condition has a gradual onset and progressive course.

The patient has no special habits of medical importance. The patient worried about her fertility in the future. The condition was associated with frequency of urine and dysuria. No manifestations suggesting other organ involvement.

On asking about the presence of the condition in any relative, the patient told me that her mother had undergone hysterectomy two years ago after bleeding and presence of multiple uterine myoma thus the family history was positive.

No past history of any operation.
3. Examination

3.1. General

Height: 163 cm.
Weight: 55 kg.
Blood pressure: 110 over 70 mmHg.

3.2. Abdominal examination

Inspection: there was a suprapubic swelling.
Palpation: on superficial palpation there was no tenderness but a supra pubic bulge was felt. By deep palpation the swelling was pelviabdominal. The fundal level of the mass was at the level of the umbilicus.
Percussion: there was dullness over the suprapubic area up to the umbilicus.
Local examination: was not allowed as the patient was a young virgin Muslim with no relationships before.

4. Investigations

4.1. General investigations

Complete blood count: was within normal limits.
Complete urine analysis: few pus cells.
Liver enzymes: sGPT and sGOT normal.
Serum creatinine: 0.6 mg/dL.
Fasting blood sugar: 75 mg/dL.

4.2. Ultrasound examination

Abdominal ultrasound was done which revealed a uterine subserous fibroid measuring 12 by 12 cm and tilted to the left side.

4.3. MRI

Magnetic resonance image was taken which revealed uterine subserous fibroid 12 by 12 cm arising from a small pedicle on the anterior uterine wall pressing the bladder. There were no ovarian cysts or adnexal. No free fluid in the abdominal cavity was seen.

5. Treatment

The patient was prepared for laparotomy and the operation done in the Eldorra hospital for obstetric and gynecologic surgery.

5.1. Operative steps

Pfannenstiel skin incision was done then opening of the rectus sheath and its dissection off the rectus muscle were carried out.
Peritoneal opening and entering into the abdominal cavity.
A huge uterine subserous fibroid was seen coming from the middle of the anterior uterine wall arising from a small pedicle. The tumor size was 12 cm by 12 cm with irregular surface.

There was surface bleeding and the omental adhesion was found linked to the site of surface bleeding with a vascular supply larger than the uterine artery and internal iliac vessels.
The tumor was connected to the anterior wall of the uterus with a small pedicle so the main blood supply was from the omental vascular pedicle.
The omental pedicle was caught between two artery clamps and cut. The pedicle connecting the tumor to the anterior uterine wall was caught with artery clamp and cut with diathermy then the mass put into a box for histopathological examination.
Abdominal cavity was washed with warm saline then the patient’s abdomen closed in layers and the skin stitched with subcuticular stitches (see Figs. 1–5).

6. Outcome and follow up

The patient was transferred to her private room and followed up with the hospital resident till discharge on the second post-operative day.
No significant pain was felt, and the patient was discharged from the hospital fully satisfied. She had been informed to come after one week to remove the wound dressing and she
came to the hospital again after one week and the wound was clean and healthy.

7. Ethical approval

A written consent was signed by the patient preoperatively and a written consent for publishing after consultation with me was also signed. Histopathological examination of the specimen was done by professor doctor Nashwa Mohamed Emara that revealed a uterine fibroid with no cellular atypia.

8. Discussion

Parasitic myomas are rare conditions mostly secondary to laparoscopic morcellation of subserous uterine myomas. The presented case was different in that it is a primary parasitic myoma in a young virgin.

The myoma in this case aroused from the anterior uterine wall coming out and connected with a small pedicle.

On examination of the posterior wall of the myoma there was surface bleeding with a vascular omental pedicle connecting the posterior fibroid wall with the omentum.

The vessels in the omental pedicle were larger than the uterine and internal iliac vessels. The interesting part of this case was that the pedicle linking the myoma to the anterior uterine wall was small and fibrotic because the good supply came from omental large nutritive vessels.

I think if the condition is ignored by the patient it will detach from the uterine wall and become free in the abdominal cavity.

Conflict of interest

None.

References

