A RARE CASE OF VAGINAL LEIOMYOMA MIMICKING GENITAL PROLAPSE

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Abstract
Vaginal leiomyomas are extremely rare tumours of genital tract. Its diagnosis is very difficult preoperatively as its presentation is similar to genital prolapse. Surgery through the vaginal approach has generally been recommended as the treatment of choice for these tumours. Here, we report a case of vaginal leiomyoma from Kolkata presenting as mass per vaginum, diagnosed postoperatively with the help of histopathology.

Keywords: Vaginal leiomyoma, Genital prolapse, Enucleation

Introduction
Vaginal leiomyomas are rare benign neoplasms. Only 300 reported cases are found in literature.¹ The earliest reported case seems to be that of Denys de Leyden in 1733.² Bennet and Erlich found only 9 cases in 50,000 surgical specimens and only one case in 15,000 autopsies reviewed at Johns Hopkins Hospital. The clinical presentation of vaginal leiomyoma is variable and pelvic examination may be misleading.

Case presentation
Clinical history
Mrs KH, 42 years P3+0, LCB (Last Child Birth)-15 years back complained of something coming down her vagina for last 10 years. She gave history of gradual increase in the size of the mass and irreducibility of the mass. There was no history of pain or urinary incontinence. Menstrual history was regular and intermenstrual bleeding occurred at times. Conjugal life was hampered for last 4 years.

Examination
Her general and systemic examination did not reveal anything except there was mild pallor and on local examination, a mass was coming out of vagina of around 9×9 cm. Cervix was not separately visible. On palpation mass was slightly tender, hard and irregular and was irreducible. The mass was thought to be a cervical fibroid. Possibility of uterine inversion was there. On valsalva maneuver there was no change in the mass. Decision for examination under anaesthesia was taken. Preoperative anaesthetic investigations were done. A transabdominal USG was done which showed a small sized uterus posteriorly and Pouch of Douglas (POD) clear but cervix not visualized properly. There was no mass visible in USG.

Examination under anaesthesia
Under anesthesia, the patient was put in lithotomy position.

Operative notes
On examination a huge growth was found on the anterior vaginal wall. The growth was firm, solid tumour covered by thick oedematous mucous membrane. It was found to be separate from the bladder. Cervix was found posteriorly at the level of ischial spines and was healthy looking. On bimanual examination, the fundus of the uterus could be felt low down in the POD. A cervical dilator was introduced through cervix and length of uterus was assessed.

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The tumour was then sent for histopathological examination (Figure 4). The tumour on cut section was white to tan with a whorled appearance. Upon microscopy the tumour consisted of fascicles of uniform smooth muscle cells having a typical spindle configuration with indistinct cell borders and abundant pale eosinophilic cytoplasm. The tumour was suggestive of a leiomyoma.

Figure 2. Specimen of the vaginal mass

Figure 3. Repaired vaginal mucosa

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Follow-up

The postoperative period was uneventful. Indwelling catheter was removed on the third postoperative day and patient was discharged on the fifth day. Patient was in regular follow up and did not have any recurrence of such tumour again and she is leading a healthy conjugal life.

Discussion

Leiomyomas in female genital tract are common in the uterus and to some extent in the cervix followed by the round ligament, utero-sacral ligament, ovary, and inguinal canal. Occurrence in vagina is very rare. Vaginal leiomyomas are commonly seen in women between 35 to 50 years of age. It is more common among Caucasian women. They usually occur as a single, well-circumscribed mass arising from the midline anterior wall. They may be asymptomatic but depending on the site of occurrence, they can give rise to varying symptoms like lower abdominal pain, low back pain, vaginal bleeding, dyspareunia, frequency of micturition, etc. Usually these tumours are single, benign, and slow growing but sarcomatous transformation has been reported. Preoperatively, diagnosis by ultrasonography may be difficult, but magnetic resonance imaging usually clinches the diagnosis. Histopathological confirmation is the gold standard of diagnosis. Surgical removal of the tumour through vaginal approach, preferably with urethral catheterization is usually the treatment of choice. In case of large tumours, however, an abdomino-perineal approach is preferred. The patient needs to be followed up for any chances of recurrence.

Conclusion

Vaginal myomas are rare among leiomyomas. Preoperative diagnosis is extremely difficult. Histopathology is considered gold standard of diagnosis. Presentation is similar to genital organ prolapse. Symptoms arise with growth of tumour mainly due to compression. Surgical enucleation is easy due to availability of a good cleavage plane.

Editor’s comment

Vaginal leiomyomas can rarely present as mass per vaginum. They may be confused with variety of benign vaginal tumours. A pre-operative diagnosis is often difficult and can be diagnosed postoperatively with the help of histopathological examination. Usually there is an apparent cleavage plane as was there in this case so surgical removal is safe with minimal bleeding. Although no urethral damage has been reported in literature, catheterization during surgery must be done to avoid urethral injury as was done in this case.
References


