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Wandering Uterine Leiomyoma: A Case Report

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ABSTRACT

Wandering fibroids, commonly referred to as parasitic fibroids, are a relatively uncommon kind of extrauterine benign tumour in women of reproductive age. It has no myometrial connections and frequently develops in conjunction with other abdominopelvic structures' blood supply. Due to their odd placements and symptoms, these fibroids are challenging to diagnose by imaging. There are several hypotheses on the origin of parasitic fibroids, including the iatrogenic seeding of fibroid pieces after morcellation in laparoscopic myomectomy, and pedunculated subserosal fibroid separating from its stalk and joining other abdominopelvic structures.
We discuss a case of parasitic fibroid in a 41-year-old nulliparous woman who suffered from abdominal pain and whose USG findings were indicative of an atypical fibroid in this report (broad ligament fibroid).

Keywords: [fibroid, wandering or parasitic fibroid, laparotomy]

INTRODUCTION

The most prevalent benign tumour in women of reproductive age is uterine leiomyomas. These tumours are brought on by the growth of connective tissue and smooth muscle. Nearly 70% of people have fibroid by the age of 50. According to their location, they are often categorised as subserous, intramural, and submucous fibroids. In 2001, FIGO listed eight different forms of fibroids, with the eighth being "other," which includes a parasitic or cervical fibroid.
Most fibroids are asymptomatic, however in 30–40% of occurrences, symptoms including heavy menstrual flow, abdominal discomfort, pressure feelings are present. Because they are so infrequent, parasitic fibroids provide diagnostic and therapeutic challenges.

CASE PRESENTATION

A 41-year-old nulliparous woman complained of abdominal pain over the previous month when she visited the emergency room. She has a history of primary infertility, which was diagnosed as male factor infertility after an evaluation. She had no comorbidities and had never undergone surgery. There was no family history of malignancy.
Her vital signs were steady after a clinical assessment. Upon abdominal inspection, the umbilical and hypogastric areas of the abdomen were indeed distended at the midline. A firm, non-tender mass that filled the hypogastrium and umbilical area and corresponded to a 20 weeks gravid uterus could be felt on palpation. It had a smooth surface with regular palpable borders. With limited vertical movement, it could only move laterally. There were no ascites and there was a dull note over the mass on percussion. An examination with a speculum revealed a normal cervix and vagina. During a bimanual pelvic examination, the uterus was found to be 20 weeks in size. Both fornices were free with transmitted mobility.
The laboratory reports were unremarkable.

IMAGING

Ultrasonography showed a well-defined heterogenous lesion measuring *9.6*7.8*7.3 cm* in the midline towards right in superolateral aspect of uterus suggestive of right broad ligament fibroid. Ovaries and other abdominal organs were normal and there was no ascites.

CE-MRI

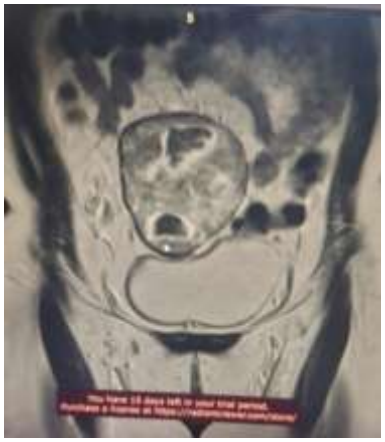

Figure 1

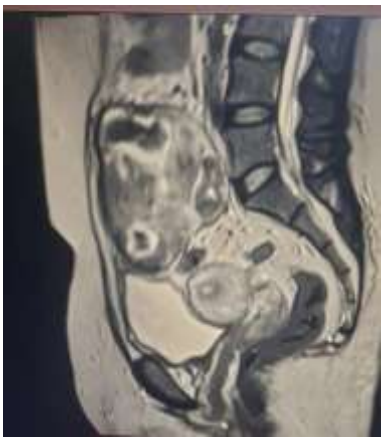

Figure 2

Figure 1& 2: Revealed well defined midline T1 iso /T2 heterogeneously hypertense lesion measuring ***8.3 X 8.8 X 9.2 cm*** noted in hypogastrium towards right not continuous with uterus with focal areas of diffusion restriction. Uterus was ***6 X 4.2 cm*** size with endometrial stipe of ***9.5 mm.***

Features suggestive of **wandering atypical fibroid** with close differential diagnosis of mesenteric desmoid tumor.

MANAGEMENT

She underwent exploratory laparotomy. An intraoperative solid midline mass measuring 10 X 10 cm X 10 cm that was attached to the small bowel and anterior peritoneum was seen with a thrombosed twisted artery on the right inferior aspect of the mass.

After releasing the adhesions by meticulous dissection, the mass was free of the uterus. Uterus had normal dimensions with normal looking bilateral chromopertubation spill positive fallopian tubes.

The 3*3 cm simple cyst in the right ovary was surgically removed.

The left ovary was healthy.

The six-day recovery period was unremarkable, and the patient was discharged.

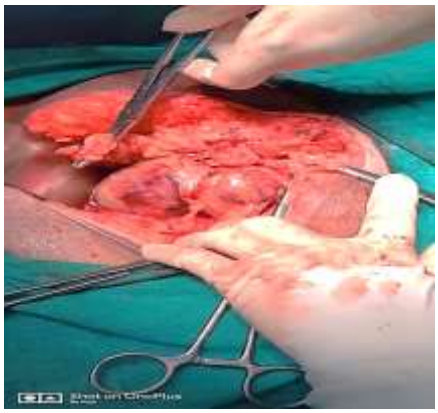

Figure 3: midline mass 10*10 cm seen while opening abdomen

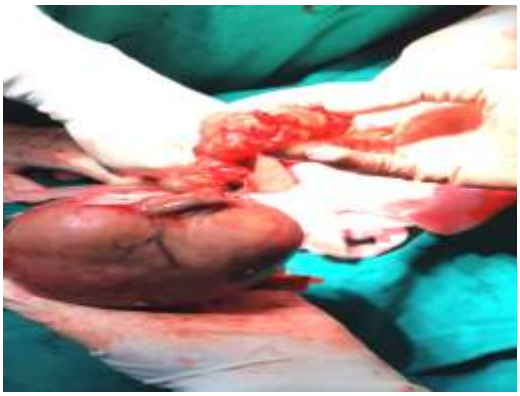

Figure 4: Mass which was adherent to anterior peritoneum & small bowel with thrombosed twisted vessel.

HISTOPATHOLOGY

On microscopy neoplasm was composed of interlacing fascicles of smooth muscle fibers

with cigar shaped nuclei with extensive areas of necrosis and myxoid change. Adjacent areas of mature adipocytes with congested and sclerosed vessels and a thrombus were present.

Diagnosis: leiomyoma with extensive degenerative changes.

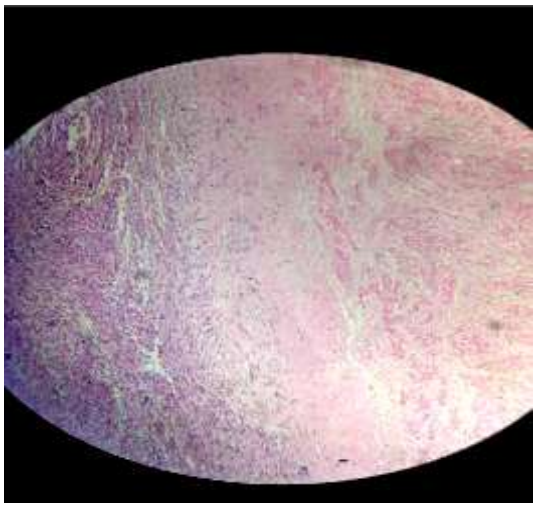

Figure 5: Neoplasm with interlacing fascicles of smooth muscles fibers with cigar shaped nuclei.

DISCUSSION

Kelly and Cullens described parasitic fibroids for the first time in 1909.(1) Formerly, it was presumed that it was formed by the separation of a pedunculated subserous uterine fibroid. Laparoscopic myomectomy led to the development of a novel iatrogenic genesis theory. According to the iatrogenic hypothesis, parasitic fibroids developed as a result of fibroid tissue being seeded during laparoscopic myomectomy's morcellation process.(2-4,6)Theory of de novo development of parasitic fibroids also have been postulated.(5) They grow as a result of receiving blood from nearby organs. Although they can be found everywhere in the abdominal cavity, parasitic fibroids are most frequently seen in the pelvis. They may be asymptomatic or exhibit signs like a distended abdomen or cramping, and they sporadically may result in consequences including intestinal obstructions. Although parasitic fibroids are frequently linked to other uterine fibroids, in our case the uterus was normal and there was no prior history of abdominal surgery.

CONCLUSION

Although parasitic fibroids are an uncommon presentation, it validates a high degree of suspicion in a woman with an abdomino-pelvic mass, to establish its diagnosis and prompt intervention, so as to prevent unforeseen complications.

Declaration by Authors

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Conflict of Interest: The authors declare no conflict of interest.

REFERENCES

1. Nezhat C, Kho K. Iatrogenic myomas: new class of myomas? *J Minim Invasive Gynecol.* 2010;17:544–550.
2. Paul PG, Koshy AK. Multiple peritoneal parasitic myomas after laparoscopic myomectomy and morcellation. *Fertil Steril.* 2006; 85:492–493.
3. Larraín D, Rabischong B, Khoo CK, Botchorishvili R, Canis M, Mage G. "Iatrogenic" parasitic myomas: unusual late complication of laparoscopic morcellation procedures. J Minim Invasive Gynecol. 2010;17:719
4. Nezhat C, Kho K. Iatrogenic myomas: new class of myomas? J Minim Invasive Gynecol. 2010;17:544–550
5. Vaquero ME, Magrina JF, Leslie KO. Uterine smooth-muscle tumors with unusual growth patterns. J Minim Invasive Gynecol. 2009;16:263–268
6. Cucinella G, Granese R, Calagna G, Somigliana E, Perino A. Parasitic myomas after laparoscopic surgery: an emerging complication in the use of morcellator? Description of four cases. Fertil Steril. 2011; 96:0–6.

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