UTERINE PARASITIC LEIOMYOMA-A RARE CONDITION

Dr.Shankar B. Burute

Dr.Mitisha V. Rana

Dr. Paidi Naga Rachana

Dr. Swapnali Sansare

ABSTRACT

Fibroid is the commonest benign tumour of the uterus. Amongst different types of fibroid, parasitic fibroid is rarest variety. Herewith we are presenting such a case along with discussion of interesting mechanism of its formation. Definition: A Fibroid that attaches itself to another organ such as omentum, mesentery, loop of bowel or sigmoid colon and uterine pedicle gradually degenerates until fibroid is no longer a part of uterus.

Key Words: *Leiomyoma, Fibroid, Wandering, Parasitic, Torsion*

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INTRODUCTION

Fibroid is known by different terms i.e. Leio(smooth) myoma(muscle) as it originates from smooth muscle of uterus. Other names are Fibromyoma - as it consists of fibrous and muscular tissue, myoma and fibroid. Fibroid is most frequently encountered benign neoplasm in the pelvis, the commonest site being uterus. According to anatomical site they are called as intramural (75%), subserous(15%). submucous (10%) & other types (5%). Basically they start developing in myometrium and due to uterine contractions they are pushed inside (submucous) or outside to become subserous.

Rarely formation of parasitic fibroid occurs due to complex interesting mechanism from subserous variety as follows: Complete bulging outside uterus by attachment of short (stalk pedicle) occurs and Inter elongation and thinning of this pedicle occurs leading to ischemia, so this fibroid gets attached to surrounding structures like omentum for blood supply and required development. Later on it either gets completely separated from uterus or remains attached to it by a thin avascular pedicle to become parasite on another structure eg: omentum , mesentry sigmoid colon. In another mechanism, where this subserosal fibroid pedicle gets partial torsion causing ischemia and then gets attaches to another structure for blood supply. Later necrosis of this avascular pedicle occurs leading to formation of parasitic fibroid.[1,2,3,4]

Nowadays a new entity has emerged called as iatrogenic parasitic fibroid. This occurs after myomectomy particularly laparoscopic route, where fragments scattered in the peritoneal cavity and gets implanted over other structures and starts growing.[5]

In other respect these fibroids behave like uterine fibroid & can show different degenerative changes. It can also undergo torsion[6,7]

CASE REPORT

A 42 year old women referred for acute abdominal pain since 2 days. It was associated with giddiness nausea and vomiting. Menstrual history 3-4days 30 days/regular moderate/painless. LMP-2 weeks back

<u>Obst History</u>: 2 para and last child birth being 12 years ago followed by tubectomy.

<u>General Exam</u>: Mild Febrile with Pulse-110beats/min, mild dehydrated and Pallor ++,BP 120/80mmHg

<u>RS & CVS: NAD</u>

Per Abdomen: marked tenderness over the lower abdomen more over the right side

Per Speculum: cervix and vagina healthy

Per Vagina: A globular mass about 5-6 cms in diameter on Rt. Side with marked tenderness present Uterus was normal in size,anteverted, anteflexed, mobile, non tender, left fornix was free. Patient was uncooperative for examination due to pains.

Per Rectum: same findings confirm

Pelvic ultrasound revealed a 6x7 cms hypoechoic mass? arising from broad ligament on right side with probe tenderness and free fluid in pouch of douglas. Uterus and both ovaries were normal.

Emergency laparotomy was done and approximately 300ml of peritoneal fluid was noted in POD and peritoneal cavity. A globular congested mass? fibroid about 6to7 cms which was adherent to omentum was seen in POD and behind the right broad ligament and blood vessels were seen in the omental attachment.

Mass delivered outside, separated from omentum and other flimsy adhesions and removed completely and sent for histopathology. Uterus and both ovaries were normal. Histopathology revealed fibroid. Postoperative period was uneventful.

Case Study: Specimen of parasitic fibroid

DISCUSSION

Parasitic fibroid is difficult to diagnose in comparison with other types and mostly they are diagnosed during laparotomy or laparoscopy. Clinically they present with lump in abdomen and due to pedunculated nature they are easily mistaken for adnexal mass.[(8)]

If careful search is made on USG and colour Doppler, it can definitely help to pinpoint diagnosis. Yeh et al luve described criteria and technique for diagnosis. They have also mentioned that colour Doppler is helpful in diagnosing torsion by absence of vascular signal particularly if it was present previous examination. They stress that marked tenderness and presence of free fluids possibility of torsion which was present in our case If patient's condition is stable, a diagnostic and surgical laparoscopy can be done if facility is available. However complete removal of fibroid and prevention of scattering fragments is must as mentioned previously. Some precaution is necessary during routine myomectomy to avoid "iatrogenic" parasitic fibroid,

Another entity also called parasitic leiomyoma may come across in medical field. It is actually parasitic infection such as dracunculosis. In fact, it represents a parasite in fibrous tissue

CONCLUSION

Though parasitic fibroid are difficult to diagnose clinically, sonologist can suspect its possibility by careful screening with USG and colour Doppler.

Ultimately laparoscopy or laparotomy and HPE are gold standard for diagnosis of parasitic fibroid.

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