

Posterior Vaginal Wall Fibroid in a Postmenopausal Lady: An Unusual Case Report

Poushali Sanyal¹, Megha Sharma², Biswajit Ghosh³, Subesha Basu Roy³, Dipa Mallick¹

¹Clinical Tutor, Department of Obstetrics and Gynaecology, Institute of Post-graduate Medical Education and Research, Kolkata, West Bengal, India, ²Junior Resident, Department of Obstetrics and Gynaecology, Institute of Post-graduate Medical Education and Research, Kolkata, West Bengal, India, ³Assistant Professor, Department of Obstetrics and Gynaecology, Institute of Post-graduate Medical Education and Research, Kolkata, West Bengal, India

Abstract

Vaginal tumors are rare and include papilloma, hemangioma, mucus polyp, and rarely leiomyoma. Vaginal leiomyomas remain an uncommon entity. We met upon one such case in our institute. A 70-year-old postmenopausal woman was admitted to our institute complaining of pain in the right iliac fossa for a month. It was suspected to be appendicitis. ultrasonography (USG) whole abdomen showed the presence of a hypoechoic space occupying lesion in the posterior vaginal wall/anterior rectal wall of size 44 mm × 30 mm. USG guided fine needle aspiration cytology reports from two laboratories showed conflicting results. As the patient was symptomatic, operative management was carried out. After putting the patient in lithotomy position, on giving an incision on the posterior vaginal wall, a mass which looked like a degenerated posterior vaginal wall fibroid, was seen, which was removed piecemeal. The post-operative histopathology showed that the mass was a leiomyoma.

Keywords: Leiomyoma, Post-menopausal, Vaginal

INTRODUCTION

Vaginal tumors are rare and include papilloma, hemangioma, mucus polyp, and rarely leiomyoma. Vaginal leiomyomas remain an uncommon entity, and there are about 300 reported cases only. The first case was detected way back in 1733 by Denis de Leyden.¹ Bennett and Erlich, two investigators, found that there were only nine cases in 50,000 surgical specimens. Moreover, they found only one case out of 15,000 autopsies which they reviewed at Johns Hopkins Hospital.² Here, we are reporting a case that was previously suspected as appendicitis based on her clinical features but came out to be a posterior vaginal wall fibroid after thorough investigations and post-operative histopathology.

CASE REPORT

A 60-year-old lady, a resident of Murshidabad district in West Bengal, was admitted to our hospital on March 17, 2014. She was complaining of pain in the right iliac fossa for about 1 month, which was not associated with fever, nausea or vomiting. Her bowel and bladder habits were regular. She had attained menopause 12 years ago. Coming to her obstetric history, she was a P5 + 0, and all her children were delivered vaginally at home. Her last child was born 30 years ago. She was a known hypertensive for the last 15 years. The medicines she was taking at the time of admission were tablet amlodipine 10 mg 1 tablet once daily, tablet torsemide 10 - ½ tablet once daily, and tablet clonazepam 1 mg 1 tablet once daily at bedtime. There was nothing significant in her past surgical or family history. She had a personal history of occasional allergic reactions to shellfish for which she took tablet cetirizine on a SOS basis.

Investigations: The following investigations were done:

- Ultrasonography (USG) whole abdomen: This was done at our institute on admission for pain lower abdomen suspecting appendicitis. It showed the presence of a hypoechoic space occupying lesion in

Access this article online



www.ijss-sn.com

Month of Submission : 12-2014
Month of Peer Review : 02-2015
Month of Acceptance : 02-2015
Month of Publishing : 03-2015

Corresponding Author: Dr. Megha Sharma, Room no. 448, Junior Doctor's Hostel, Institute of Post-graduate Medical Education and Research and SSKMH, 242 AJC Bose Road,, Kolkata - 700 020, West Bengal, India. Phone: +91-882071100. E-mail: drmegha0102@gmail.com

the posterior vaginal wall/anterior rectal wall of size 44 mm × 30 mm. The other organs were normal.

- A USG-guided fine-needle aspiration cytology was also carried out. The histopathology reports came as - Fibrosarcoma/cellular leiomyoma. Simultaneously, the sample was also sent outside to a reputed pathological laboratory. The histopathology reports from the laboratory came out to be a proliferative spindle cell tumor.
- A two-dimensional echocardiography was done which showed mild grade left ventricular hypertrophy with diastolic dysfunction of left ventricle, which were within normal limits for a chronic hypertensive.

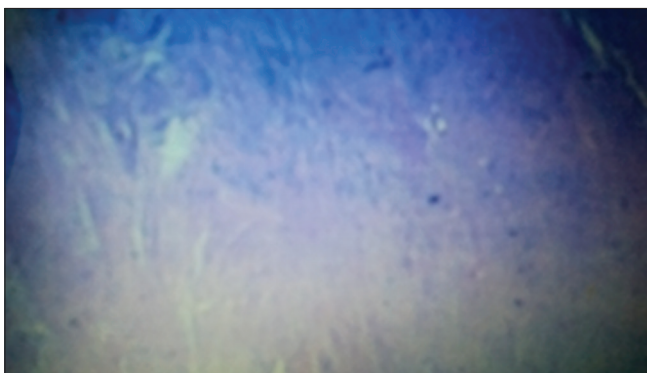
Based on these findings, we decided to go for surgical removal of the tumor. Pre-operative investigations done came out to be normal.

Per-operative findings were as follows:

- Under spinal anesthesia bladder was catheterized, ASS and ASD were done. The patient was put in lithotomy position. A small incision of about 2-3 cm was given over posterior vaginal wall. The posterior vaginal wall flap was separated from the mass by a gradual separation and the mass that resembled a degenerated fibroid was found. It was taken out in piecemeal and sent for histopathological examination. Hemostasis was secured, the posterior vaginal wall repaired, and betadine wash was given.

The per-operative images are depicted in Figures 1-3.

Histopathology



Histopathology reports of the mass were as follows:

Gross: Multiple pieces of greyish white tissue, the largest measuring 1.5 cm in its greatest axis. All the pieces embedded.

Microscopic examination: Sections show a lesion composed of interlacing fascicle of spindle-shaped cells

with elongated nuclei having blunt ends. The tumor cells show nuclear pleomorphism and exhibit occasional mitotic activity. Focal areas of hyaline degeneration are seen. There is no evidence of malignancy.



Figure 1: A bulge showing on the exposed posterior vaginal wall

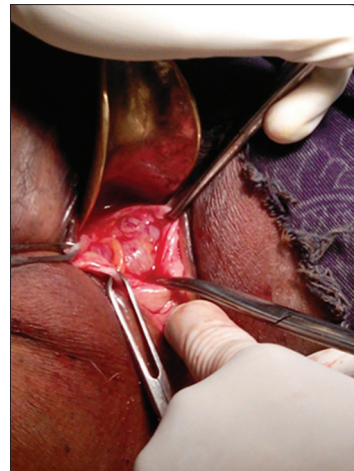


Figure 2: The posterior vaginal wall being separated from the mass



Figure 3: The mass after removal piecemeal

Impression: Leiomyoma. The sutures healed and the patient was discharged on the 7th post-operative day in good health.

DISCUSSION

Most leiomyomas are benign myometrial tumors, though, at times, uncommon loci may be found in the round ligament, broad ligament, renal pelvis, spermatic cord, urinary bladder, urethra, and rarely the peritoneum.³ Vaginal fibromas are rare benign neoplasms; approximately 300 have been reported previously.^{4,5} The clinical presentation is variable, and the consistency of the mass on pelvic examination may be misleading. A mass can originate anywhere along the vagina. It is generally localized, mobile, non-tender, and circumscribed. Its consistency can vary from solid to cystic. These lesions are at times asymptomatic. However, they can also give rise to variable symptoms such as pain or urinary tract symptoms, dyspareunia, and obstruction to the birth passage. Occasionally, they may just be present as a swelling in the vagina.⁶ In our patient, the presentation was pain in right iliac fossa. They are generally slow growing. They commonly arise from the anterior and lateral vaginal wall, and rarely are found to originate from the posterior vaginal wall.^{7,8}

Transabdominal and intravaginal sonography along with needle biopsy are valuable in making the pre-operative diagnosis of a benign smooth-muscle tumor. The treatment of choice is vaginal enucleation, and generally it is easily done due to the availability of good cleavage plane.^{6,9} Some cases require an abdominal⁷ or abdominopelvic⁹ approach. Operative management should include evaluation of the urethral and vesical support and possible reconstruction, such as placation of the bulbourethral ligament.

If a diagnosis is possible pre-operatively, a gonadotropin-releasing hormone analog can be used intramuscularly to reduce the size of these tumours.^{4,6} Otherwise, a pre-operative embolization can be performed to reduce intra-operative blood loss.¹⁰

CONCLUSION

Vaginal leiomyomas that present as a mass are most often diagnosed clinically and readily treated by surgery. As our case had an uncommon presentation, we performed some investigations to decide on the mode of treatment. The patient was successfully treated.

REFERENCES

1. Young SB, Rose PG, Reuter KL. Vaginal fibromyomata: Two cases with preoperative assessment, resection, and reconstruction. *Obstet Gynecol* 1991;78:972-4.
2. Bennett HG Jr, Erlich MM. Myoma of the vagina. *Am J Obstet Gynecol* 1941;42:314-20.
3. Shrivastava D, Bhute S, Kakani A, Patil V, Jajoo S, Joshi S. A rare case of vaginal leiomyoma diagnosed postoperatively. *J South Asian Fed Obstet Gynaecol* 2011;3:143-4.
4. Park SJ, Choi SJ, Han KH, Park KH, Chung H, Song JM. Leiomyoma of the vagina that caused cyclic urinary retention. *Acta Obstet Gynecol Scand* 2007;86:102-4.
5. Gowri R, Soundararaghavan S, Oumachigui A, Sistla SC, Iyengar KR. Leiomyoma of the vagina: An unusual presentation. *J Obstet Gynaecol Res* 2003;29:395-8.
6. Theodoridis TD, Zepiridis L, Chatzigeorgiou KN, Papanicolaou A, Bontis JN. Vaginal wall fibroid. *Arch Gynecol Obstet* 2008;278:281-2.
7. Vineeta G, Prafull A, Vandana G, Rawat DS. A rare case of vaginal fibroid presenting as an ovarian tumour. *J Obstet Gynecol India* 2006;56:537-8.
8. Yogesh K, Amita M, Rajendra K, Raju A, Rekha W, Hemant T. Vaginal leiomyoma developing after hysterectomy - case report and literature review. *Aust N Z J Obstet Gynaecol* 2005;45:96-7.
9. Lucas J, Dreyfus M, Bekkari Y. Surgical management during labour of giant vaginal fibromyoma. *J Gynaecol Surg* 2004;20:17-9.
10. Bapuraj JR, Ojili V, Singh SK, Prasad GR, Khandelwal N, Suri S. Preoperative embolization of a large vaginal leiomyoma: Report of a case and review of the literature. *Australas Radiol* 2006;50:179-82.

How to cite this article: Sanyal P, Sharma M, Ghosh B, Roy SB, Mallick D. Posterior Vaginal Wall Fibroid in a Post-Menopausal Lady: Int J Sci Stud 2015;2(12):186-188.

Source of Support: Nil, **Conflict of Interest:** None declared.