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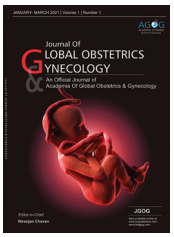
Case Report



# Degenerating Cervical Fibroid: An Uncommon Twist in Obstetrics: A Case Report

Vishwaja Bakshi[1], Ruchi N. Thakur[2]

*[1]Department of Obstetrics and Gynecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai, Maharashtra, India, [2]Department of Obstetrics and Gynecology, B. J. Government Medical College and Sassoon General Hospital, Pune, Maharashtra, India*

## ABSTRACT

Cervical fibroid is a gynecological pathology complicating pregnancy. Rarity of the condition, atypical presentations or overlapping symptoms with other conditions make the diagnosis difficult. Obstetric complications add another layer of complexity ranging from pre-existing maternal conditions to issues arising during labor or delivery, requiring careful monitoring and intervention to ensure the safety of both the mother and the baby. Without clear protocols, there is variability in treatment approaches and uncertainty about outcomes. Therefore, a highly coordinated and skilled approach is required to tackle the medical, surgical and obstetric challenges.

**Key words:** Cervical fibroid, Pregnancy, Complete abortion, Hysterectomy

## INTRODUCTION

Fibroids (leiomyomas) are hormone- dependent, benign smooth muscle cell tumors of the uterus with an unclear etiology, although they are extremely common. Their growth during pregnancy is affected by placental estrogens, progesterone, and an array of endocrine and paracrine factors. Fibroid blood supply, growth rate, and risk of degeneration change significantly during pregnancy and postpartum.[1] The risk of placenta previa, placental abruption, fetal malpresentation, and pre-term births associated with increased operative interference is seen in many studies, particularly with large submucosal and retro-placental fibroids.[2,3] The presence of multiple, large submucosal fibroids, especially in subfertile women, may increase the risk of pregnancy loss.[3] They have varied effects on pregnancy, depending on location. The prevalence of clinically evident cervical leiomyomas in pregnancy is <1%.[4] As the data are limited, there are no clear guidelines for the management of cervical fibroids in pregnancy.

We present a case that illustrates a very rare complication of pregnancy with fibroid and the difficulties that were encountered in the management.

**Corresponding Author:**
Vishwaja Bakshi, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai, Maharashtra, India.
E-mail: vishwaja.bakshi@gmail.com

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## CASE REPORT

A 34-year-old woman, G4P3L3 (full-term vaginal home deliveries), was referred from the district hospital with a diagnosis of 24 weeks of ANC with pre-eclampsia and pain in the abdomen and per vaginal (PV) bleeding with absent fetal heart sounds for further management. The patient had received a loading dose injection of MgSO4 at the same referral center.

She complained of vomiting (2 episodes), pain in the abdomen, and PV bleeding associated with the passage of clots for 3 days. The patient gave a history of amenorrhea for 3 months. She gave a history of consumption of unknown pills for the purpose of MTP by a quack 5 days ago, following which bleeding started.

Her previous cycles over 4 years were regular, frequent, lasting for 20 days, alternated with bleeding for 15–20 days associated with soakage of 10 pads per day with severe dysmenorrhea and passage of clots.

On examination, the patient was afebrile with a moderate general condition and a body mass index of 18.05 kg/m$^2$. Pulse was 120/min, blood pressure was 150/90 mmHg, and $SpO_2$ was 99% on room air. Severe pallor, marked exophthalmos, and a uniform, non-tender thyroid swelling and moving with deglutition were noted on the general examination. A systemic examination showed no abnormality. On the per-abdomen examination at 24 weeks, uniformly enlarged uterus, and hard in consistency, with no fetal heart sound heard on the stethoscope and Doppler. Per speculum and PV examination showed altered bleeding and a large, fleshy, foul-smelling, fragile, necrotic mass arising from the uterus with

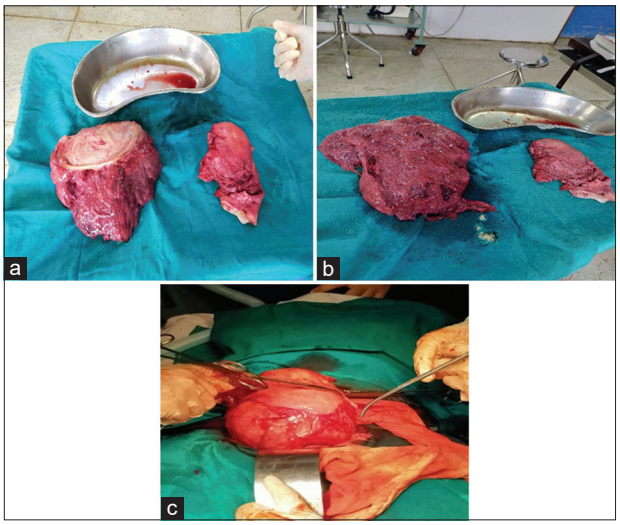


**Figure 1:** (a and b) Post-operative specimen of total abdominal hysterectomy with infected, degenerated cervical fibroid. (c) Intraoperative specimen of cervical fibroid

thinning of the cervical rim around it (probe test not done as the patient was referred as pregnant).

Therefore, a provisional diagnosis of 34-year-old G4P3L3 with 3-month amenorrhea and PV bleeding with a history of consumption of unknown pills and hyperthyroidism was made. Retained placenta, leiomyoma (cervical), large endometrial polyp, and leiomyosarcoma were the working differential diagnoses.

The investigations were as follows: Hb-8 g/dL; serum beta human chorionic gonadotropin - 6.5 mIU/mL, Sr. thyroid-stimulating hormone levels: 0.014 mIU/L. No growth of organism on culture sensitivity of swab from mass. Transvaginal ultrasound (USG) was suggestive of a 17*15*10.5 cm sized heterogeneously predominantly hypoechoic lesion arising from the lower anterior uterine wall, located in the anterior cul-de-sac with few cystic areas within and minimal vascularity. No evidence of intrauterine gestational sacs or retained products of conception was noted. Contrast-enhanced computed tomography (CECT) Abdo+ Pelvis: large heterogeneously enhancing soft-tissue density lesion of 10.7 * 14 * 13.5 cm involving anterior wall of the uterus, likely suggestive of fibroid. The lesion posteriorly compresses the distal part of the right ureter, leading to mild hydronephrosis and hydroureter. USG and CECT were suggestive of Thyroiditis or colloid goiter. Other laboratory and radiological investigations were within normal limits.

Examination under anesthesia demonstrated a mass of 24 weeks uterine size, firm in consistency, not felt separately from the uterus. It was foul-smelling, fleshy, and fragile, with the cervix effaced all around the protruding mass. There was a continuation of the mass anteriorly with the cervical wall present on the probe test, and cervical motion was transmitted to the mass. Rectal mucosa is free.

The histopathology report of the biopsy showed beefy-red, necrotic, autolytic tissue with focal hyaline changes in the whorled pattern suggestive of leiomyoma.

Final diagnosis: 34-year P3L3A1 with large cervical degenerative fibroid with anemia and hyperthyroidism with complete abortion was made. A total abdominal hysterectomy was performed in view of a complete infection, red degeneration of the fibroid (Figure 1). The patient recovered well in the post-operative period and was discharged after optimization.

## DISCUSSION

Fibroid-complicating pregnancy is commonly seen in clinical practice. Cervical and prolapsed submucosal leiomyomas are rarely seen in pregnancy. The prevalence of clinically evident cervical leiomyomas in pregnancy is <1%.[4] The majority of uterine leiomyomas in pregnancy have favorable pregnancy outcome. Indications for surgical intervention in pregnancy for cervical leiomyomas include bleeding, infection, degeneration, pain, and urinary stasis. Conflicting reports and limited data on cervical fibroids in pregnancy make management strategies difficult. Preoperative imaging with USG and magnetic resonance imaging may help to delineate the location and nature (e.g., pedunculated) of the cervical leiomyoma when clinical examination is inconclusive.

Vaginal myomectomy is recommended as the treatment of choice for a prolapsed, pedunculated submucous myoma, except when other indications necessitate an abdominal approach.[5,6] In this case, an abdominal hysterectomy was performed because the degenerated myoma originated in the anterior cervical region. Challenges in the management of patients included the correction of hyperthyroidism, the treatment of ongoing infections, and anemia. Surgical challenges due to distorted anatomy and post-abortal status.

## CONCLUSION

The majority of fibroids in pregnancy are asymptomatic. A few, especially cervical fibroids, may be associated with some complications affecting the course of pregnancy and labor. Ignored degenerative massive fibroid in the reproductive age group can mimic pregnancy. A thorough clinical examination is still essential for a correct clinical diagnosis. Cautious screening and monitoring through regular follow-up in the antenatal period are a must to detect any adverse obstetric complications and improve pregnancy outcomes.[7] Lack of literature and guidelines for management calls for an individualized approach to such cases.

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## CONFLICTS OF INTEREST

None declared.

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