GIANT UTERINE MYOMA AND OVARIAN MYOMA - ASSOCIATION OF TWO RARE ENTITIES. CASE REPORT AND LITERATURE REVIEW

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GIANT UTERINE MYOMA AND OVARIAN MYOMA - ASSOCIATION OF TWO RARE ENTITIES - CASE REPORT AND LITERATURE REVIEW (Abstract): Uterine myomas are the most common benign tumors of female reproductive system. They affect 25% of women of reproductive age. Giant uterine myomas are quite rare and are a challenge both for a complete diagnosis and for surgical management. Extra-uterine myomas are rare and they usually appear in the genitourinary tract (ovaries, vulva, broad ligament, round ligament, urethra). Primary ovarian leiomyoma is one of the rarest solid tumors of the ovary accounting for 0.5%–1% of all benign ovarian neoplasms. We report a 45-years-old nulliparous woman who came with abdominal distension and fatigue for several months. Abdominal-pelvic ultrasound and computer tomography showed a large myoma-like mass that filled the pelvis and abdomen. The diagnosis of giant uterine myoma was established and after careful discussion with the patient total hysterectomy was proposed. Surgery confirmed the diagnosis of a giant uterine myoma with several parasitic omental blood supplies. An additional ovarian myoma was discovered and total hysterectomy with right adnexectomy was performed. Our case stresses several clinical points that should be kept in mind before planning a surgery for a giant myoma - the possible presence of parasitic blood vessels and adherences which can pose some difficulties for the surgical team and the coexistence of different pathologies masked under the size of the tumor. It is important before planning a surgery to discuss with the patient the possibility to adapt the surgery according to associated pathology. Keywords: UTERINE LEIOMYOMA, GIANT LEIOMYOMA, GIANT MYOMA, LARGE MYOMA, OVARIAN MYOMA.

Uterine myoma is the most common benign tumors of female reproductive system. It affects 25% of women of reproductive age (1). Giant uterine myomas are quite rare and are a challenge both for a complete diagnosis and for surgical management. The challenge in diagnosis comes from their size, as they can hide other associated conditions, which sometimes are discovered during surgery and require changing the initial surgical plan. We present a case with two rare associated entities: a large uterine myoma associated with an ovarian fibroma.
CASE REPORT

A 45-year-old nulliparous woman comes to gynecological exam for a progressive increase of the abdomen and lower abdominal pain. Her medical history was normal, and she has no pregnancies. Her vital signs were all within normal limits. Clinical examination reveals the distension of the abdomen and the presence of a firm not tender lumpy abdominal and pelvic mass (fig. 1). A rectal examination was performed (the patient being a virgin) and it revealed a very large firm central mass filling the pelvis and abdomen. It was difficult to specify the origin of tumor. The results of routine laboratory testing were normal. Trans-abdominal ultrasound confirmed the presence of a large tumor highly suggestive of a uterine leiomyoma localized intramural and subserous. Bilateral ovaries could not be detected. An abdominal and pelvic computed tomography (CT) showed a large mass, approximately 25/20/13 cm in size, occupying the abdomen from pelvis to the upper abdominal cavity.

In the light of the clinical examination, the routine laboratory findings and US and CT results, the preoperative diagnosis was giant uterine myoma and after the informed consent of the patient was obtained, total abdominal hysterectomy was proposed.

Laparotomy revealed a large multilobular tumor originating from the uterus occupying the whole abdomen. Adhesions and parasitic vessels between the mass, omentum and descending colon were present. After careful dissection of the adhesions the examination of the ovaries revealed normal left ovary and a 3-cm myoma-like tumor at the right ovary. Because this tumor and giant uterine myoma total hysterectomy and right adnexitomy were performed. The postoperative evolution was uneventful, and the patient was discharged three days after the operation in excellent condition. The removed specimen was 4.5 kg in weight and size was 25/20/12 cm (fig. 2). Microscopic examination revealed a multilobulated leiomyoma, endometrial polyp and ovarian myoma.

DISCUSSION

Uterine leiomyomas are common benign tumors affecting 25% of women of reproductive age (1). Uterine myoma can be asymptomatic or can cause a variety of symptoms, including abnormal bleeding,
pain, infertility, miscarriage and compression on neighboring organs. Although the size of leiomyoma varies from microscopic to large, giant uterine myomas are uncommon. Giant uterine myomas are almost always symptomatic because of the tumor bulk-related symptoms.

Extra-uterine myomas are rare and present a great diagnostic challenge. They usually appear in the genito-urinary tract (ovaries, vulva, broad ligament, round ligament, urethra) (2). Ovarian fibromas are benign ovarian tumors of sex cord stromal origin. Primary ovarian leiomyoma is one of the rare solid tumors of the ovary, accounting for 0.5%–1% of benign ovarian neoplasms (3). Ovarian fibroma is generally asymptomatic and seen in women >50 years of age. Most ovarian leiomyomas are small, measuring only a few millimeters to centimeters in diameter but sometimes they can get larger and the ovary may become completely absorbed by the tumor (4). The differential diagnosis includes ovarian fibroma-thecoma, cellular fibroma, and sclerosing stromal tumor leiomyosarcoma. Ovarian fibroma is benign and complete surgical resection is the treatment.

A useful tool for diagnosis of uterine or ovarian myoma is the ultrasound examination where typically a myoma has whorled pattern appearance with variable echogenicity, depending on the presence of degeneration and calcification. In some cases, cystic degeneration with extensive edema forming cystic fluid-filled spaces can occur and the diagnosis can be more difficult to establish. Computed tomography and magnetic resonance imaging can also be used to diagnose fibromas.

The association of ovarian myoma and uterine myoma was reported by Doss et al. (5). According to our knowledge this is the first case that associates a giant uterine myoma with ovarian myoma and endometrial polyp. Our case stresses several clinical points that should be kept in mind in cases with giant uterine myoma. First, as leiomyomas enlarge, they can outgrow their blood supply and several parasitic blood vessels can appear from the structures it is adherent to. Such structures include the omentum, common iliac artery and inferior mesenteric artery (6, 7). Both parasitic vessels and adhesion can pose some difficulties to surgical team during surgery. Various types of degeneration such as hyaline, cystic, myxoid or red degeneration may appear in cases of giant myoma (8,9). These degenerations give atypical appearances and can cause confusion in diagnosis with imaging techniques like USG, CT, and MRI. The most frequent confusion that could appear is with an ovarian tumor (10,11). The final diagnosis can be made either intraoperative or histologically. Also imaging technique can in some cases miss some associated pathologies due to the size of the giant myoma. The patients should be informed about this possibility and about the need for adapting or changing the planned surgery to attempt a complete recovery.

CONCLUSIONS

Giant uterine myoma needs a careful preoperative exploration, as its size can sometimes hide other associated pathologies. To prevent discovering these pathologies during the surgery and to avoid surgical management without patient's consent, it is appropriate to carefully explore all the cases. Even so it is important to discuss with the patient and to inform him that due to the size of the tumor it is possible to change the surgical plan.
Giant uterine myoma and ovarian myoma - association of two rare entities.
Case report and literature review

REFERENCES


WHEN AND HOW TO CORRECT VITAMIN D DEFICIENCY?

In the last teen years, more than 30,000 articles regarding the importance of vitamin D in some physiological process, have been published worldwide. Now, we know the importance of vitamin D in immunoregulation, insulin production, cellular growth and cardiovascular protection. What we don’t really know is: what is the optimal level of vitamin D to cover all needs of the tissues that have vitamin D receptor (VDR)? For human well-being we need at least 20 ng/mL (the cut-off for treatment) and Endocrine Society it recommended achieving more than 30ng/mL with the preferred range of 40-60 ng/mL. Recommendations are: infants up to 1 year, 400-1,000 IU/day, for children over one year 600-1,000 IU/day, and for adults 1,500-2,000 IU/day. There are no reports regarding the intoxication with vitamin D in adults (Pludowski P, Holick MF, Grant WB, et al. Vitamin D supplementation guidelines. Journal of Steroid Biochemistry and Molecular Biology. doi: 10.1016/j.jsbmb.2017.01.021. Epub 2017 Feb 12).

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