

Massive recurrence of Uterine Fibroids: Case report and Literature Review

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Introduction

Uterine fibroids are the most common benign tumours that develop in the muscular wall of the uterus and are common in women of African origin.¹ Fibroids affect 20-50% of women of reproductive age.² The aetiology of uterine fibroids is unclear; however, their growth is regulated by ovarian steroids, and growth factors. Nulliparity, hereditary, black race, obesity, polycystic ovary syndrome, hypertension and diabetes mellitus are associated with increased risk of uterine fibroids³.

Fibroids may present with menstrual dysfunction, pains, pressure related symptoms, sub-fertility and pregnancy related problems.^{5,4}

Uterine fibroids may recur after myomectomy with a reported incidence of 1 to 58.8%⁶ .. Large uterine fibroids are common in our environments; however it is uncommon for a recurrent uterine fibroid to grow to a large size without seeking intervention.

Case Report

This 45 year old nulliparous lady presented to our clinic with a five year history of progressive abdominal swelling that had rapidly increased in the last 2 years. There were associated abdominal pains, easy fatigability and heavy menstrual loss but no history of post coital bleeding. Her menarche was at the age of 15 years with a regular 30 day cycle. She had two spontaneous miscarriages in the past and myomectomy 12 years ago.

General examination revealed a middle aged woman, moderately pale. Her pulse rate was 82 beats/minutes and her blood pressure was 110/70mmHg. The abdomen was enlarged with a right paramedian scar. There was a mass measuring 38 cm from the pubis to the xiphisternum. It was firm, irregular, and fairly mobile. Pelvic examination was unremarkable. A provisional diagnosis of recurrent symptomatic uterine fibroids was made. Pelvic ultrasound scan revealed features suggestive of huge multiple uterine fibroids and moderate bilateral hydro-nephrosis; intravenous urography showed right renal pelvis diverticulation and incomplete right ureteric obstruction presumably due to an intraluminal filling defects. Full blood counts revealed haemoglobin of 8.9g/dl. Chest x-ray, echocardiograph (ECG), liver function test, urea, electrolytes and creatinine were essentially normal. She was transfused two units of blood and counselled for total abdominal

hysterectomy and bilateral salpingo-oophorectomy. She was offered preoperative treatment with gonadotrophin releasing hormone. She declined as she wanted the operation as soon as possible.

Intraoperative findings were moderate pelvic adhesions, huge multiple uterine fibroids, largest measuring about 37 x 30 cm. Fallopian tubes and ovaries were normal. Moderate intra abdominal/pelvic adhesions were noted. Careful adhesiolysis, total abdominal hysterectomy and bilateral salphingo-ophorectomy was done. The tumour weighed 7.6 kg estimated blood loss was one litre. She had two more units of blood. She made a good post-operative recovery and was discharged home seven days later. She was reviewed 6 weeks at the gynaecology clinic, with no complaint. Her Haemoglobin was 11.8g/l. She was commenced on hormone replacement therapy (Premarin 0.625mg) and histopathological result confirmed benign leiomyoma with no evidence of malignancy.

Discussion

Uterine fibroids represent the most common large solid benign tumour of the female genital tract in our environment. The average uterine size at presentation is 15+/- 9.7 weeks⁷. Our patient presented with a uterine size of 38 weeks having had myomectomy in the past. This is an uncommon occurrence in this community. In a review of uterine fibroid from south western Nigeria, out of the one thousand two hundred and fifty nine cases of uterine fibroids, only 4% presented with a uterine size of greater than 20 weeks⁷. The delay in presentation is probably due to the strong desire of our female folk for a pregnancy and aversion to surgery⁸. Therefore patients tend to delay presenting to hospital rather resort to traditional medications with claims of dissolving uterine fibroids and only present to hospital at advanced stage of the disease.

Myomectomy has been the traditional surgery for the tumour though unsuccessful myomectomy may result in hysterectomy⁹. The size of the fibroid in our patient made us counsel her primarily for hysterectomy despite her strong desire for pregnancy as myomectomy in her could be threatened by severe Intraoperative complications.

For smaller tumours laparoscopic myomectomy is done in centres with the necessary equipment and expertise. Laparoscopic bipolar coagulation of uterine vessels have been reported.⁷ The essence is to deprive the fibroid of its blood supply.

Interventional radiology also have a place in management of large fibroids in the form of uterine artery embolisation. However as of now this is not available in the unit. Heavy bleeding and infection have been reported as side-effects.

We offered her treatment with gonadotrophin releasing hormone analogue, Zoladex to shrink the fibroid prior to surgery as this is known to reduce blood loss at operation and to make the operation easier. She however declined.

In an environment with high incidence of uterine fibroid, a uterine mass weighing 7.6 kg can be regarded as huge though larger sizes of uterine fibroids have been documented in the literature¹⁰. There is need to adequately educate women in environment with high incidence of uterine fibroids of the risk of recurrence. This may probably encourage such women to present to hospital early.

Hormone replacement therapy is found to be effective for treatment of severe vasomotor and oestrogen-deficient mucosal symptoms as well as in slowing down the rate of bone demineralization¹¹, it was considered in this case because her ovaries were removed during the procedure.

Conclusion

This case highlights the problem of dealing with difficult cases in under- resourced environment. We are aware other treatment options are available in many well resources centres.

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Fig I: Uterine Fibroid described



Figure II :Uterine fibroid described above

