



Management of Giant Prolapsed Submucous Leiomyoma: A Surgical Challenge for Gynecologists



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INTRODUCTION:

Uterine myomas are among the most common benign tumors affecting women of reproductive age. Leiomyomas are categorized as submucosal, intramural, or subserosa. Submucosal myomas may sometimes become pedunculated, eventually protruding through the cervical canal into the vaginal cavity. In symptomatic cases, myomectomy is the treatment of choice for reproductive-aged women seeking to preserve fertility. This case series presents cases of a large prolapsed submucosal myoma associated heavy menstrual bleeding, successfully removed via a vaginal approach.

OBJECTIVE:

This aims to present a case of giant prolapsed submucous myoma with chief complaint of prolapsed introital mass and heavy menstrual bleeding, highlighting a unique surgical approach for management. The large size of the myoma present a dilemma on the management of the patient.

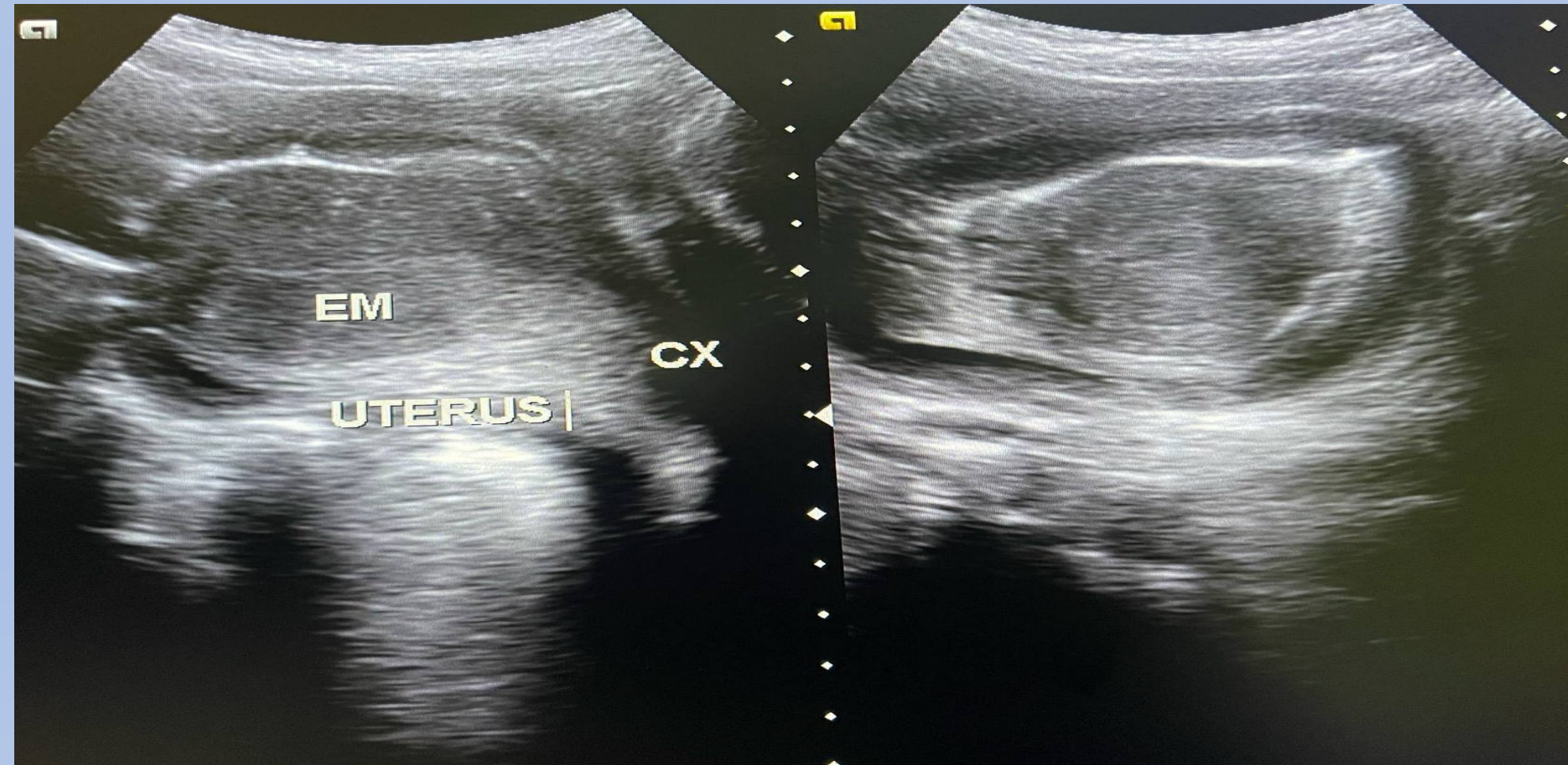


Figure 1: Actual image of the transvaginal ultrasound. Showed a normal sized anteverted uterus with smooth serosal contour. Myometrial walls are symmetrical with homogenous echogenicity. The uterine fundus was intact with absent fallen fundus sign. On transverse view, there was a hypoechoic space surrounding the uterus, with target-like appearance with the uterus seen at the lower pelvic floor.

CASE REPORT:

The patient is a 39-year-old G3P3 who presented with introital mass and a 5-month history of heavy menstrual bleeding with associated palpable hypogastric mass. Pelvic examination revealed a necrotic mass measuring 24x12x11 cm prolapsing from the introitus. The cervix was not appreciable and on bimanual examination, the uterus was not palpable at the suprapubic area. Transvaginal, transperineal and transabdominal ultrasound confirmed the mass as a prolapsed submucous myoma with the uterus at the vaginal vault. Vaginal myomectomy under general anesthesia was performed by excising and ligating the pedicle after diagnostic hysteroscopy confirmed the findings.

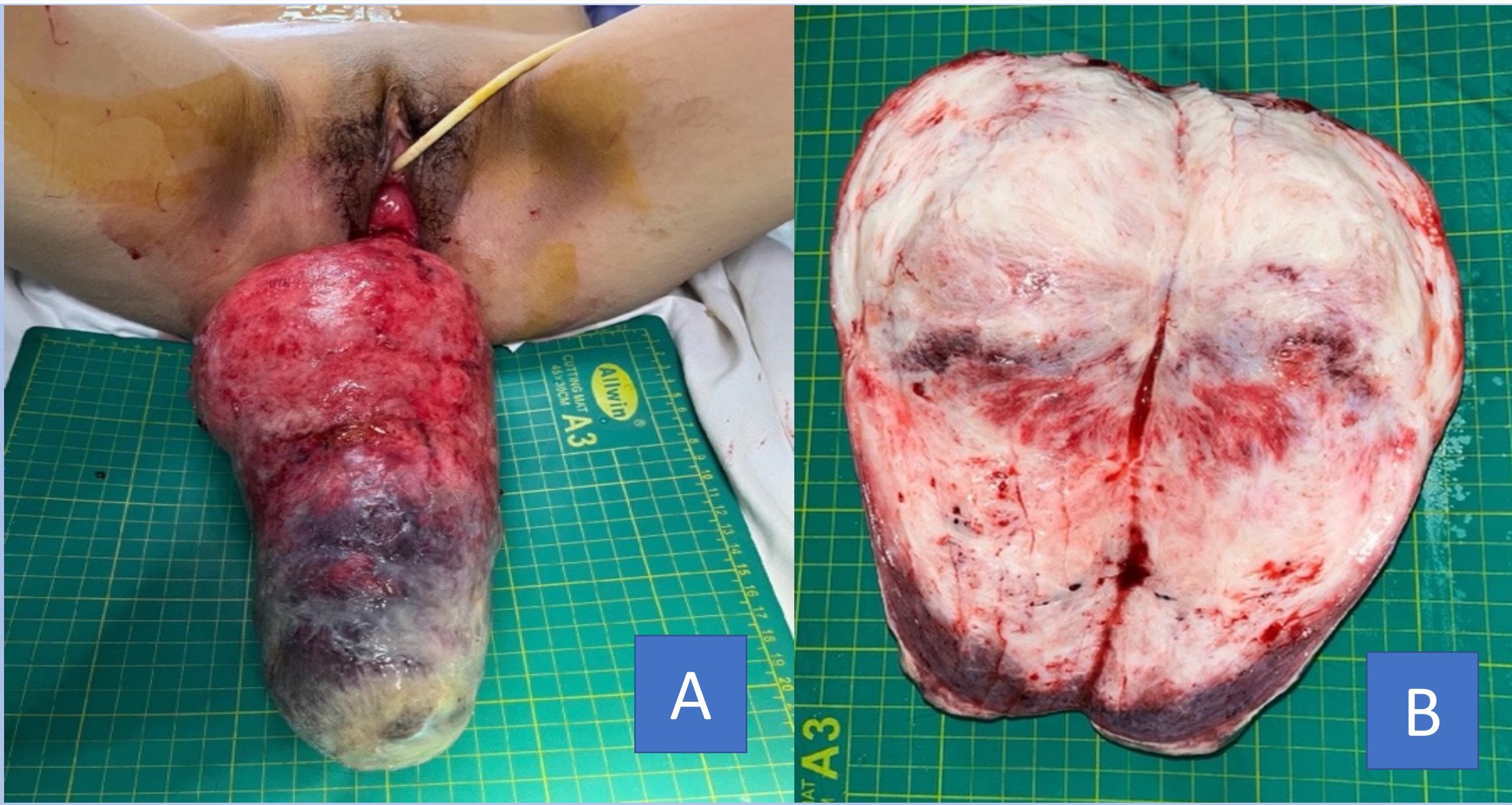


Figure 2: A. Actual Image of the prolapsed submucous myoma. Prolapsed vaginal mass with necrotic surface measuring 24 x 12 x 11 cm, pedicle attached at the posterior cervical lip encompassing the 3 to 10 o'clock position, B. Cut section of the myoma. The huge submucous myoma grossly weighed 1540g, total dimensions: 24x12x11 cm with cystic degeneration and necrotic areas appreciated

DISCUSSION:

Leiomyomas are common uterine tumors, with submucous types comprising 5–10%. Of these, 1.3–2.5% are pedunculated and at risk of prolapse. Symptoms include dysmenorrhea, menorrhagia, anemia, and occasionally infertility. Prolapsed myomas are often small, measuring 1–6 cm, though sizes exceeding 10 cm have been reported.

Initial evaluation includes pelvic examination and ultrasonography, with MRI reserved for complex cases. Vaginal myomectomy is the standard treatment, though emergency hysterectomy may be required in cases of severe bleeding or infection. Surgical success depends on the myoma's size, pedicle characteristics, and vaginal mobility. The large size of the prolapsed submucous myoma in this patient presented difficulty in the diagnosis as uterine inversion can also be a consideration because of the presentation of the mass. With the help of imaging and diagnostic hysteroscopy, conservative management was done successfully.

CONCLUSION:

Vaginal myomectomy remains an effective, minimally invasive procedure for managing prolapsed submucous myomas, regardless of size. Larger myomas, however, pose greater surgical challenges, occasionally necessitating alternative approaches like diagnostic hysteroscopy. Proper execution of surgical techniques ensures favorable outcomes and rapid recovery.

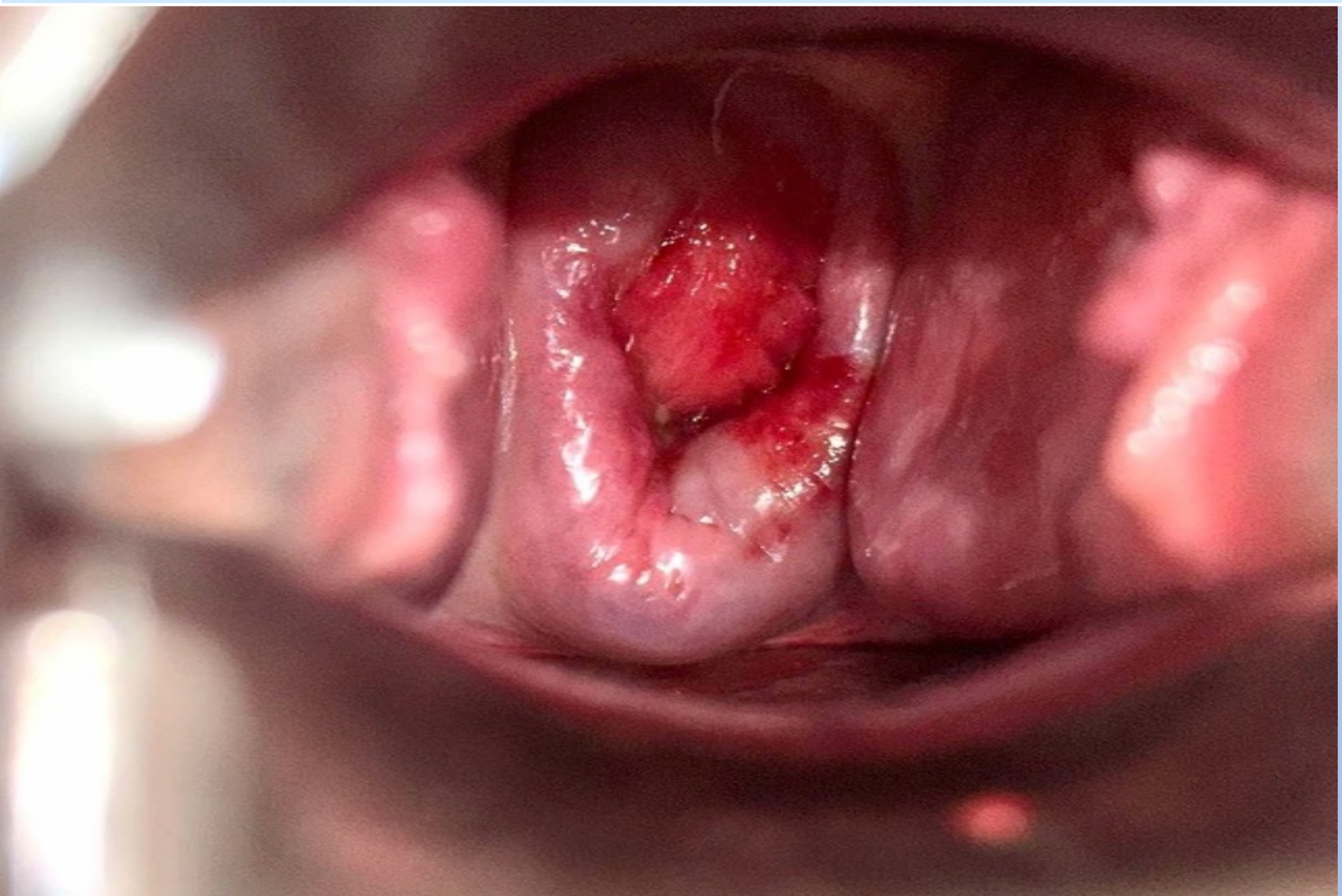


Figure 4: Post-operative cervical inspection

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