CARFAX

GYNAECOLOGY CASE REPORT

Vaginal leiomyoma

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Introduction

Since Denys de Leyden reported his first case of vaginal leiomyoma in 1733 not more than 300 cases have been reported (Tourneux, 1934). The variable clinical presentation and the consistency of the tumour quite often misleads the diagnosis.

Case report

A 52-year-old-white woman para 1 was admitted as an emergency with profuse vaginal bleeding and passage of clots. On examination there was a cystic mass in the anterior and right lateral vaginal wall extending from the fornix up to the lower one-third of the vagina which made the cervical and uterine examination difficult. Ultrasonography showed a solid mass of 6×7 cm size between the lower portion of the uterus and the bladder of uncertain nature. Under anaesthesia cervical manipulation was not easy. Laparoscopy revealed a normal-sized uterus, mobile and free from the mass. Four units of blood were transfused as the haemoglobin was 8 g%. She was prescribed norethisteron 10 mg three times daily to control uterine bleeding. A preoperative attempt for needle biopsy did not succeed. The solid anterior vaginal wall tumour of size $8 \times 7 \times 7$ cm and weighing 440 g was enucleated. After confirming haemostasis and intactness of the urethra and the bladder, the anterior vaginal wall was repaired in layers. There was no demonstrable cervical cause of bleeding. Hysteroscopic finding was also normal and dilation and curettage was performed.

Histopathologic evaluation showed a benign leiomyoma. Endometrial biopsy did not confirm any endometrial cause for bleeding. Two months later she was asymptomatic without any recurrence or urinary problem.

Discussion

Vaginal leiomyoma occurs mostly in white patients commonly in the midline anterior wall. Embryonal rests and local artery musculature are the likely sites of origin though the exact aetiology is uncertain (Moghissi, 1960). Though fewer cases have been reported, the real incidence might be much higher because of a high number of coloured patients who never become aware due to lack of symptoms, slow growth, smaller size and spontaneous regression after menopause (Liu, 1988).

With most of the patients being over 40, it seems to be a tumour of late reproductive life. In fact, due to slow growth these tumours, though beginning at a much younger age, are noticed when they become symptomatic later. They are usually moderately firm and undergo the same degenerative changes such as those of the uterus; hence they may vary considerably in consistency from firm to soft (Moghissi, 1960).

Cystocoele, urethrocoele, urethral diverticulum, inclusion cysts, cervical myoma, rectocoele, enterocoele, tumour of the rectum and rectovaginal septum, Gartner's duct cyst, paraurethral and Bartholin's cyst or abscess, endometriosis and malignant tumours of the vagina should be considered as differential diagnosis.

Meticulous vaginal examination, ultrasonography and needle biopsy are valuable in making preoperative diagnosis, though hysteroscopy and laparoscopy might be required at times.

Whenever such a tumour is detected, it should be removed *en bloc* to prevent further growth and sarcomatous change. In case of tumours located in the lateral fornix or anterior wall preoperative indwelling catheterisation is indicated in order to avoid injury to the bladder and the urethra.

Since these tumours are oestrogen dependent, oophorectomy should be considered in case of repeated recurrence or sarcomatous change (Liu, 1988).

References

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