Abstract:
Fibroids are common benign tumors of the uterus in reproductive age group. If the tumor grows outward towards the peritoneal surface it shows itself as a bossy growth and termed as subserous fibroid. Further growth leads to formation of a pedunculated fibroid. Such a tumor gets attached to a vascular organ and is cut off from its uterine origin. (PARASITIC FIBROID). Our patient, a 28 YEAR OLD P1L1, previous caesarean section presented with 24 weeks size pelvic mass. Routine blood investigations were normal. Ca 125---248 iuml (high). CT scan showed a vascular subserous fibroid. The patient underwent laparotomy revealing a 30x15 cm parasitic fibroid deriving vascular supply through highly tortuous feeders from greater omentum with coexisting ascites of about 1.5 litres. Myomectomy done by clamping the pedicle. The tortuous risky feeders in greater omentum were clamped and ligated. Uterus was preserved after intra op confirmation of benign nature grossly.

Keyword: Parasitic Fibroid, pedunculated fibroid, subserous fibroid

AN INTERESTING CASE OF PARASITIC FIBROID WITH ASCITES

INTRODUCTION: Uterine myomas occur in approximately 25% of reproductive-aged women and are noted on pathologic examination in approximately 80% of surgically excised uteri. The subset of parasitic myomas is rare, with few reported cases in the literature. Although first described by Kelly and Cullen in 1909, as myomata that have for some reason become partially or almost completely separated from the uterus and receive their main blood-supply from another source, the cause, natural history, and pathologic basis of parasitic myomas are still not clearly understood. The conventional thinking is that parasitic myomas are a rare variant of pedunculated subserosal myomas. It has been suggested that if a pedunculated subserosal myoma develops a long stalk and becomes what is termed a wandering or migrating...
leiomyoma such a tumor can then go on to adhere to surrounding structures such as the omentum or broad ligament and develop an auxiliary blood supply. In this way, a parasitic myoma is formed when a wandering myoma loses its uterine blood supply and becomes attached and feeds from a nonuterine source. The literature has been limited to case reports and small series of such findings since the early 1900s; more recently, a few case studies have identified parasitic myomas after laparoscopic morcellation procedures. Diagnosis of parasitic myomas is often incidental at the time of abdominal surgery for treatment of symptoms due to uterine myomas; however, there are case reports in which parasitic myomas have been found to cause symptoms themselves.

**CASE-REPORT:**

This is a case report of a 28yr old P1L1 belonging to Class III socioeconomic status coming from Chennai presented to our hospital in April 2011 with complaints of mass lower abdomen associated with pain for the past one month. She was married since six years. Her menstrual cycles were regular 5/30. No history of dysmenorrhea. She was apparently normal one month back and then she noticed mass per abdomen which was progressively increasing in size. She developed pain lower abdomen which was dull aching for the past one week for which she had come to hospital. She is a P1L1 delivered by full term caesarian section five years back. No history of any contraception used. Her bowel and bladder habits were normal. There was no history of any abnormal vaginal discharge. She underwent umbilical hernia repair in 2008. On examination she was moderately built and nourished. Systemic examination was normal. Abdomen examination revealed a firm mass corresponding to 24 weeks gravid uterus arising from the pelvis. The mass was irregular, with restricted mobility. No other organomegaly. Free fluid abdomen was elicited. Speculum examination revealed congested cervix.

On bimanual pelvic examination the uterus was found to be of normal size and the same firm mass was felt in all fornices which measured about 25X15cm. Her investigations were normal. CA-125 level was 243 U/ml which was on the higher side (Ref <35U/ml). Ultrasound was done which couldn’t delineate where the mass was arising from the ovary or from the uterus. CT Abdomen showed subserous fibroid with large feeding vessels. Both the ovaries were normal. Bilateral hydro ureteronephrosis were present. IVP revealed bilateral HUN. She was taken up for laparotomy under spinal anaesthesia. Intra op findings showed 1.5 litres straw coloured ascitic fluid and the same drained and sent for cytology. There was a huge subserous parasitic fibroid measuring 30X15cm in the greatest dimension arising from the right cornual end of the uterus entirely covered by the greater omentum with worm like large tortuous feeder vessels coursing all around the fibroid. The fibroid was found to be attached to the uterus by a thin fibrous stalk. Bilateral tubes and ovaries were normal. The omental adhesions over the fibroid were released by clamping cutting and ligating the large tortuous blood vessels. Myomectomy of the large parasitic fibroid was done. The myoma bed was sutured and hemostasis secured. It was decided to conserve the uterus as the pathologist ruled out sarcoma grossly intra-operatively and the patient was young with only one living child. The tortuous vessels of the omentum were explored and perfect hemostasis was secured. Abdomen
closed with intra peritoneal drain in situ. Post-operative period was uneventful and she was discharged with advice for regular follow up. Ascitic fluid cytology showed smear with reactive mesothelial cells in a proteinaceous background. The parasitic fibroid showed features of leiomyoma with areas of hyaline degeneration on histopathologic examination.

DISCUSSION:
Parasitic myomas are a rare variant of pedunculated subserosal myomas that have outgrown their uterine blood supply and become separated from the uterus, receiving blood supply from another source. Pedunculated lesions can have obscure origins and may be mistaken for a lesion of ovarian origin. If a pelvic mass is seen separate from both the ovary and uterus, a sonographic diagnosis of a pedunculated, subserosal leiomyoma can be made if a vascular pedicle is demonstrated or if a recurrent shadowing sign suggestive of leiomyoma is present. Pedunculated subserosal leiomyomas can be twisted on the uterine pedicle, and become detached in the peritoneal cavity. Such leiomyomas are referred to as “parasitic leiomyomas”; this tumor survives by revascularization from adjacent structures. However, sometimes the tumor can adhere to the surrounding structures. The initial pedunculated fibroid likely develops premenopausally, whereas the parasitic leiomyoma may become clinically evident either before or after menopause. As leiomyomas enlarge, they may outgrow their blood supply, resulting in various types of degeneration: hyaline or myxoid degeneration, calcification, cystic degeneration, or red degeneration. In general, hyaline degeneration is the most common (63%) form of degeneration, while the others occur less frequently, such as myxomatous changes (13%), calcification (8%), mucoid changes (6%), cystic degeneration (4%), red degeneration (3%). Our case was diagnosed as a common leiomyoma that presented with hyaline degeneration. Surgical excision is the treatment of choice. MRI imaging may show the vascular pedicle or its attachment to the uterus and may show the hypointense T1 and T2 signals of non-degenerated areas. This case of parasitic fibroid with ascites fits the category of PSEUDO MEIGS SYNDROME. This could be explained by the fact that twisting of the vascular pedicle of the parasitic fibroid leading to congestion and transudate from the largefeeder vessels leading to formation of ascites. Also peritoneal irritation due to the fibroid can have led to ascites formation. Elevated levels of CA125 with benign leiomyoma as in our case has also been reported by some authors, but the etiology remains unclear. Another fact is that more parasitic myomas may be iatrogenically after surgery particularly after surgery using morcellation techniques. With increasing rates of laparoscopic procedures surgeons should be aware of the potential for iatrogenic parasitic myoma formation, their likely increasing frequency and intra operative precautions to minimize occurrence.
ligation of large omental feeder vessels
Parasitic myomas may occur spontaneously as pedunculated subserosal myomas lose their uterine blood supply and parasitize to other organs. More parasitic myomas may be iatrogenically created after surgery, particularly surgery using morcellation techniques.

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