



Laparoscopic assisted vaginal myomectomy of a cervical fibroid-A case report

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Abstract : Cervical leiomyomas contribute to less than five percent of all uterine leiomyomas. Cervical myomas exacerbate surgical difficulties. Surgery to treat uterine fibroids includes uterine preservation or involves subtotal or total hysterectomy. Management of cervical fibroids is usually by hysterectomy especially for central cervical fibroids. Uterine artery embolization and myomectomy can be performed depending on patients symptoms, fertility desire and the site of the mass. Preference is shifted from an abdominal/vaginal approach to endoscopic or endoscopically assisted procedures to treat uterine fibroids(4). Some of the benefits of laparoscopic procedure over abdominal myomectomy are shorter convalescence time, lower intraoperative blood loss, fewer postoperative wound infections, lower postoperative pain, shorter hospital stay and better cosmesis. In this case, laparoscopic assisted vaginal myomectomy was done. It was a successful procedure with minimal morbidity.

Keyword : Cervical leiomyoma, Laparoscopy, Myomectomy

Introduction

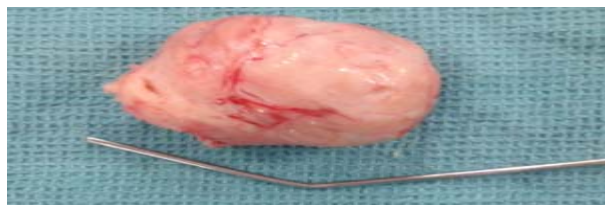
Cervical leiomyomas contribute to less than five percent of all uterine leiomyomas. Cervical myomas exacerbate surgical difficulties, such as poor operative field, difficult suture repairs, and blood loss(1). Ureteric injury during gynaecological procedure is one of the serious complications and is associated with significant morbidity. Ureter can be injured due to its anatomical proximity to the female reproductive system and identification of ureters is the main problem in pelvic surgeries(2). Ureteric injury, bladder and rectal injuries can occur while operating on cervical fibroid due to distorted anatomy(3). The appropriate surgical technique for the treatment of uterine fibroids is still a matter of debate. Surgeries to treat uterine fibroids include uterine preservation or involve subtotal or total hysterectomy. The different approaches for myomectomy, either abdominal, laparoscopic, vaginal and hysteroscopic or a combination of these can be performed. Preference is shifted from an abdominal/vaginal approach to endoscopic or endoscopically assisted procedures to treat uterine fibroids(4). Some of the

benefits of laparoscopic procedure over abdominal myomectomy are shorter convalescence time, lower intraoperative blood loss, fewer postoperative wound infections, lower postoperative pain, shorter hospital stay and better cosmesis. A vaginal approach may be considered an alternative to laparotomy, laparoscopy or hysteroscopic resection in surgery to treat accessible myomas and seems to be the simplest method (5). Primary abdominal myomectomy to preserve the uterus is indicated in exceptional cases if minimally invasive surgical procedures cannot be used. Surgical treatment of cervical myoma is usually difficult. It is important that the approach be changed according to the location and size of the myoma(6).

Case report

34 year old multiparous woman with two prior lower segment caesarean sections presented with heavy menstrual blood loss and post coital bleeding for the past 6 months. She has multiple risk factors. She is a known case of chronic kidney disease stage IV, systemic hypertension, hypothyroidism and moderate anaemia. Speculum aided examination revealed a 10 x10 cm mass in the vagina and cervix was not visualised separately. On vaginal examination: 10 x10 cm firm mass was felt arising from posterior cervical lip .It was a single sessile cervical fibroid. Scan was done which showed uterus measuring 11.5 x4.4 cm and a large cervical fibroid measuring 8.5 x 5.5 cm. Both kidneys appeared normal. Blood investigations revealed moderate anaemia (Haemoglobin: 9.9 gm%) and elevated creatinine level (2.2 mg/dl) which was secondary to chronic kidney disease. Cervical cytology was negative for malignancy. She was planned for the laparoscopy proceed. Laparoscope was used to locate the extent of myoma, it's relationship to the ureters and rectum and to rule out the presence of other smaller fibroids. Under general anaesthesia, patient was positioned in semi lithotomy position. Under aseptic conditions, bladder was drained.3 port open laparoscopy was done. During the laparoscopy 10 x10 cm fibroid arising from posterior lip of cervix distorting the posterior anatomy was noted. Extent of fibroid and its relation to surrounding structures was noted. No other fibroids were noted. Rest of the pelvic findings were normal. Vasopressin was

Injected laparoscopically into the base of the myoma. In the lithotomy position, through the vaginal route, incision was made on the myoma in the midline and the myoma was enucleated with ease and with minimal blood loss. Dead space was obliterated and the posterior lip of the cervix was reconstructed with 2-0 vicryl. Check laparoscopy was done at the end of the vaginal myomectomy to confirm the integrity of rectum, bladder and ureters. Total blood loss was very minimal, approximately fifty millilitres. Surgery lasted for forty five minutes. Post operative period was uneventful and she was discharged in stable condition on second post operative day.



CERVICAL FIBROID

Discussion

Cervical fibroids can arise from the supra vaginal or vaginal portion of the cervix. There are several types of cervical fibroid and each can present in a different manner. As in this case, supravaginal fibroid was lying centrally in the pelvis displacing the uterus superiorly and anteriorly. Ureteric injury, bladder and rectal injuries can occur while operating on cervical fibroid due to distorted anatomy. Management of cervical fibroids is usually by hysterectomy especially for central cervical fibroids. Uterine artery embolization and myomectomy can be performed depending on patients' symptoms, fertility desire and the site of the mass (7). Uterine artery embolization was not considered in this case because of the large size of the fibroid compressing the surrounding structures. Uterine myomectomy is the only uterus-sparing surgical conservative approach. It can be performed either by hysteroscopy, laparotomy or laparoscopy according to fibroid location and size (8). Dealing with posterior uterine myomas by the vaginal route, after laparoscopic inspection and location of uterine myomas makes hemostasis and uterine repair easier (9). In this case, laparoscopy assisted vaginal myomectomy was preferred. The patient had uneventful postoperative period and she was discharged within two days post operatively reducing the cost associated with hospital stay.

Conclusion

Laparoscopic assistance gives a better visualization and hence the extent of the fibroid can be noted and injury to other visceral organs can be prevented. Success of laparoscopic assisted vaginal myomectomy depends on appropriate selection of patients. In this case, laparoscopic assisted vaginal myomectomy was done. It was a successful procedure with minimal morbidity.

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