CASE REPORT

Wandering Fibroid Presented as Acute Abdomen: A Rare Case with Diagnostic Dilemma

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Abstract

Background: Fibroids are the most commonly occurring benign uterine tumor in the reproductive phase of a woman's life. Wandering fibroid (Parasitic leiomyoma) is an extrauterine fibroid with a very low incidence.

Case description: We are reporting an interesting case of a 20-year-old, nulliparous female with acute abdomen, who turned out to be a wandering fibroid with torsion of the right fallopian tube intraoperatively.

Conclusion: Due to the unusual location of the parasitic fibroids, patients usually present with atypical clinical presentation and it is challenging to reach on accurate diagnosis preoperatively. With the help of a high index of suspicion and radiological imaging like ultrasound, we can reach close to the diagnosis and be able to do the proper management of the patients.

Keywords: Case report, Diagnostic dilemma, Extrauterine fibroid, Fallopian tube torsion, Wandering fibroid.

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Introduction

Fibroids (Leiomyoma) are monoclonal, benign uterine tumor comprising mainly of smooth muscle cells and fibrous connective tissue.[1] Incidence varies with age, 4.3 per 1,000 women from 25 to 39 years to 22.5%from 40 to 44 years of age.[2] Leiomyoma can be broadly classified into three main types: Subserosal, intramural, and submucosal. International Federation of Gynaecology and Obstetrics (FIGO) classify them into 8 subclasses from 1 to 8.[2] Type 8 is classified as an extrauterine fibroid such as a broad ligament fibroid, Parasitic leiomyoma etc.

In the year 1909, Kelly and Cullens first described parasitic leiomyoma and stated it as a "fibroid that has due to some reason become almost completely or partially detached from the uterus and receive their major blood supply from another source". Less than 30 case reports have been reported in the literature of wandering fibroid (parasitic leiomyoma).

Case Description

A 20 years nulligravida reported in the emergency with severe right iliac fossa pain for one day which was associated with vomiting and syncopal attack. The pain started 5 months back and was insidious in onset, mild to moderate in intensity, and relieved on taking analgesics. For the past 1 month, pain increased in intensity and became colicky in nature. Her blood pressure was 106/62 mm Hg, Pulse: 110/min, RR: 20/min, afebrile. Her abdomen was soft, and tenderness was present over the right iliac fossa. On per speculum examination, mixed discharge was present, cervix hypertrophied, erosion present and nabothian follicles were seen. On digital vaginal examination, the uterus was normal, anteverted, and cervical motion tenderness was present along with right fornical tenderness.

All her baseline investigations were within normal limits. In ultrasonography a well-defined heterogeneous hypoechoic space-occupying lesion with cystic content measuring 7.5 cm × 7.1 cm × 7.2 cm, extending into the right iliac fossa likely large fundal subserosal fibroid or adnexal mass, torsion can't be ruled out. The patient was taken up for emergency exploratory laparotomy, intraoperatively around 50 mL hemoperitoneum was present. A large firm to cystic mass of 9 cm × 8 cm × 7 cm was found on the right side of the uterus, attached to the proximal part of the right fallopian tube which was oedematous, necrosed, and torted three times over the mass and detached from its original site at uterus probably due to necrosis. A rent of 1 cm × 1 cm was present on the right cornual end with a remnant of a thin pedicle (the original attachment of the right fallopian tube with subserosal fibroid) (Fig. 1) which was bleeding. Right fallopian tube along with mass was removed, the right corneal uterine rent was repaired, homeostasis was achieved (Fig. 2). The cut section of the specimen showed a whorled appearance. The histopathology examination report of mass was suggestive of leiomyoma with hyaline changes.

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Patient consent statement: The author(s) have obtained written informed consent from the patient for publication of the case report details and related images.

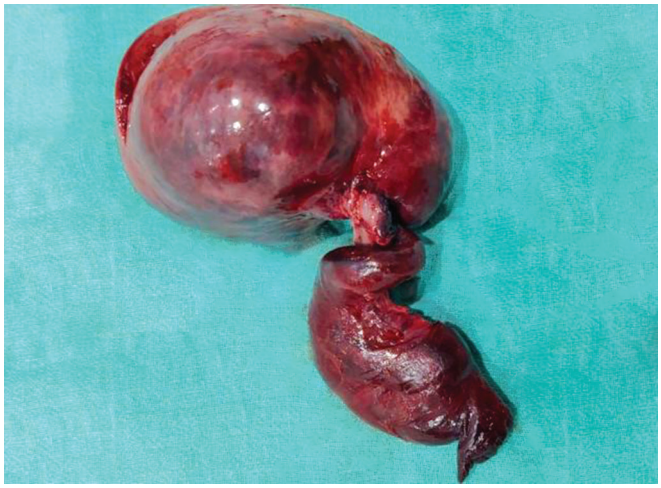

Fig. 1: Gross specimen showing necrosed fallopian tube attached to wandering fibroid

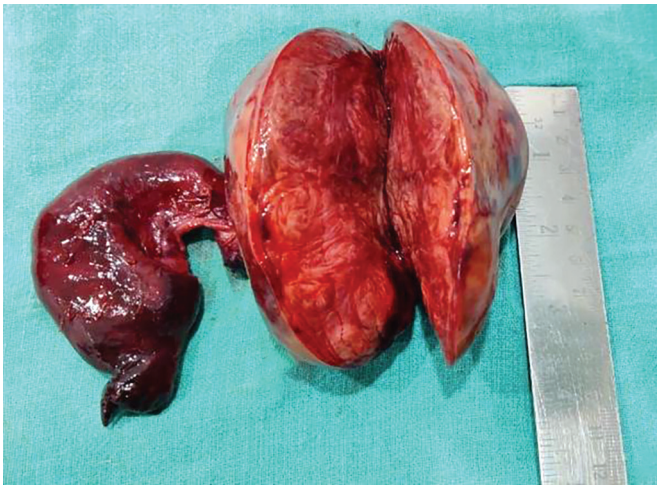

Fig. 2: Cut section of wandering fibroid showing whorled pattern

Discussion

Some authors consider Parasitic leiomyoma as a subtype of subserosal leiomyoma which after undergoing torsion gets isolated from the uterus and derives its major blood supply from adjacent tissue for its survival while others consider its origin as an iatrogenic cause due to complications of uterine procedures such as laparoscopic morcellation performed for some uterine pathology.[3]

The pelvis is the usual location of parasitic fibroids. However, they can be found anywhere in the abdominal cavity and have also been reported in the lungs, bladder, urethra, and sigmoid colon but are extremely rare.[4]

Patients with parasitic fibroid usually present with vague symptoms, often due to mass effects such as heaviness in the abdomen and pain abdomen. However, our patient presented with acute abdomen which is not an usual presentation. On the basis of intraoperative findings in our case, we can suggest that the mass initially was a subserosal fibroid which was arising from the cornual end of the uterus near the right fallopian tube and got detached from its origin with the fallopian tube attached to it as a pedicle and became a wandering fibroid. A residue of a thin pedicle and a rent was present on the cornual end of the uterus. Bleeding from that rent leads to hemoperitoneum. Fibroid underwent torsion around the fallopian tube because the fallopian tube was acting as a long pedicle. Management of wandering fibroid is usually by surgical resection either by laparoscopy or open surgery.

We are reporting this case because of its rarity and unusual presentation of wandering fibroid and to increase the insight into varied atypical clinical presentations of parasitic fibroid among practicing gynecologists to avoid delay in diagnosis and management.

Conclusion

Wandering fibroids are rare extrauterine tumors. Radiological modalities are resourceful in diagnosing but not always. Surgical excision is the definitive treatment.

Ethical Approval

Patient identifiers have been anonymized.

References

1. Melmed S, Polonsky KS, Larsen PR, et al. Williams textbook of the endocrinology, 14th edition. Philadelphia: Elsevier; 2019;953–954.
2. Berek JS. Uterine Fibroids. In: Berek JS (Eds). Berek & Novak's Gynecology, 15th edition, Philadelphia: Lippincott Williams & Wilkins; 2013. pp. 444–445.
3. Grover A, Bhalla S. Parasitic leiomyoma: A rare complication following laparoscopic myomectomy with review of literature. Curr Med Res Pract 2015;5(6):278–281. Available from: https://doi.org/10.1016/j.cmrp.2015.10.002.
4. Lu B, Xu J, Pan Z. Iatrogenic parasitic leiomyoma and leiomyomatosis peritonealis disseminata following uterine morcellation. J Obstet Gynaecol Res 2016;42(8):990–999. DOI: 10.1111/jog.13011.