

Spontaneous Parasitic Leiomyoma: A Rare Clinical Experience

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ABSTRACT

Although leiomyoma is one of the commonest uterine tumors prevalent among reproductive aged women, certain types like parasitic fibroid are rare and among these the primary variety rarer. The present case report is of a primary parasitic fibroid of large size neither connected with uterus and adnexae nor having any history of previous laparoscopic procedures. Aim of our reporting is to acknowledge the rarity, clinical parameters and management.

Keywords: Parasitic leiomyoma, Laparoscopic morcellation, Rare.

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INTRODUCTION

Subserosal leiomyomas may be beneath the uterine surface or exophytic or pedunculated. If a pedunculated subserosal leiomyoma develops an extremely long, tenuous stalk, it is called a wandering or migrating leiomyoma.¹ Occasionally, such tumors become adherent to surrounding structures, such as the broad ligament or omentum, develop an auxiliary blood supply, and lose their original attachment to the uterus. They are then called parasitic leiomyomas.^{1,2} It can develop from a morcellation remnant following laparoscopic myomectomy.³ But primary parasitic fibroids are rare. Thorough Medline search revealed only two cases of such primary or spontaneous parasitic leiomyoma.⁴

In this article, we report a case of primary parasitic fibroid in a young woman, without any history of laparoscopic myomectomy or hysterectomy.

CASE REPORT

A 36-year-old primipara presented a slow growing swelling of lower abdomen for last 1 month with cramping pain.

Her menstrual cycles were regular and painless. She had conceived spontaneously and had an uneventful vaginal delivered 12-year back.

Per abdominal examination revealed a 15 cm firm lump palpable in right iliac fossa and extending up to hypogastrium. Bimanual examination confirmed the mass to be separate from uterus. Other systemic examinations were unremarkable.

Ultrasonography showed 11.1 × 8.68 cm pelvic SOL with heterogenous echotexture and ascites, nonvisualization of right ovary, grade II right sided hydronephrosis and hydroureter. Computerized tomography report was also in a confused way defining the SOL as a quire degenerated fibroid. Her routine



Fig. 1: Parasitic leiomyoma of size 15.5 × 10 × 11 cm



Fig. 2: Parasitic leiomyoma with vascular connection to intestine

hematological investigations were within normal limits. Except CA-125 (70 mg/dl), all tumor markers were normal.

Laparotomy was carried out and in our utter surprise we found a white glistening mass (15.5 × 10 × 11 cm) with irregular consistency lying in the hypogastrium separated from the uterus and ovaries (Fig. 1). It was connected with gut, omentum via feeding vessels (Fig. 2). No other abnormality was noted. The mass was explored with meticulous dissection, followed by clamping, cutting and ligating the feeding vessels. Histopathological examination revealed the diagnosis of a leiomyoma.

DISCUSSION

Few postulations have been suggested regarding pathogenesis of parasitic myomas. The first theory describes these as rare variants of pedunculated subserosal myomas that have outgrown their uterine blood supply and become separated from the uterus, receiving blood supply from another source.⁴ Second

theory proposes iatrogenic origins; these may result from seedling particles of fibroid left behind during morcellation done for myomectomy or hysterectomy.³ Nowadays with increasing laparoscopic interventions, there remain high chance of retained bits of myoma in the abdomen following morcellation. Some author suggested to remove completely the morcellated myoma particles properly to avoid such complications in further.³ Parasitic leiomyoma can be classified it into spontaneous/primary and iatrogenic/secondary forms. Kimberly A et al outlined a large series of parasitic myomas (12 cases).⁴ They observed 83% with prior abdominal surgery, 67% had prior myomectomy (6 by laparoscopy morcellation and 2 by laparotomy). The most important observation concerned to our reporting was finding of only two cases of parasitic fibroid those had no previous operative interference. All most all cases presented with pain and uterine bleeding. They attributed these symptoms to concomitant uterine fibroid. In the present case since its vascular attachment were with adjacent organs, it required a fine and meticulous dissection for exploration. So management part can be more appropriate if prior diagnosis by USG or CT scan or MRI will be more accurate.

Etiopathogenesis of parasitic fibroid in the present case can be related to first theory of pathogenesis explained by Kullen which explains spontaneous evolvement. Essence of this case lies in its rarity. We must include parasitic fibroid in the differential diagnosis of any firm abdominal swelling presenting to the clinician which may or may not have a prior history surgery.

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