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Prolapsed giant cervical fibroid polyp mimicking procidentia – aftermath of traditional therapy for fibroids – a case report and review of the literature

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Abstract

An extremely large endocervical fibroid polyp masquerading as uterine procidentia in a young low parity woman is reported. Lesions of this size and complexity are uncommon. However, after careful evaluation, simple polypectomy was possible and proved curative. Good anatomical and clinical judgment is critical to successful management of bizarre introital pathologies. The literature on this subject is briefly reviewed.

Keywords

Giant Cervical Fibroid, Polyps, Uterine Procidentia, Traditional Fibroid Treatment, Nigeria

1. Introduction

Uterine fibroids are benign smooth muscle tumours of the uterus and the most common neoplasm in the female pelvis[1]. Fibroids are thought to arise through somatic mutations of smooth muscle cells possibly through different mutations[2].

Fibroids are present in 20% of women of reproductive age but thought to be 3 – 9 times more common in blacks, including African-American women, than caucasians[1].

Uterine fibroids are known to assume various locations in relation to the uterus and by which they are often classified. They may be submucous, intramural, subserous, pedunculated, interligamentary or parasitic. Solitary anterior abdominal wall leiomyomas have also been reported[3, 4, 5]. Pedunculated fibroids are connected to the myometrium by a narrow stalk and "float" in the abdominal cavity, or through the cervical os, in the vagina. Cervical leiomyomas can also present as introital polypoid masses[6].

But typically, a cervical polyp is a benign pedunculated tumour covered with columnar epithelium. Cervical polyps are a common pathology in the female adult population but they are usually small with most measuring less than 2cm [7, 8, 9], hence they are often incidental findings on routine vaginal examination[10].

Giant cervical polyps are described as polyps greater than 4 cm in size and are rarely seen in clinical practice. Till date only 12 cases have been described in the international literature[11].

Although cervical fibroids have been shown on rare occasions to grow to large sizes, the size and complexity of the endocervical fibroid polyp seen in this lady (18x15x12cm gross dimensions) is an uncommon event, hence this report.

2. Case Report

Mrs. C.W. is a 35years old Para $^{2+0}$ 2 alive trader whose last confinement was 4 years previously. She is married, a Christian by religion and resides in a rural community about 40 kilometers from Warri metropolis, accessible by both road and water. Her two deliveries were uncomplicated spontaneous vaginal deliveries. She is sexually active and her last menstrual period prior to presentation was 5th March 2007.

She presented to the emergency unit of Central Hospital Warri on the 1st of April 2007 at 20:10 hours with one day history of sudden uterine prolapse following vaginal insertion of traditional herbal pessaries for the purpose of treatment (elimination) of uterine fibroids. She had spent two weeks at the herbal home before the incident.

She had a 5 year history of a lower abdominal mass which has gradually been increasing in size and had been previously diagnosed as uterine fibroid and for which she had been told she would require surgery but she declined.

At presentation she was in severe pains, very febrile(temperature 39.4°C) with an offensive odour about her. But she was neither pale nor in shock. Her abdomen was flat, soft but tender with a midline pelvic mass of about 14 week gestation size. Pelvic examination revealed a huge fungating fleshy mass with marked degeneration and necrosis, dangling from the introitus (Figure 1). The vaginal walls were hyperaemic with marked excoriation of the posterior fornix leading to large epithelial tissue slough and profuse purulent discharge. Abdominal ultrasonographic examination confirmed multiple uterine fibroids.

She was admitted and placed on massive antibiotics (including metronidazole, ceftriaxone and clavulanate potentiated amoxicillin), analgesics and frequent vulval toileting with antiseptics and saline irrigation of the mass. She had examination under anaesthesia and cervical polypectomy (vaginal myomectomy) 3 days later with successful reduction of the uterus and cervix without recurrence. Endometrial curettage was also done. At surgery, the findings were basically as described above. Grossly the mass measured 18x15x12cm after removal and weighed 2.0kg! Histopathological examination confirmed the mass to be a vascular leiomyoma and the uterine curetting to be simple columnar epithelium. There were no malignant changes.

She did very well postoperatively but still declined surgery for the intramural uterine fibroids.

3. Discussion

Although cervical polyps can be seen at any age, they occur most frequently in multiparous women in their fifth decade of life[8, 12-16]. Giant cervical polyps, as seen in this woman, are rare in any age group, but commoner in the younger nulliparous reproductive age woman[10].

Mrs C.W. was a low parity woman who presented with the huge lesion seen in figure 1.Only one report in the literature[17], also from Nigeria, seems to be larger than the lesion shown in this report.

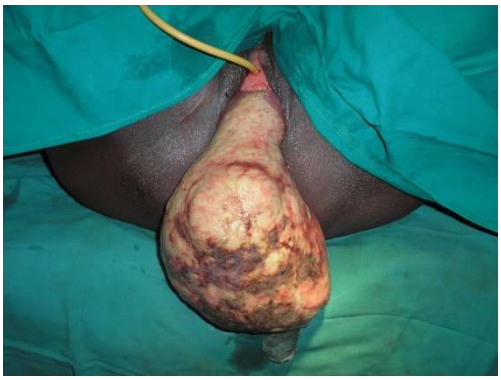

Figure 1: *The giant cervical fibroid polyp with ischaemic necrosis dangling from the introitus.*

Cervical polyps can be described as great masqueraders as they have been mistaken for many things they are not, especially when they present as protruding introital masses.

Quite frankly, the presence of this huge fungating mass at the introitus in this patient was confusing but most reminiscent of a neglected 3rd degree utero-vaginal prolapse with cervical hypertrophy and decubitus ulceration as shown in figure 1. From previous reports, such huge introital lesions have been diagnosed as cervical malignancy[17,18], uterine rhabdomyosarcoma[19], inevitable abortion[20],etcetera.

Mrs C.W.'s case was intimidating and intriguing as well. Though it appeared confusing initially, with careful evaluation, definition of anatomy and good clinical judgment, successful excision of the mass was achieved after which the uterus retracted upwards (i.e. inwards into the vagina) leaving behind an apparently normal cervix, intact vagina and pelvic floor with no anterior or posterior wall descent (figures 2, 4 and 5).

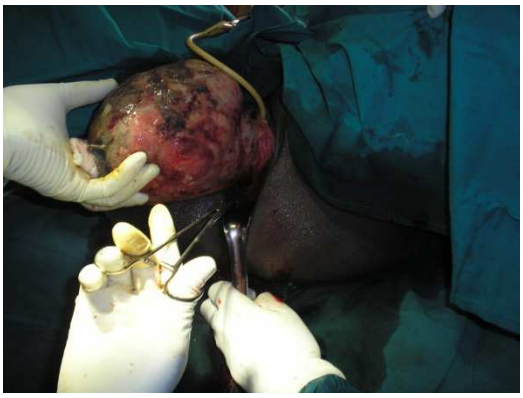

Figure 2: *Defining the anatomy of the complex desquamating mass in relation to the vestibule(urethral orifice indicated by Foley's catheter), the cervical canal(with Kocher's forceps) and the vaginal fornices (with Sims' speculum)*

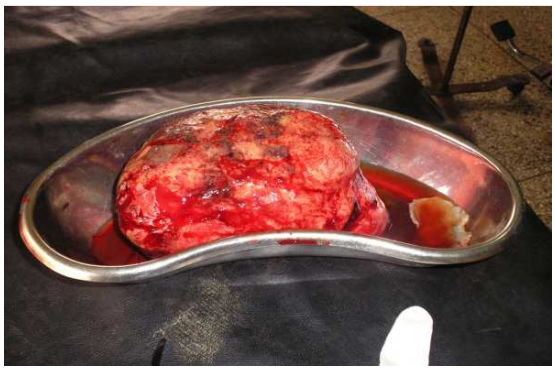

Figure 3: *The mass after excision, occupying more than half of a large size kidney dish with tissue slough adjacent to it.*

Figure 4: *Closing the excision site on the inner aspect of the anterior lipof the cervix extending into a dilated external cervical os and canal(shown by Kocher's forceps)*

Figure 5: *Showing intact vaginal introitus, vestibule and perineum after the polypectomy.*

Previous reports indicate that giant cervical polyps originate more often from the ectocervix and rarely from the endocervix in contrast to the commonly seen cervical polyps[10]. The base of the giant cervical polyp in this patient extended from the endocervix across the squamo-columnar junction unto the ectocervix (figure 4).

How much the traditional treatment contributed to the clinical situation of Mrs. C.W is unclear. But the horrendous pelvic sepsis seen in this case could be associated with the unhygienic, unsterile traditional vaginal pessaries which she had been receiving two weeks prior to presentation in the presence of a decaying mass of tissue from ischaemic necrosis of a polypoid mass that has outgrown its blood supply.

Histological patterns of reported cases are diverse but recurring themes include the following: endocervical mucosa with squamous metaplasia in pseudo – papillary configurations, chronic inflammation, prominent vessels in fibrous stroma; squamous mucosa with ulceration; squamous mucosa with pseudo – papillary proliferations; fibrovascular tissue with endocervical glands, haemorrhage, necrosis and acute inflammation; squamous mucosa admixed with endocervical mucosa, chronic inflammation and ulceration[10].

The histology report of Mrs C.W. was that of a vascular leiomyoma with no evidence of malignant change. Carcinomatous change occurs rarely in cervical polyps (seen only in 1.7% of cases). Thus, it has been suggested that biopsy of these tumours before excision may not be necessary[21]. This will only prolong morbidity and discomfort in the critically ill. Excision biopsy as practiced in this case should be the rule rather than the exception. If histology eventually shows malignant degeneration, appropriate therapy can always be advanced.

4. Conclusion

Giant cervical fibroids are rare and their management can be quite challenging. Hospitalization, clinical optimization, thorough evaluation and clear definition of pathology coupled with meticulous surgery under appropriate anaesthesia, remain the mainstay of successful management of gravely ill patients presenting with a bizarre introital pathology as seen in this woman.

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