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A RARE CASE OF LARGE LEIOMYOMA IN POSTMENOPAUSAL WOMAN

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ABSTRACT

We report a case of huge fibroid in a postmenopausal woman which is a rarity as fibroids are oestrogen dependent benign tumours. A rapidly growing fibroid should raise suspicion of leiomyosarcoma and calls for definitive management.

KEYWORDS: Leiomyoma, Postmenopausal, Leiomyosarcoma.

INTRODUCTION

Leiomyoma or fibroid uterus is one of the most common benign tumour in the reproductive age group. It is an oestrogen dependent tumour with an estimated prevalence of 40–50% in women over 35 years.[1,2] The reported incidence in the postmenopausal age group is as low as 1–2% in the 60–80 year age group.[3] Due to its lower incidence in postmenopausal women, a rapid growth noted in the fibroid calls for a strict clinical vigilance and should raise suspicion for leiomyosarcoma until proven otherwise. A hysterectomy followed by histopathology is the definitive management in such cases. We report one such case in an elderly postmenopausal woman who presented to us with a large abdominopelvic mass with sudden enlargement, raising the suspicion of malignancy.

CASE PRESENTATION

A 64-year-old postmenopausal woman, with previous 1 vaginal delivery and an abortion, presented with complaints of progressive abdominal heaviness and a lump in in the abdomen for the last 5 years. Initially, the patient felt that a lump

was reaching just above the pubic bone , however she noticed a gradual increase in size of the same. In the past 1 year she experienced a rapid growth in the mass and the current size of the mass reached up to her umbilicus. She also reported generalized pain in the abdomen for past 15 days. There was no history of weight loss, gastrointestinal disturbance, breathing difficulties, or abnormal vaginal bleeding. She was postmenopausal for 15 years and had not experienced any postmenopausal bleeding. She gave history of using oral contraceptive pills for 5 five years. There was no history of breast, ovarian, or endometrial cancer in the family.

On general physical examination, she was overweight with a body mass index (BMI) of 26 kg/m^2. Her vital signs were stable. Her abdominal examination revealed an abdomino-pelvic mass corresponding to 24 weeks of uterus reaching 2 cm above the umbilicus. The mass was arising from the pelvis and its lower border could not be palpated. It was a firm, smooth surfaced, non-tender mass with restricted mobility in the transverse plane. Gynaecological examination revealed a normal external vulva and cervix. The uterus could not be appreciated separately. On imaging the ultrasound depicted a well-defined solid mass in the lower abdomen measuring 14×13.8x 9.2 cm. It was lobulated with solid mural nodules and hypoechoic areas. Bilateral ovaries and uterus were visualized separately. On further evaluation, magnetic resonance imaging (MRI) revealed a large well-defined globular mass measuring 20×9×16 cm originating from the anterior wall of the uterus, and was suggestive of a degenerating leiomyoma of the uterus. A provisional diagnosis of uterine leiomyosarcoma was made. Her blood investigations were normal range, including a normal serum CA 125 (20.1 IU/ml)and lactate dehydrogenase LDH (120 IU/L). The patient underwent exploratory laparotomy where the abdomen was opened by a midline incision which revealed, a large intramural fibroid originating from the anterior wall of the uterus and occupying the whole of the lower abdomen was found. (Fig 1 and figure 2) Peritoneal washings were collected and a total abdominal hysterectomy (TAH) with bilateral salpingo-oophorectomy (BSO) was performed. The postoperative period was uneventful with satisfactory recovery. The gross histopathological examination showed a 20 × 9 × 16 cm intramural leiomyoma with normal bilateral tubes and ovaries. No malignant cells were seen in peritoneal washings. There was no evidence of sarcomatous changes on histopathology. The final diagnosis was benign intramural uterine leiomyoma with cystic and fatty degeneration. On follow-up visits at 6 weeks, 3 months, and 6 months, the patient was asymptomatic and healthy.

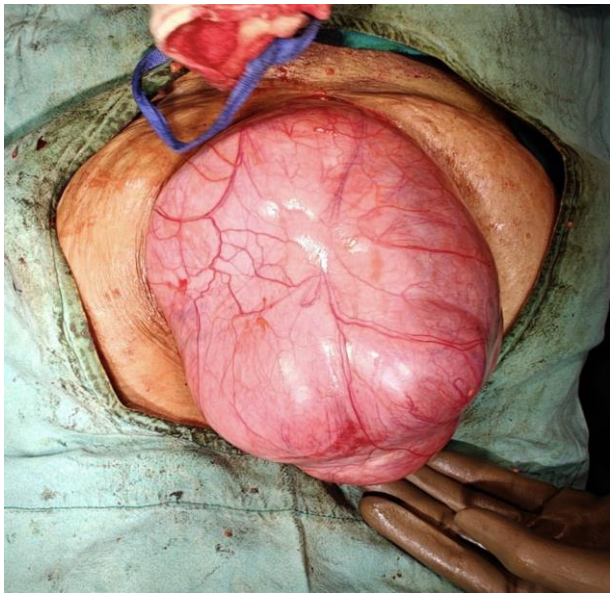

Figure 1: A huge fibroid exposed by a midline abdominal incision occupying the entire lower abdomen.

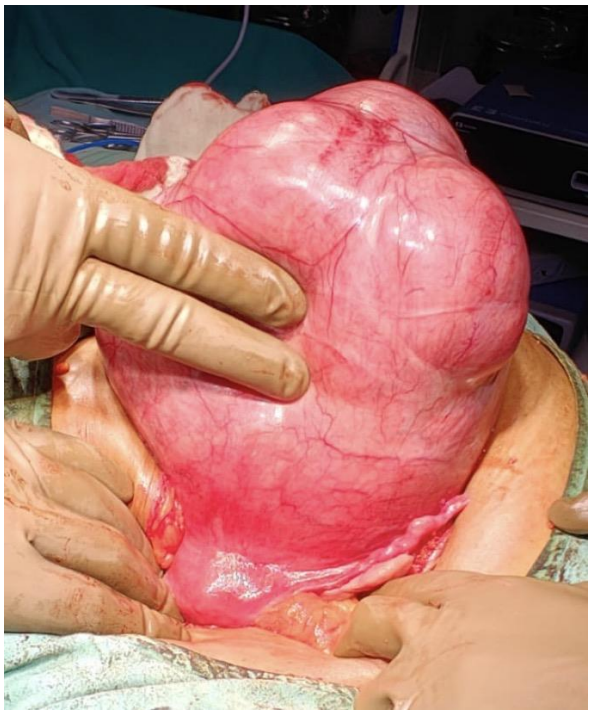

Figure 2: A large 20×9×16 cm originating from the anterior wall of the uterus with lobulated surface and areas of degeneration.

DISCUSSION

Uterine leiomyomas are benign smooth muscle tumours that are common in the reproductive age group and are extremely rare after menopause.[4,5] Although rare, cases of huge fibroids in postmenopausal women have been reported in the literature previously.[6,7] Their occurrence after menopause has been attributed to the growth stimulation by estrone, insulin-like growth factor, or epidermal growth factor.[8] In obese postmenopausal women, peripheral aromatization of adrenal-derived androstenedione into estrone has been implicated for the increase in size. Our patient was overweight with BMI of 27kg/$m^{2.}$ The enlarging fibroid often outgrow their blood supply or cause mechanical compression of feeder arteries and undergo degenerative changes.[9] The most common type of degeneration is the hyaline degeneration (63%) followed by myxomatous (13%), calcareous (8%), mucoid (6%), cystic (4%), carneous (3%), and fatty changes (3%). The cause for fibroid degeneration in postmenopausal women has been attributed to production of growth factors (epidermal or insulin like) although the exact mechanism remains unclear.[9] Rarely, in less than 1% cases the fibroid may undergo malignant degeneration to become leiomyosarcoma.[7] Interestingly the clinical profile of benign leiomyoma and uterine leiomyosarcoma is identical and one should keep a high index of suspicion while dealing with fibroids in a postmenopausal woman. The definitive diagnosis of a uterine sarcoma can only be made on histopathology following hysterectomy or myomectomy.[6] Ultrasound is the first line investigation for diagnosing fibroids, because it is cheap, non-invasive and readily available even in low resource setups. MRI must be considered in cases with a large fibroid or a rapidly growing fibroid in a non-emergent clinical scenario.[1]

The patient may be asymptomatic or present with pelvic pain, irregular vaginal bleeding, acute abdomen, abdominal lump, pressure-related symptoms like urinary urgency or retention or constipation and a quick increase in size similar to our case. An interesting case of a large and rapidly growing fibroid in a 56-year-old postmenopausal woman who presented with polycythaemia has been reported by Ghaffar.[3] Another case of huge fibroid with omental blood supply

has been described by Osegi *et al*. in a 58-year-old menopausal lady. They performed total abdominal hysterectomy with bilateral salpingo-oophorectomy and partial omentectomy. Histopathology revealed it to be benign leio- myoma with cystic changes which was similar to our case.[4] Other interesting cases of large degenerating fibroid has been described by Seet *et al* and Garg et al in postmenopausal women which is akin to our present case.[1,10] Another case of a calcified fibroid was reported in a postmenopausal woman, managed with hysterectomy.[8] The treatment of fibroid is dependent on the patient's age, type and size of the fibroid, severity of symptoms, desire to conceive in the future, suspicion of malignancy, and proximity to menopause.[6] Since our patient was an elderly postmenopausal woman with rapidly enlarging fibroid raising the suspicion of malignancy, TAH with BSO was the treatment of choice.

CONCLUSION

Uterine leiomyomas are relatively rare in postmenopausal women. When a patient in this group presents with a rapidly enlarging fibroid, the possibility of leiomyosarcoma—although uncommon—should be considered. The initial clinical features are often misleading, and a definitive diagnosis can only be confirmed through histopathological examination. Therefore, definitive treatment with hysterectomy should be offered to reduce the risk of further morbidity and mortality.

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