

Leiomyoma After Hysterectomy: The Case of the Silent Return - A Case Report

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Abstract: *Benign metastasizing leiomyoma represents the benign lesions consisting of leiomatous tissue present in position away from the uterus. These benign tumours consist of smooth muscle fibres consisting of connective tissue and as reported they can behave as malignant and metastasize in various areas such as pelvis, lungs, broad ligament, vagina and adnexal regions. We present a rare case of an extra uterine leiomyoma located in the adnexa adherent to the lateral wall of bladder in a 45 year old female.*

Keywords: benign metastasizing leiomyoma, smooth muscle tumor, extra uterine growth, adnexal mass, diagnostic challenges

1. Case Report

This is a case of 45 year old P2L2A1 with status post Total abdominal hysterectomy with bilateral salpingo-oophorectomy done 1 year back in view of mass per abdomen - multiple intrauterine fibroid, came with an incidental finding on Ultrasound Pelvis report showing pelvic mass during routine follow up scan. Patient was asymptomatic. She attained surgical menopause 1 year back. She is known case of Bronchial asthma on medication. On per abdomen examination, no palpable mass felt. On per speculum examination, vault Healthy. On Ultrasound pelvis, an ill-defined heterogeneously hypoechoic lesion in left adnexa measuring 9.0x 6.0x 3.0cm noted. On MRI pelvis, large heterogenous solid cystic mass lesion measuring 8x7cm seen in left adnexal region. Her CA 125 level was 13.2U/ml. She underwent Exploratory Laparotomy with left adnexectomy. There was 12x10cm solid cystic mass noted in the left adnexa adherent to the lateral wall of bladder. Subcentric lymph node present in the left iliac group of lymph node and sample sent for Histopathology was reported as Cellular Leiomyoma and section from the lymph node showed negative for malignancy. Post operatively patient was advised for 21 days of catheterization and post operative period was uneventful.

2. Discussion

Uterine leiomyomas are benign neoplasm that arise from the uterine smooth muscle cells, fibroblasts, and extracellular matrix. They are encapsulated by a pseudo-capsule formed from areolar tissue and muscle fibres separating the tumour from the local surrounding structures and cause abnormal uterine bleeding and symptoms secondary to a large pelvic mass. They originate from somatic mutation in myometrial cells. Leiomyomas are monoclonal. They are present (diagnosed by ultrasound) in about 30% of women and in about 1-2% of pregnancies. It develops during the reproductive (hormonally active) years and regress after menopause. The environment within leiomyoma is hyperestrogenic. The growth of leiomyomas is thought to be dependent on vascularization, hormones, and patient age. Presenting features are dependent on the location of the leiomyoma, in our case no symptoms were noted for the adnexal extra-uterine leiomyoma. Despite often being found incidentally, uterine leiomyomas can be investigated using ultrasonography. Ultrasound provides a fast method in detailing the size, site, and number of uterine fibroids. Magnetic resonance imaging (MRI) is utilized to evaluate the

leiomyoma in relation to the rest of the pelvis, including relations to neurovascular structures and nearby organs. The use of MRI as in our case can assist in the planning of operative management. However, imaging methods are not reliable in determining the probability of malignant transformation which is reserved for histological evaluation. The patient in our case report had previously undergone a hysterectomy for this indication. Recurrence of leiomyoma, as well as benign metastasizing leiomyoma and leiomyosarcoma after hysterectomy, have been reported in the literature

3. Conclusion

Benign metastasizing leiomyoma is a rare entity that usually affects women after hysterectomy for leiomyomas. Our Case supports the recurrent appearance of leiomyomas in pelvis after hysterectomy. It also adds new entity to the differential Diagnosis of adnexal masses.

References

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