FIBROID UTERUS AN UNUSUAL PRESENTATION (A Case Report)

Wg Cdr CD CHAWLA*, Wg Cdr MS CHAUDHARY+,
Wg Cdr GS JONEJA+, Sqn Ldr ANJALI BUGGA#

MJAFI 1995; 51 : 218-219

KEY WORDS : Uterine fibroid; Polycythemia.

Introduction

Fibroid uterus is the commonest benign pelvic tumor encountered in gynaecological practice. On rare occasions it is associated with polycythaemia. Since 1953, only 30 cases of such an association have been reported in world literature [1]. The case discussed here had a massive fibroid uterus with secondary polycythaemia. The patient also had associated liver cirrhosis and gastric ulcer. Secondary polycythaemia and gastric ulcer reverted to normal after surgery.

CASE REPORT

This patient, a 72-year-old lady, noticed a mass in the abdomen which was increasing in size gradually over the last 12-14 years. During the last 8 months, the mass started increasing rapidly in size. She started having pain abdomen, abdominal distension and occasional vomiting. There was no history of weight loss or suggestion of pressure symptoms. Patient experienced menopause 25 years ago. She was para 8 and last delivery was 33 years back. On examination, abdomen was found uniformly distended. There was a large tumor arising out of the pelvis and extending upto xiphisternum. Both flanks were full. The mass had a smooth surface. It was dull on percussion and nontender. Per vaginal examination revealed atrophic vagina and cervix. Uterus could not be palpated separately from the mass. No nodule was felt in the pouch of Douglas. There was no evidence of hemorrhoids and rectal mucosa was free anteriorly on per rectal examination.

Investigations revealed, Hb 19.0 gm/dL, PCV 58%, serum bilirubin 3.5 mg%, SGOT 39 IU/L, SGPT 56 IU/L, total serum proteins 6.5 g%, albumin 3.5 g%, globulin 3.90 g%, blood urea 60 mg%, uric acid 5.6 mg%, serum creatinine 1.8 mg%, and random blood sugar 82 mg/dL. Bile salt and bile pigments were absent in urine. Platelets

were 1,50,000/mm³, prothrombin time control-12 seconds and test 16 seconds. Radiogram chest showed raised dome of diaphragm due to presence of large abdominal tumor. ECG was within normal limits. Ultrasonography showed an adnexal mass and uterus could not be made out separately. Kidneys and ureters were normal. CT abdomen showed a large solid abdominal tumor arising from pelvis and pushing up all the viscera. Gastroscopy revealed four superficial gastric ulcers with esophageal varices. Biopsy was taken from the gastric ulcer.

Patient was provisionally diagnosed as a case of solid ovarian tumor or fibroid uterus. Exploratory laparotomy was done under general anaesthesia after preparation of the bowel. Patient was found to have a large solid tumor with a smooth surface arising out of the pelvis. There were no adhesions and no nodules on the surface of the tumor. Both ovaries were shrunken. Pelvic lymph nodes were not enlarged. Liver was found to be shrunken and cirrhotic (macronodular). Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Omental biopsy was taken from multiple sites. Liver biopsy was taken from nodular tissue of the liver. Abdomen was then closed in layers.

Post-operatively, the patient made an uneventful recovery with satisfactory wound healing. Repeat investigations after 8 hours revealed Hb 16.9 g/dL, PCV 48%, serum bilirubin 1.5 mg%, blood urea 42 mg%. After 2 weeks the values were Hb 11.0 g/dL, PCV 33%, serum bilirubin 0.75 mg% and blood urea 28 mg%. Ultrasonography done after 2 weeks showed a shrunken liver and normal spleen. Gastroscopy revealed healed ulcers.

Histopathological examination revealed leiomyoma uterus. Liver biopsy showed post-necrotic cirrhosis with activity. The omentum was unremarkable. Biopsy from gastric ulcer showed chronic gastric ulcer.

Discussion

Fibroid uterus is the commonest condition encountered in gynecological practice.

*Reader, Dept of Obstet and Gynae, AFMC Pune 411 040; +Associate Prof and Classified Specialist; #Graded Specialist; (Obstet and Gynae) Command Hospital Air Force, Bangalore.

However, certain features seen in this case prompted the authors to report the case and they were :

1. A massive fibroid which had probably grown entirely during the post-menopausal years.
2. Associated secondary polycythaemia.
3. Presence of peptic ulcers.
4. Associated cirrhosis of liver.

Most fibroids are known to increase in size during the child bearing years (estrogen dependent). However 10% of fibroids continue to grow during the post-menopausal years. This may be because of the availability of estrogens from extra-genital sources. Sudden increase in size of a silent tumor prompts one to keep the possibility of a sarcomatous change (though not found in such massive tumors) in mind.

Certain tumors like hypernephroma [2] hepatomas, cerebellar haemangiomas, cystic kidneys and ovarian tumors [3,4] are known to produce secondary polycythemia. Fibroids constitute 7% of such tumors associated with secondary polycythaemia.

A few mechanism which may explain secondary polycythaemia are induction of renal hypoxia, systemic hypoxia due to large sized tumor and associated respiratory embarrassment [5], erythropoietin secretion by the tumor itself, secretion of an erythropoietin releasing factor, and, ureteric obstruction with resultant back pressure changes in the kidney [6,7]. Whatever be the mechanism, secondary polycythaemia is known to regress after re-

moval of tumor [3,8,9]. Polycythaemia is known to cause vascular engorgement in the GIT with resultant ulceration. This could be the reason for peptic ulcers observed in this case which healed spontaneously after regression of polycythemia.

Etiopathology of cirrhosis of liver associated with fibroid and polycythaemia could not be established in this case. However hyperestrogenemia consequent to liver cirrhosis could be a possible trigger for the massive growth of the fibroid actively in the post-menopausal years in this woman.

REFERENCES

1. Thomson AP, Marson FGW. Polycythaemia with fibroids. *Lancet* 1953; ii : 759-60.
2. Berger L, Sinkoff MW. Systemic manifestations of hypernephroma : A review of 273 cases. *Am J Med* 1957; 22 : 791-6.
3. Donati RM. Erythrocythemia and neoplastic tumours. *Ann Intern Med* 1963; 58 : 47-55.
4. Eldor A, Even Paz Z, Pollack A. Erythrocytosis associated with multiple cutaneous leiomytomata. Report of a case with demonstration of erythropoietic activity in the tumor. *Scand J Haematol* 1976; 16 : 245-9.
5. Paranjothy D, Vaish SK. Polycythemia associated with leiomyoma of the uterus. *J Obstet Gynaecol Br Commonwealth* 1967; 74 : 603-5.
6. Babuna C, Gardner GH, Green RR. Erythrocytosis associated with myomatous uterus. *Am J Obstet Gynecol* 1969; 77 : 427-9.
7. Gordon AS, Zanjani ED, Zahusky R. A possible mechanism for erythrocytosis associated with hepatocellular carcinoma in man. *Blood* 1970; 35 : 151-7.
8. Naets JP, Wiltek M, Delwiche F, Kram I. Polycythaemia and erythropoietin producing uterine fibromyoma. *Scand J Haematol* 1977; 19 : 75-8.
9. Weiss DB, Aldor A, Aboulafia Y. Erythrocytosis due to erythropoietin producing uterine fibromyoma. *Am J Obstet Gynecol* 1975; 122 : 358-60.