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prolapsed submucous leiomyomata. However, in cases with concurrent gynaecological problems or those cases with satisfied parity, total abdominal hysterectomy should be considered. Specific antibiotics should be used pre and post operatively in cases with necrotic tumours.

INTRODUCTION

Fibromyoma arising in the uterus is the most frequently occurring neoplasm found in women. It occurs also in the broad ligament, round ligament fallopian tube, vagina, urethra and vulva. The tumour originates as a leiomyoma.

Varied estimates of the occurrence of uterine fibromyomata have been given in the literature. An incidence of 33 pc of Negroid women over the age of 20 years and 10 pc of Caucasian women of the same age group has been reported.¹ Of all the fibromyomata, only about 5 pc of these are submucous² and they are perhaps the most important clinically. They tend to lead to a foul smelling vaginal discharge and vaginal bleeding which may be quite heavy at times.

This type of fibroleiomyoma is often single. It may remain sessile at its myometrial attachment but there is an increasing tendency for it to be extruded further into the cavity of the uterus forming a "cup and ball" tumour.³ The resultant fibroleiomyoma polyp may pass into and through the cervical canal to the vagina. A submucous fibroleiomyoma often develops a pedicle which at first is thick and tough, being composed of myometrial fibres and blood vessels. The pedicle becomes thinner as it lengthens and blood supply to the tumour is reduced. Obstruction of the vessels in the pedicle due to pressure or twisting, further impedes the blood supply. Such fibroleiomyomata are frequently infected and necrotic because of exposure to vaginal bacteria and poor blood supply.⁴

These fibroleiomyomata are treated surgically either by vaginal myomectomy or total abdominal hysterectomy following a course of broad spectrum antibiotics to prevent spreading the infection into the peritoneal cavity and the general circulation. This study reviews the management of 12 women with prolapsed pedunculated submucous fibromyomata treated at UTH's Department of Obstetrics and Gynaecology during a two year period.

MATERIALS AND METHODS

Between 1st January 1989 to 31st December 1990 13 patients with prolapsed pedunculated submucous

CASE REPORTS

Prolapsed pedunculated sub-mucous uterine fibroleiomyomata at the University Teaching Hospital, Lusaka

N C SIKAZWE

SUMMARY

During a two year period 901 cases were admitted and diagnosed as benign gynaecological neoplasms. Five hundred and thirty three of these (59,1 pc) were uterine fibroleiomyomata. Of these, 103 had surgery and 13 (12,6 pc) had pedunculated fibroleiomyomata presenting as a vaginal mass. Eight of the 13 cases were treated by vaginal myomectomy. Total abdominal hysterectomy was carried out in two cases because of failed vaginal myomectomy. Two others had total abdominal hysterectomy for dysfunctional uterine bleeding and for satisfied parity. One case absconded. Vaginal myomectomy should be the first choice of treatment for

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fibroleiomyomata (one absconded) were treated in the Department of Obstetrics and Gynaecology of the University Teaching Hospital, Lusaka. In all these cases the pedunculated fibroid polyps had their bases of origin at or above the cervical internal os. During the same period 103 women had surgery for uterine fibroleiomyomata. The incidence of pedunculated fibroleiomata was 12,6 pc. These tumours varied in sizes ranging from 3cm to 10cm in diameter. Seven of the 13 cases were necrotic, presenting with a blood stained foul smelling vaginal discharge of the duration of one to five weeks. The necrotic cases were treated with specific antibiotics followed by surgery five days later and continued for five days more.

RESULTS

In the study group, the youngest patient was 23 years. The mean age was 34,91 years. One patient was menopausal for two years and all the 13 patients were multiparae with an average parity of 4,82.

Table I indicates the most frequent presenting symptoms in the study group. Most of the patients had a combination of symptoms. The commonest presenting symptom was a feeling of "something coming down" in 11 patients (84,6 pc) and a blood stained foul smelling vaginal discharge in seven patients (53,8 pc). A previous history of backache and low abdominal pains was common in all the patients.

Table I: Notable presenting symptoms.

Symptoms	Number	pc
Blood stained, foul smelling discharge	7	53,8
Abnormal vaginal bleeding	5	38,4
Vaginal mass	4	30,7
Something coming down	11	84,6
Abdominal mass	3	23,0
Fever	1	7,6

Pelvic examination revealed vaginal masses of different sizes in all the 13 patients. In seven of these, the tumours were necrotic particularly in the distal areas. In 11 patients the uteri were enlarged presumably due to concurrent presence of fibroleiomyoma in the body of the uteri.

The operative procedures carried out on 12 patients are as indicated in Table II.

Table II: Surgical procedure done.

Procedure	Number	pc
Vaginal myomectomy	8	66,6
TAH	2	16,6
TAH after failure of vaginal myomectomy	2	16,6

Eight patients (66 pc) had a vaginal myomectomy. Total abdominal hysterectomy was carried out in two patients (16,6 pc). One of these two patients was 33 years old. She had had six children and she was not willing to use any form of contraception. The other patient was 41 years of age, she had had five children and apart from having a pedunculated fibroleiomyoma she also had dysfunctional uterine bleeding. Total abdominal hysterectomy after failed vaginal myomectomy was carried out in two patients.

There was no vaginal hysterectomy done on any of the cases. Histological examination of all the specimens showed benign fibroleiomyomata.

The post operative period was mostly uneventful except in the case of one patient (total hysterectomy for satisfied parity) who developed pyrexia due to *P. falciparum*. She was treated with a course of chloroquine.

DISCUSSION

During the study period, 1st January 1989 to 31st December 1990, 103 patients underwent operative procedures for benign fibroleiomyomata. Thirteen of these (12,6 pc) had pedunculated submucous fibroleiomyomata. This is a much higher incidence compared to other reports.^{5,6} The high incidence is most likely related to the large number of cases diagnosed as uterine fibroleiomyomata. During the study period out of 901 cases admitted with benign gynaecological neoplasia 533 (59,1 pc) had uterine fibroleiomyomata. The mean age in the study group was 34,95 years. This was younger than the other reports although the mean parity was much higher.⁶ The high mean parity is probably due to the cultural background of the population being served by the hospital or a failure of contraceptive strategies being pursued. The low mean age in this study group *vis-a-vis* the occurrence of pedunculated submucous fibroleiomyomata is difficult to explain.

The common presenting symptoms among the patients were a feeling of "something coming down"

(84,6 pc) blood stained foul smelling vaginal discharge (53,8 pc) and abnormal vaginal bleeding (28,4 pc). The first symptom is probably inevitable as a result of the presence of a mass in the vagina. This occurred in patients who had pedunculated submucous fibroleiomyomata bigger than 5cm in diameter. The vaginal discharge was often profuse and foul smelling because of necrosis and infection of the fibroleiomyomata. The abnormal vaginal bleeding was most likely due to the two processes of necrosis and infection.

There were more cases treated by vaginal myomectomy (66,6 pc) and this is in agreement with other reports.^{6,7} Two patients had total abdominal hysterectomy after failed vaginal myomectomy. This was because the tumours were large and had broad pedicles which made it impossible to twist. Mere cutting of the pedicles would have made securing haemostasis very difficult.

One other case had total abdominal hysterectomy for family planning and the other had this procedure for having a concurrent gynaecological ailment apart from fibroleiomyoma.

In all these four cases of hysterectomy, contamination and spillage into the peritoneal cavity were inevitable. However, post operative complications such as pyrexia and wound infection due to bacterial infection were not evident. This was because all the patients who underwent either vaginal myomectomy or total abdominal hysterectomy received specific antibiotics five days before and five days after the procedure.

Post operative follow up of these patients was done once, six weeks after the operation. As a result of this, it is not possible to comment on a recurrence of pedunculated submucous fibroleiomyomata in patients who had vaginal myomectomy. This would have required a long follow up. This was not possible due to poor compliance. Ben Baruch⁶ reported 8,8 pc of his cases having recurrent submucous fibroleiomyomata and repeat vaginal myomectomy.

There was no malignant tumour in this study group. However, carcinoma of the cervix is very common at the University Teaching Hospital, Lusaka. During the study period 251 cases of gynaecological malignancies were diagnosed and out of these, 189, 75,2 pc were carcinoma of the cervix. These were mostly fungating tumours. It is therefore important to consider the differential diagnosis of cancer of the cervix in patients with

pedunculated fibroleiomyomata particularly when they present with abnormal vaginal bleeding or a profuse foul smelling vaginal discharge. In fact, if the suspicion of malignancy arises, a biopsy specimen for histological examination should be taken before proceeding to any surgical treatment. This way a correct management of the case will be instituted.

CONCLUSION

Vaginal myomectomy is the treatment of choice for prolapsed pedunculated submucous fibroleiomyomata except where there are indications for hysterectomy. These indications may be concurrent dysfunctional uterine bleeding or satisfied parity. Where there is suspicion of malignancy, a biopsy for histological examination is mandatory before any surgical procedure is done. Specific antibiotics are necessary in cases where the tumours are necrotic and infected. This way the risk of infection due to spillage of infected materials into the peritoneal cavity is avoided.

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REFERENCE

1. Kelly H A, Cullen T S. Myomata of the uterus, Philadelphia: Saunders, 1990.
2. Novak E R, Woodruff J D. Gynaecologic and obstetric pathology. 7th ed. Saunders, 1974: 243-5.
3. Haines M, Taylor C W. Gynaecological Pathology. 2nd ed. Churchill Livingstone, 1975:199.
4. Mattingly R F. Leiomyomata uteri and abdominal hysterectomy for benign disease. Te Linde's Operative Gynaecology. Philadelphia: J B Lippincot Co., 1985:203-57.
5. Dicker D, Feldberg D, Dekel A *et al*. The management of prolapsed submucous fibroids. *Aust NZS Obstet Gynaecol* 1986;26:308-11.
6. Ben Baruch G, Schiff E, Menashe Y. Immediate and late outcome of vaginal myomectomy for prolapsed pedunculated myoma. *Obstet Gynaecol* 1988;72:858.
7. Brooks G G, Stage A H. The surgical management of prolapsed pedunculated submucous leiomyomas. *Surgery Gynaecol Obstet* 1975; 141:397.



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