

A RARE CASE OF ANTERIOR VAGINAL WALL LEIOMYOMA – CASE REPORT

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Submitted on: October 2016
Accepted on: November 2016
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Abstract

Leiomyomas are common benign neoplasm derived from smooth muscle cells, most commonly they occur in uterus and cervix, followed by round ligament, uterosacral ligament, ovary, inguinal canal but rare in the vagina. Here we report a case of vaginal leiomyoma in a 27-year-old female who presented with a mass in vagina and dyspareunia.

Introduction

Leiomyoma in the female genital tract is common in the uterus and to some extent in the cervix followed by the round ligament, uterosacral ligament, ovary & inguinal canal. Vaginal Leiomyomas remain uncommon entity with only about 300 reported cases since the first detected case backing 1733 by Denys de Leyden(1). Vaginal Leiomyoma most commonly arises from anterior vaginal wall causing varied clinical presentations; they may or may not associate with Leiomyomas elsewhere in the body. Vaginal Leiomyomas are commonly seen in the age group ranging from 35 to 50 years and are reported to be more common among Caucasian women (2).

Case Report:

A 25-year-old P2L2 was presented to outpatient department with complaints of mass per vagina since 1 1/2 year, Dyspareunia since 1 1/2 year; there was no

history of Dysuria, frequency of micturition or urinary retention.

Menstrual History: Her LMP was 15 days back. Her periods were regular with 4-5/28-35 days cycle, Flow was normal.

Obstetric History: She was P2L2 (both full term NVD) with last child birth 1 year back.

Medical & Surgical History: Nil Significant

On Examination

- The patient was afebrile, her vitals were within normal limits, Per Abdomen was soft, non-tender, non-distended.
- **Per Vagina:** Uterus was normal size, anteverted, Fornices free. A mass of 2x2 cm present over anterolateral vaginal wall diagnosed as Gartner's cyst.
- **Investigations:** HB-12.7 gm/dl, Blood group –A positive, Rest all parameters were within normal limits.
- **Ultrasonography:** Uterus- Anteverted, Anteflexed, ET-7.2mm, Both

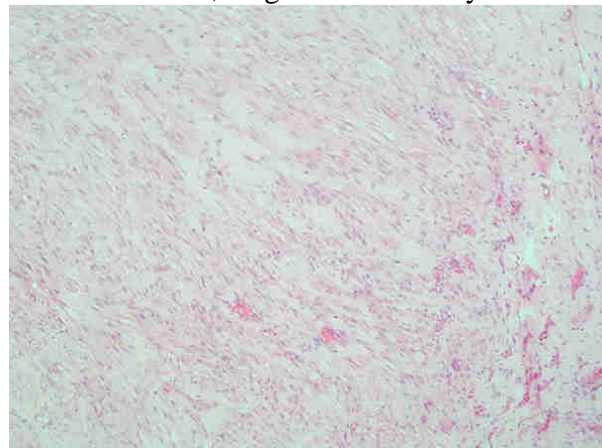
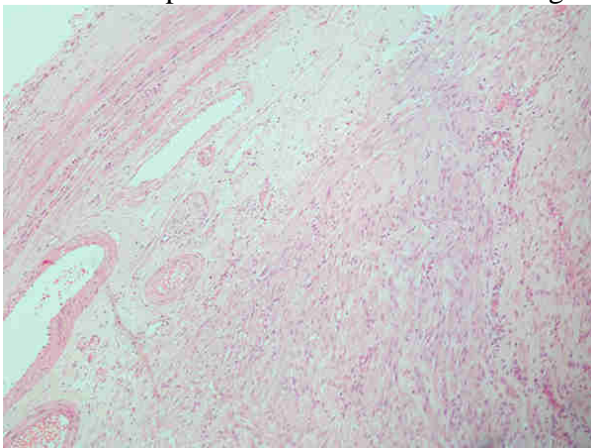
ovaries-polycystic **Vagina** - 31x22x22mm hypoechoic mass with regular margins seen in vagina from anterior wall s/o anterior vaginal wall polyp? Cyst Her consent was taken for surgery, Preoperative cystoscopy done which shows patchy lesions over posterior wall of the bladder. Tumour was surgically removed by vaginal route.

Tumour was enucleated by given incision over the cyst mass and then sharp dissection done, cyst removed of size 4x4 cm and sent for HPE. Dead space sutured, pedicles clamped, Bladder catheterized, Patient stable postoperatively, Catheter removed after 48 hrs, and she was discharged after 3 days.



The histopathological report revealed it as leiomyoma with section shows interlacing fascicles of spindle cells with focal whorling

pattern & hyaline change. The capsule is seen at one aspect with thickened & dilated blood vessels, diagnosed as leiomyoma.



Discussion:

Vaginal tumours are rare and include papilloma, haemangioma, mucus polyp, and rarely leiomyoma. Vaginal leiomyomas remain uncommon entity with only about 300 reported cases since the first detected case back in 1733 by Denys de Leyden (1). Bennett and Erlich (2) found only nine cases in 50,000 surgical specimens and only

one case in 15,000 autopsies reviewed at Johns Hopkins Hospital. They usually occur as single well-circumscribed mass arising from the midline anterior wall (1,3) and less commonly from posterior and lateral walls(4). Leron and station reported a case of vaginal leiomyoma with symptom complex of prolapse with urinary urgency and urge incontinence (5). Gowri et al(6)

reported a case of leiomyoma arising from the lateral vaginal wall presenting as a gluteal swelling with pus discharge vaginally, creating a dilemma in diagnosis. Usually, these tumours are single, benign, slow growing but sarcomatous change has been reported (7) Preoperatively, diagnosis by ultrasonography may be difficult, but magnetic resonance imaging is usually clinched the diagnosis. In magnetic resonance imaging, they appear as well demarcated solid masses of low signal intensity in T1-and T2-weighted images, with contrast enhancement, while leiomyosarcomas and other vaginal malignancies show characteristic high T2signal intensity with irregular and homogenous areas of necrosis and haemorrhage(6,7). Histopathology is the gold standard for diagnosis. Surgical removal of tumour through vaginal approach is the treatment of choice with urethral catheterization to protect urethra. In large tumours abdominoperineal approach is the treatment of choice. Patient has to be followed up as there is a chance of recurrence. Our patient is symptom-free for 3 months.

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