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Atypical presentation of leiomyoma: A case report

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Abstract
Leiomyoma is a benign tumor of the uterus. It typically does not present with weight loss, massive ascites, gastrointestinal symptoms, elevated CA_{125}, and elevated alpha fetoprotein.
This was a rare case of a 48-year-old nullipara, emaciated with grossly distended abdomen, huge abdominal mass corresponding to 36 weeks' gestation, associated anorexia, easy satiety, constipation and vomiting that had TAH and BSO for suspected ovarian malignancy, which histology report revealed leiomyoma.
Abdominal ultrasound scan done noted huge right ovarian mass, possibly malignant, with massive ascites. Findings at surgery, revealed a large, firm mass with necrotic patches, attached to the uterine fundus by a thin stalk 5 x 3 cm thick and to the omentum by large dilated blood vessels and adhesions. Mass weighed 5.8 kg. Eleven (11) liters of ascitic fluid was aspirated, sent for cytology and report showed no malignant cells. Histology confirmed a degenerated leiomyoma with no evidence of malignancy.
Atypical presentation of leiomyoma can mimic that of malignancy. This knowledge will help Clinicians and Gynaecologists to have a high index of suspicion with such clinical features, in making prompt diagnosis and instituting appropriate management.

Keywords: Leiomyoma, fibroid, benign, ascites, malignancy

Introduction
Leiomyoma, also known as uterine fibroid is a non-cancerous tumor of the uterus [1, 2]. It has varied clinical presentations. The association with massive ascites, anorexia, weight loss, elevated CA_{125} elevated alpha fetoprotein simulating ovarian malignancy is an atypical occurrence. The association of nulliparity and infertility in both uterine fibroid and ovarian malignancy is already known. Also, an abdominal mass is common to both cases.
This was a case of a 48-year-old nullipara who presented with features suggestive of ovarian malignancy, but histopathology report of the abdominal mass, after surgery, confirmed leiomyoma.

Case report
Mrs. F.I., a 48-year-old trader presented with a 10-year history of inability to conceive and abdominal bloating and swelling of eight months duration, all prior to presentation. The swelling gradually increased in size and associated with difficulty in breathing which was noticed two days prior to presentation. Initially, she thought it was pregnancy and did a serum pregnancy test that was negative and an ultrasound scan that showed no pregnancy intra- or extra- uterine. A repeat abdomino-pelvic ultrasound scan done noted an abdominal mass with ascites. There was associated weight loss of about 12 kg, poor appetite, and constipation. Her last menstrual period was 5th of June, 2021. It lasted for four days, and there was no irregularity in her menstrual cycle. She was not hypertensive or diabetic and had no systemic illness.
Physical examination revealed an emaciated lady lying in cardiac position, afebrile, pallor+, anicteric with no pedal oedema. There were no significant palpable peripheral lymph nodes.
Her pulse rate was 98 beats per minute, full volume and regular. Blood pressure was 110/60 mmHg. Her respiratory rate was 24 cycles per minute with mild flaring of Alae Nasi.
Abdominal examination revealed a grossly distended abdomen, with an abdomino-pelvic mass which corresponded to 36 weeks gestation. Mass was firm and nontender. The liver, spleen, and kidney were not palpably enlarged. Fluid thrill was positive.
The pelvic examination revealed healthy vulva and vagina. On bimanual examination, the mass appeared separate from the uterus. Adnexa filled with fluid.

Based on her history of weight loss, pallor, gastrointestinal symptoms, and abdominal mass associated with ascites, ovarian malignancy was suspected. Differential diagnosis were pedunculated uterine fibroid, benign ovarian mass and pancreatic mass.

Her packed cell volume was 28%, total white blood cell count was 4850 per cubic millimeter with a normal differential count. She was seronegative to HIV 1 & II. Results of full blood count, Chest X-ray and Electrocardiogram (ECG) detected no abnormality. The platelet count was 150 x $10^9/_L$. The liver and renal function tests were normal. CA_{125} test was 800 miu/ml, α fetoprotein level was 31.1 ng/ml. Magnetic resonance imaging (MRI) of the abdomen revealed a large intra-abdominal complex cystic mass, ?Ovarian cystic Adenoma. She was subsequently billed for exploratory laparotomy.

At surgery, a large firm tumor, weighing 5.5 kg was seen, with multiple necrotic and oedematous patches (Figure 1). It was attached to the uterine fundus by a thin stalk about 5 x 3 cm thick (Figure 2). The uterus was normal size. The tumor occupied the whole of the abdominal cavity attached to the omentum by large dilated blood vessels. The right and left fallopian tubes and ovaries were entangled with adhesions. The ovaries appeared normal. Non- bloody ascites up to 11 liters was drained.

Fig 1: Mass showing dilated blood vessels

Fig 2: Showing the abdomen-pelvic mass attached to the uterine fundus, both ovaries, tubes and two subserous fibroids.

She had excision of the huge abdominal mass. Total abdominal hysterectomy (TAH), bilateral salpingo-ophorectomy (BSO) and partial omentectomy. No obvious seedlings on the peritoneal cavity. Ascitic fluid was sent for cytology and all the masses for histopathology.

Her recovery was uneventful. Histology revealed degenerate (Hyaline) leiomyoma with no evidence of malignancy. The ascetic fluid showed no malignant cells.

Discussion

The case of a 48-year-old nulliparous woman with huge pedunculated leiomyoma was reported. Leiomyoma, also known as uterine fibroid is a benign growth in the uterus that normally develops during childbearing years of a woman [3, 4]. They are the most common benign tumors in women [1]. It is estimated that 60% of reproductive age women are affected [3, 5]. There are more than 100,000 cases in Nigeria [6, 7]. The symptoms are multiple, including abnormal uterine bleeding, abdominopelvic mass, pelvic and back pain, pressure symptoms on the bladder and lower limbs, anemia due to excessive blood loss.

Massive ascites and profound weight loss are rare. These symptoms coupled with anemia, huge abdominopelvic mass, elevated CA_{125}, and elevated α fetoprotein led to a mis-diagnosis before surgery.

Peritoneal effusions are not confined to malignant tumors; however, it creates diagnostic problems when it occurs in association with benign tumors. Presence of ascitic fluid in such benign tumors has been ascribed to exudates from the peritoneum resulting from mechanical irritation by the hard and degenerate tumor [7, 8]. This could account for the massive ascites noticed in our patient. Additionally, exudation of the fluid from the extensive neo-vascularization may have been contributory [6, 9].

Elevated CA_{125} can be seen in malignant and benign conditions like uterine fibroids, endometriosis, pelvic inflammatory disease and even menstruation often resulting to diagnostic dilemma. The intra-operative findings of pelvic adhesions in index case, could be due to co-existing chronic pelvic inflammatory disease, which significantly compromised her fallopian tubes and her reproductive career.

She had a total abdominal hysterectomy and bilateral salpingo-oophorectomy because she was 48 years old, thus in her perimenopausal period. Also, the nature of the tumor was not confirmed as of the time of surgery, as malignancy was suspected. Sarcomatous changes of the leiomyomata was suspected.

The intent of this presentation is to make gynecologists aware that leiomyoma can present atypically, as well as the diagnostic dilemma and the challenges of proper treatment. With increasing delay amongst our women to start a family, due to academic and career pursuits, more of similar cases are expected.

Conclusion

Uterine leiomyoma (fibroid) commonly presents with abdominal mass, urinary symptoms, feeling of incomplete emptying of urine, and menorrhagia amongst others; but can present atypically by mimicking symptoms of malignancy. Knowledge of this, will be helpful to Clinicians and Gynaecologists in making prompt diagnosis and instituting appropriate management.

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Conflict of interest: None to declare

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