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The complexities of an eccentric myoma causing complete uterine inversion in a postmenopausal woman

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Abstract
Introduction: Uterine fibroids remain a major women's health issue with significant economic and reproductive impact. Fibroids have long been known to be the most common indication for hysterectomy. These myomas can present as abdominal or as vaginal masses.
Case Report: We present a case of eccentric myoma in a 58 year old woman which was different in presentation and hence a surgical challenge.
Discussion: Around 150 cases of chronic non puerperal uterine inversion, most often incomplete and affecting middle aged women, have been reported in literature and a fundal submucus myoma is the commonest cause in most. However, several peculiarities made this case a surgical challenge.

Keywords: Key words-proximal tibia fracture, MIPPO, knee stiffness, wound dehiscence

Introduction
Vaginal masses in older women can present in perplexing ways and have the potential to cause serious surgical complications if undetected. One such case with an extremely rare clinical presentation and management is presented.

Case report
A 58 years old para 5 lady menopausal for 10 years presented to the out patient department with a manually repositable mass coming out of vagina for 4 months. She did not have any postmenopausal bleeding/discharge, chronic cough, constipation or any menstrual complaint earlier. Examination revealed a pink, rounded, ragged, stalked swelling of 7 X 6 cm size at the introitus with no visible opening at its tip. Slight traction on it brought out another reddish pink smooth swelling of same size on left lateral aspect of the stalk 5 cm proximal to the distal mass (Fig 1). Palpation of vagina above the 2 swellings suggested firm contents. Pelvic ultrasonography and MRI were inconclusive and the patient was taken up for examination under anaesthesia and vaginal hysterectomy. A small transverse incision placed on the stalk 3 cm above the distal swelling revealed a bunch of vertically running vessels. Anticipating distorted anatomy and with a clinical suspicion of inversion uterus, a deeper cut at the same site revealed a smooth vertical cavity that was blind at lower end and narrowed upwards where cord like ligaments and tubes traversed it from the upper swelling. The incision was extended upwards to open the tight completely inverted cervix to bring into clear view the stretched tubes and ovarian/round ligaments. Excision of lower myoma and vaginal hysterectomy was carried out. Postoperative recovery was uneventful and histological confirmation received.

Discussion
Around 150 cases of chronic non puerperal uterine inversion, most often incomplete and affecting middle aged women, have been reported in literature and a fundal submucus myoma is However, several peculiarities made this case a surgical challenge.
One was the presence of two same-sized swellings at an angle to each other with irregular surface of the distal myoma and the completely inverted uterus being slightly reddish but with a relatively smoother surface. Long standing menopause may have contributed to the smoothness and reduced color demarcation of inner uterine lining and obliteration of tubal openings while the angulation could be on account of origin of myoma from one of the lower lateral uterine walls.

Bulk of a fundal myoma is believed to pull on the fundus to cause inversion [1]. The myoma in this case was neither fundal nor bulky but still managed to cause a peaked extension of pelvic cavity into the elongated stalk thus implying that most of the length of the myoma stalk was actually formed by the inverted uterine walls. This may be a pointer towards a significant contribution of strength of uterine contractions and thickness of myometrium at the myoma attachment site. Another clinical pitfall in this case was the presence of completely inverted elongated cervix in the vaginal stalk proximal to the inverted uterus and the palpability of adnexa in place of uterus just above the inverted cervix. In addition, rarity of the condition in menopausal women, grossly distorted genital anatomy and atrophic endometrial lining in this case could have contributed to missing of the condition even on MRI which otherwise is regarded as the best imaging modality exhibiting a U-shaped uterine cavity on the sagittal and coronal images, a reversed uterine fundus (target sign) and a bulls eye aspect on axial images in classical cases [2]. Most of the reported cases of this condition in elderly women are managed by open abdominal or laparoscopy assisted vaginal hysterectomy [3]. To the best of our knowledge, this is the second such case to be managed exclusively vaginally and supports our belief that the condition should be strongly suspected in elderly women presenting with vaginal masses [4]. A cautious surgical approach relying on anatomic landmarks by experienced clinician can ensure benefits of vaginal surgery for the patient [5].

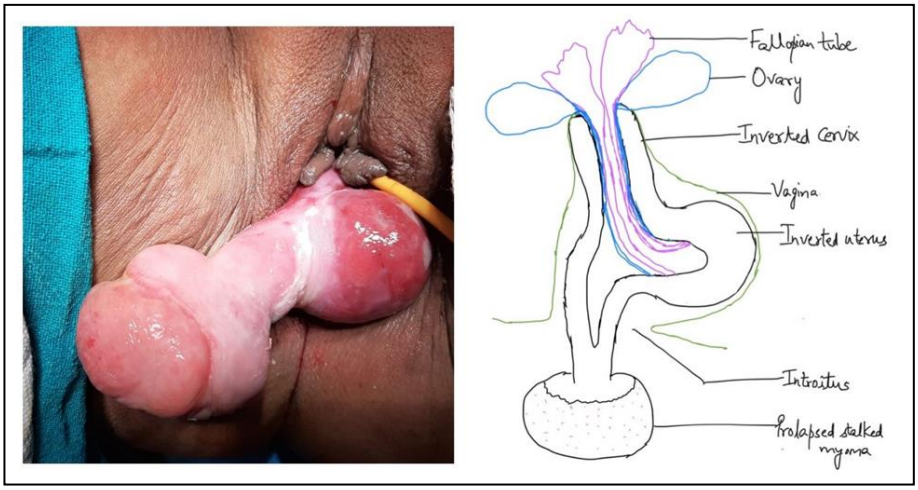

Fig 1: (a) is a clinical photograph showing the distal stalked myoma and proximal completely inverted uterus. (b) is a freehand drawing of the prolapsed masses.

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