

Lipoleiomyoma Of The Uterine Cervix (About An Observation)

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Abstract: The diagnosis of benign cervical that does not rely on imaging, but the clinical and histological examination. Indeed, the main question is: is it a benign or malignant lesion? Among the benign lesions, the variety of lesions that may be encountered is important. However, knowledge of the typical aspects of the most common injuries helps confirm a diagnosis and avoid unnecessary explorations. Lipoleiomyomas are uncommon benign neoplasms of uterus and are considered to be a variant of uterine myomas. Their reported incidence varies from 0.03 to 0.2%. We report this case of cervical lipoleiomyoma because of its rarity, and we emphasize the difficulty of making the diagnosis of malignancy and benign cervical lesions.

Index Terms: Benign tumor, cervix, cervical leiomyoma, cervical fibroid, lipoleiomyoma.

1 INTRODUCTION

THE diagnosis of benign cervical tumor depends on histological examination. Cervical leiomyoma is the most common benign tumors of these; it arises in the cervical muscular tissue. It looks like uterine leiomyoma, which is more common. Cervical leiomyoma is usually small, typically measuring 0.5 to 1 cm. It occurs most often in women aged 30 and over but can affect women of all ages [1]. Through this observation, we emphasize the difficulty of making the diagnosis of malignancy or benignity of a cervical lesion and describe the clinical and radiological features of cervical leiomyoma.

2 CASE REPORT

Mrs. L.H. aged 39 years old, G4P4, who consults for bleeding that had started three months ago. Speculum examination finds a registered cervical peri-orificial inflammation. The vaginal examination finds a cervix doing 3 cm with supple vaginal. Digital rectal examination finds a tumor of the cervix to 4 cm bulging into the rectum with flexible rectovaginal septum and free parameters. An ultrasound found a hyperechoic image depends on cervico-isthmic posterior region (Fig. 1). In front of the high suspicion of a malignant tumor of the cervix, pelvic MRI finds a cervico-isthmic process involving 52 x 47 mm extending to the right proximal parameter with a dilatation of right ureteral making suspect a cervical cancer classified IIB according to FIGO classification (Fig. 2 and Fig. 3).

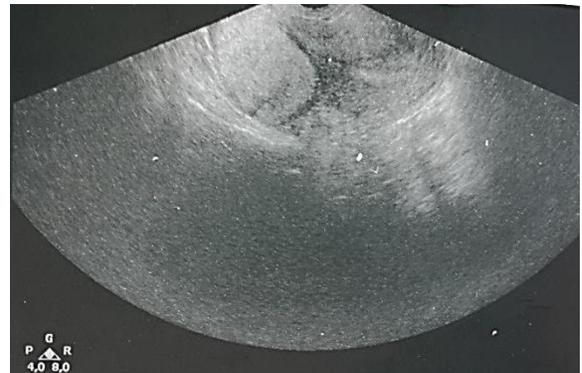


Fig.1. Sagittal sonogram shows hyperechoic mass arising from the cervico-isthmian region.

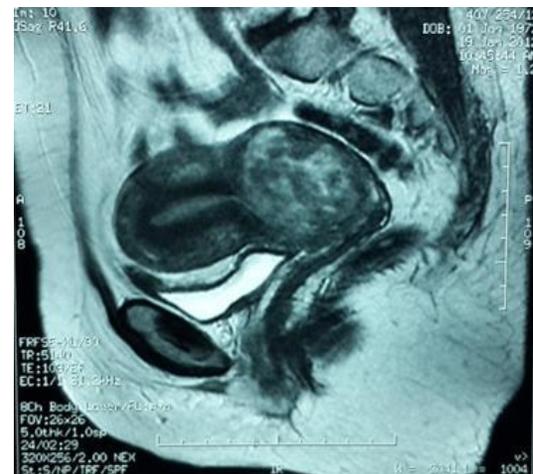


Fig.2. Sagittal T1-weighted MR image also shows mass in lower uterine segment measuring 57x42x57 mm suggesting a cervical process.

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Fig.3. Frontal T2-weighted MR image after IV administration of gadolinium shows high-signal, well-circumscribed mass in lower uterine segment with ureteral dilatation.

A cervical biopsy finds glandular polyp with no evidence of malignancy. In front of the clinical and pathological outcomes and despite the pejorative radiological results, we decide to carry out only inter-adnexal hysterectomy for suspicion of a benign tumor of the cervix. The final result was in favor of a cervical isthmic lipoleiomyoma than 5 × 6 cm without histological signs of malignancy. The outcome was favorable and operative follow simple.

3 DISCUSSIONS

The diagnosis of benign cervical depends on histology. Among the cervical benign lesion: leiomyoma. In order of frequency, cervical leiomyoma is the most common cervical benign tumors. Cervical myomas are smooth, firm masses that are similar to myomas of the fundus. A cervical myoma is usually a solitary growth in contrast to uterine myomas, which in general, are multiple. Depending on the series, 3% to 8% of myomas are categorized as cervical myomas. Because of the relative paucity of smooth muscle fibers in the cervical stroma, the majority of myomas that appear to be cervical actually arise from the isthmus of the uterus [1]. There are several types of cervical fibroid and each can present differently. Supravaginal fibroids can be central surrounding the entire cervical canal and lying centrally in the pelvis displacing the uterus superiorly. They can also be unilateral or bilateral, can be intramural or subserosal, and can be lying in the pelvis. When symptoms do occur, they are dependent on the direction in which the enlarging myoma expands. The expanding myoma produces symptoms secondary to mechanical pressure on adjacent organs. Cervical myomas may produce dysuria, urgency, urethral or ureteral obstruction, dyspareunia, or obstruction of the cervix. Occasionally a cervical myoma may become pedunculated and protrude through the external os of the cervix. These prolapsed myomas are often ulcerated and can simulate a malignant tumor [2]. During pregnancy, these can be very large and cause recurrent vaginal bleeding with the option of being removed vaginally in emergency [2], [3]. Spontaneous vaginal expulsion of the cervical fibroid have been described: the pathological analysis of the product must be systematic because it is

necessary to eliminate the presence of malignancy, especially leiomyosarcoma [4]. Diagnosis is based on pelvic ultrasound and MRI. The histological diagnosis is rarely obtained preoperatively as is the case in our patient. Uterine lipoleiomyomas are uncommon benign neoplasms of uterus and are considered to be a variant of uterine myomas. Their reported incidence varies from 0.03 to 0.2%. Lipoleiomyoma consists of variable proportion of mature lipocytes and smooth muscle cells. These tumors generally occur in asymptomatic obese perimenopausal or menopausal women [5] which is not the case of our patient. The sonographic appearance of leiomyomas is that of a hyperechoic mass partially encased by hypoechoic rind. The rind is thought to represent a layer of myometrium surrounding the fatty component. CT shows more specific findings, revealing a well-circumscribed, predominantly fatty mass with areas of nonfat soft-tissue density arising from the uterus. On MRI, the lipomatous nature of the lesion is suggested by high signal intensity on T1-weighted images in the lesion. The fatty components may be confirmed using fat-suppression techniques [6]. Management of these fibroids is usually by hysterectomy especially for central cervical fibroids. Uterine artery embolization and myomectomy can be performed depending on patients' symptoms, fertility desire, the site of the mass, and associated uterine fibroids.

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