CASE REPORT

A Huge Submucosal Fibroid Polyps; A Hidden Cause of Necroturia

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ABSTRACT

Background: Fibroids are benign neoplasms of the uterus arising from smooth muscle. They are also termed uterine leiomyomas. It is the most common growth found in the female reproductive system and may undergo malignant transformation in less than 1% of cases to form leiomyosarcoma. Fibroids may present with abnormal uterine bleeding and pelvic pressure symptoms. Fibroid polyp can be a cause for concern especially if it grows so large to cause symptoms of obstructive uropathy. Thus, the patient may present with dysuria, anuria, or even necroturia as seen in our patient. **Case summary:** We present a case of 40-year-old P_5 + 0, A_3 lady, whose last childbirth was 10 years before presentation. She presented with 3 years history of recurrent vaginal bleeding, dizziness, and a mass protruding through her vagina. Her packed cell volume was 14%. She was fully investigated and upon catheterization, nectroturia was observed. She was counselled and had vaginal polypectomy. **Conclusion:** Necroturia associated with uterine fibroid polyp is a rare occurrence, hence physicians should have a high index of suspicion when evaluating patients with necroturia.

Keywords: Submucosal Fibroid Polyps, Nectroturia, Foley Catheter.

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Introduction

Fibroids are monoclonal benign tumors that arise from uterine smooth muscles and are steroid-responsive.[1] Fibroid is the most common reproductive tract tumor in women and present a major quality of life problem for a large fraction of the population. It is estimated that up to 77% of all women will develop uterine fibroid in their lifetime, and 15-30% of these women suffer from substantial symptoms, ranging from pelvic discomfort, dysmenorrhea, menorrhagia, anaemia, urinary incontinence, recurrent miscarriages, preterm labour and sometimes infertility.[2]

Large submucosal or subserosal uterine fibroids can cause pressure on adjacent structures leading to pain, urinary symptom and constipation.[3]

Submucosal fibroid polyp may cause acute urinary retention and possible necroturia. Necroturia may be due to compression of the upper urethra and the bladder neck caused by forward and upward displacement of the cervix from the impacted fibroid. During normal micturition, the cervix is moved away from the urethra and bladder neck; but this action is prevented by the impacted uterine fibroid.[4,5,6] A direct compression of only the lower portion of the bladder due to forward and upward displacement of the cervix has been hypothesized to cause urine retention.[4] All these pressure effects may lead to some degree of ischemia, necrosis, and subsequent sloughing of the bladder wall which may be seen in the urine as necroturia. In untreated and neglected cases, bladder perforation may result leading to vesico-vaginal fistula.

This case report highlights the dangers of late presentation of submucosal fibroid polyps and its attendant complications if left untreated. Hence

highlighting the need for early presentation and treatment.

Case Presentation

presentation. She presented with a 3-year history of recurrent vaginal bleeding and a feeling of mass in her vagina. She had an associated history of dizziness and one episode of acute urine retention in the past.

She was worried, moderately pale, with a pulse rate of 110b/m regular and moderate volume. Her blood pressure was 90 /70 mmHg. The chest was clinically clear. The uterus was 14 weeks in size. A vaginal examination revealed normal external genitalia. A polypoid mass was felt in the vagina measuring about 10cm by 8cm. The base of the stalk could not be palpated; a rim of cervix was felt around the stalk. The gloved finger was clean. An assessment of the submucosal fibroid polyp was made. A pelvic ultrasound scan revealed multiple small uterine fibroids, the largest measuring 4.8cm in the upper anterior uterine segment but missed the submucosal

The patient was a 40-year-old P_5 +0 A_3 whose last menstrual period was 10 days prior to presentation and whose last childbirth was 10 years prior to

fibroid polyps. A full blood count revealed haemoglobin of 3.7g/dl, but other parameters and serum chemistry were normal. The patient was admitted and her blood level was optimized by blood transfusion. The findings were explained to the patient including the need for polypectomy in the theatre, which she consented.

She was given spinal anesthesia, and urethral catheter was inserted where the necrotic tissue was observed in the tube (Fig 1).

Vaginal polypectomy was done under direct vision using ovum forceps and the findings were noted as earlier explained (Fig 2). Her post-operative condition was satisfactory. The catheter was left for 10 days (to prevent possible vesicovaginal fistula). She was reviewed two weeks after discharge in the clinic, with no complaints.

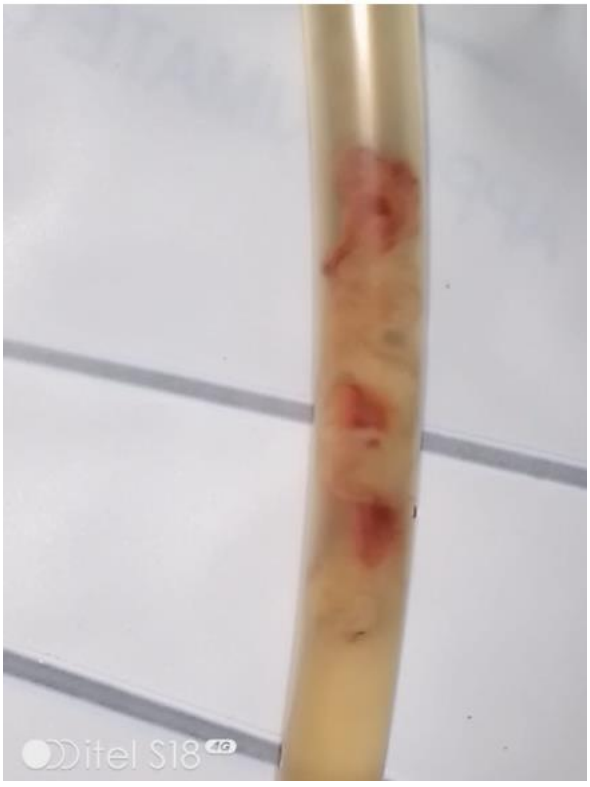

Fig 1: Necrotic Tissue Within a Catheter

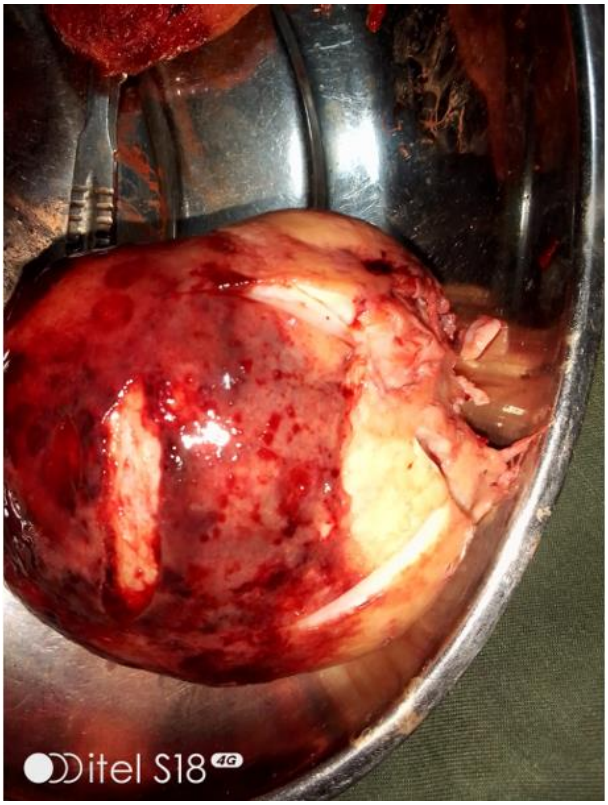

Fig 2 Fibroid polyp seen through the vagina, showing some areas of necrosis and hemorrhage

Discussion

The large submucosal uterine fibroid within the uterus contributes to the symptoms a patient presents with. The location can be subserosal, intramural, cervical, intraligamentary, parasitic, submucosal, or pedunculated.[3] Large submucosal uterine fibroids can lead to pressure on adjacent structures resulting in pain, constipation, or urinary symptoms.[4]

Our patient had a fibroid polyp compressing the bladder causing an episode of acute urine retention that warranted catheterization in a comprehensive health centre and she was noticed to have necroturia during the second catheterization before surgery. The treatment for fibroid polyp includes polypectomy which can be hysteroscopic[7] or by direct vision using ovum forceps (which our patient had).

She had the urethral catheter left in situ for 10 days to prevent the possible development of a vesicovaginal fistula. Vesicovaginal fistula was not observed in our patient following the removal of the catheter and also during a follow-up visit.

In conclusion, a uterine fibroid can present as a submucosal pedunculated mass which may be huge enough to protrude through the vagina and compress the bladder and may present with necroturia. Hence, early presentation, detection, and appropriate management is important to prevent complication that may arise.

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