# Vaginal Leiomyoma

*Serag I, MD* and Aboulghar W, MSc***

**Lecturer and **Assistant lecturer, Department of Obstetrics and Gynecology, Ain Shams University*

**Day 1 at 10:45 A Private Hospital – Outpatients' Gynecology Clinic (OPC).**

A 52 years old patient, para 2002 presents to the clinic with the complaint of a painless, slowly growing mass protruding from the introitus, of 2 years duration.

She has an irrelevant family & past history. She states that the mass can be partially reduced into the vagina in the dorsal position, but easily protrudes back on cough or movement. During that visit, sonographic examination reveals a normal appearance of the uterus and adnexae. The patient has no history of vaginal bleeding and has been menopausal for 2 years.

On examination, her blood pressure is 120/70 mmHg, pulse is 90 bpm, temperature is 37.1C. Abdominal examination reveals no abnormalities.

The examining specialist registrar could not do a digital pelvic examination because of the mass protruding through the introitus. The patient is admitted for further management.

**Day 2 at 11:00 the Same Hospital - Inpatient Ward.**

The patient's laboratory investigations reveal no abnormality. Her chest X-ray is free. A provisional diagnosis of uterine procedentia is put and the specialist registrar notifies the supervising consultant in preparation for vaginal hysterectomy.

**Day 3 at 09:00 the Same Hospital – Operative Theatre.**

The patient undergoes general anesthesia. Examination under anesthesia reveals a firm mass protruding from the lower anterior vaginal wall. The overlying vaginal tissue appears rather healthy and not adherent to the mass. No cervical os is seen at the tip of the mass. Vaginal examination reveals the cervix and uterus are in normal place and separate from the mass. Rectal examination reveals no abnormality. Urinary catheterization shows that the urethra is directly related to the outer surface of this mass.

**Day 3 at 09:15 the Same Hospital – Operative Theatre.**

The consultant leaves a metal catheter in the urethra to identify it then proceeds to open the vaginal wall covering this mass. A plan of dissection is identified and a solid mass is enucleated with minimal blood loss. Hemostasis is ensured and anterior vaginal repair is done. The mass is sent for histopthologic examination which later reveals the diagnosis of ectopic leiomyoma.

## Comment by the Editorial Board

Fibroids are almost universally uterine in origin. Only very rarely, is an ectopic fibroid discovered. The most common site of such a presentation is the vagina. When a patient presents with what seems initially to be uterovaginal prolapsed, it is essential to try to identify the anatomy of the displaced mass. That is why vaginal and rectal examination should have been done on preoperative assessment to differentiate procedentia from cervical or uterine polypi and from vaginal lesions whether benign or malignant in nature. Malignant metastases from choriocarcinoma are common to affect the anterior lower vagina but usually ulcerate and cause heavy bleeding.

A case provisionally diagnosed as procedentia deserves senior gynecologist examination preoperatively to plan the surgery and also warrants assessment for ureteric kinking with potential hydroureter formation.

The data from the examination under anesthesia and the operative notes suggest a benign nature of the mass. At this site, the most probable diagnoses would be a Gartner's cyst or vaginal fibroid.

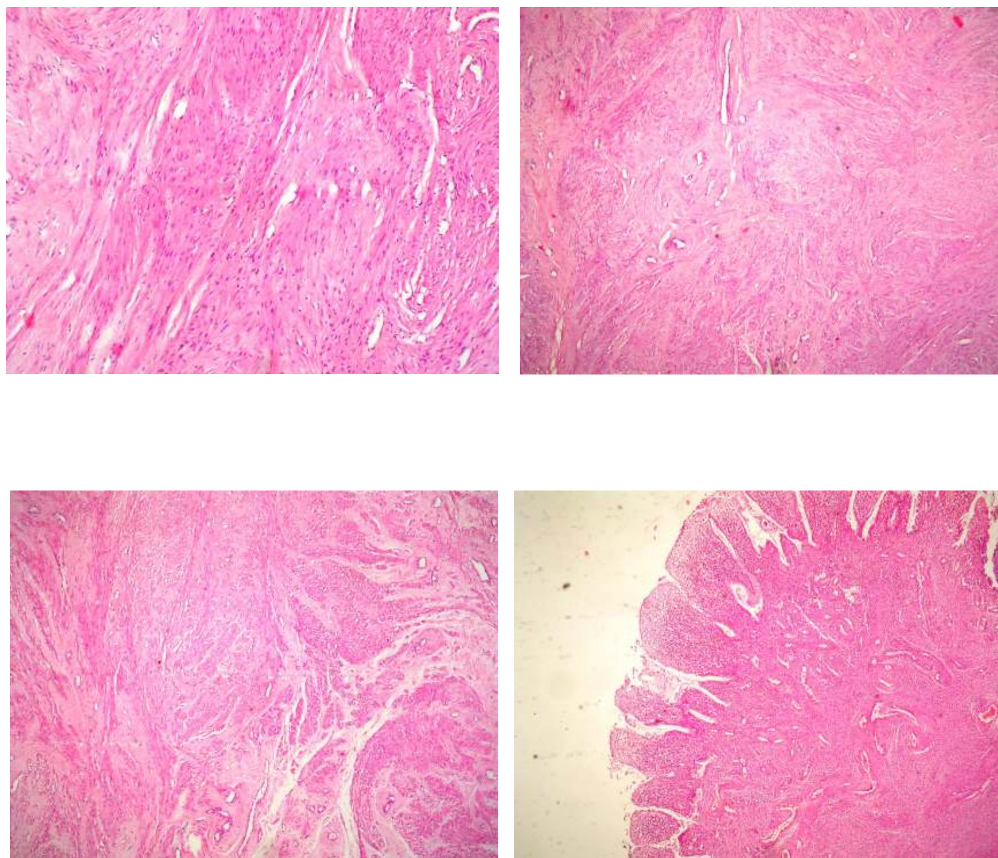

**Figure 1 (a to d)** Histopathological findings of the vaginal fibroid showing the whorly arrangement of the benign smooth muscle tissue and the vaginal epthileum next to it.