

Parasitic leiomyoma: a case report

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Summary: A case of parasitic leiomyoma is presented. The clinical significance of such a rare condition is discussed.

Key word: Myoma uteri.

INTRODUCTION

Leiomyomas are categorized as submucosal, intramural or subserosal. The subserosal leiomyomas can become pedunculated and, in the event of torsion with necrosis of the pedicle, the leiomyoma can lose its connection with the uterus and, in some instances, become attached to other pelvic structures. This condition is called parasitic leiomyoma⁽¹⁾. Such parasitic leiomyomas are rather rare⁽²⁾. We present a case of parasitic leiomyoma and evaluate its clinical significance.

CASE DESCRIPTION

A usually healthy, 40-year-old woman, gravida 12, para 7, spontaneous abortion 5, presented with low abdominal pain and dysmenorrhea during the preceding 12 months. She had had regular menstrual periods, every 28 days, with menstrual flow lasting 5-6 days. She had had an intrauterine device for the last six years. On pelvic examination, the cervix appeared normal with the intrauterine device tail present in the cervix. The uterus was small, in midposition and a firm, solid mass, about 10 cm in diameter

was palpated riding anteriorly in the fundus. The uterus was mobile and was not tender. Otherwise the examination was unremarkable. On ultrasonographic examination the uterine size was estimated as $48 \times 90 \times 75$ mm with the intrauterine device in situ. A single fundal homogeneous leiomyoma measuring $114 \times 81 \times 116$ mm was detected. Otherwise the ultrasonographic examination appeared to be unremarkable. On the basis of the clinical and sonographic data an abdominal hysterectomy was suggested.

On laparotomy, a solid tumor 11-12 cm in diameter was seen attached to the peritoneum. It was not connected to the uterus or any other pelvic structure. No additional myomas were found. The uterus and the adnexa appeared to be normal. The tumor was resected completely. It was partially encapsulated. On cut section the tumor showed a white, whorled pattern with a rubber consistency. Histological sections showed interlacing masses of smooth muscle, separated by collagen with areas of hyalinization (Fig. 1). Mitotic figures were absent. A diagnosis of leiomyoma was made.

DISCUSSION

The parasitic leiomyoma symptoms are related to a pelvic mass, like abdominal pain and dysmenorrhea. Menorrhagia in leiomyoma of the uterus is usually explained by interference of the tumor with normal uterine contractility, increase of endometrial surface area or compression of venous plexus of the adjacent myometrium and endometrium⁽³⁾. Thus, it is not sur-

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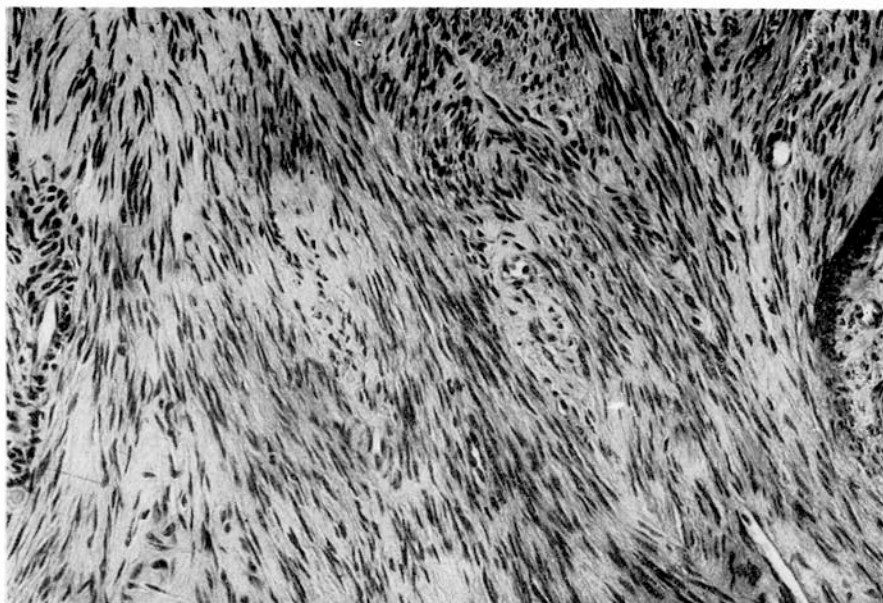


Fig. 1. — H & E $\times 120$, showing interlacing masses of smooth muscle, separated by collagen with areas of hyalinization.

prising that menorrhagia is not seen in parasitic leiomyoma, since there is no connection between the tumor and the uterus.

From the clinical point of view, the parasitic leiomyoma represents an interesting diagnostic problem. The pedunculated subserous leiomyoma could be easily confused with parasitic leiomyoma. Adnexal masses, either inflammatory or neoplastic, may be so firmly adherent to the uterus that they may simulate subserous or parasitic leiomyoma on pelvic and ultrasonographic examination. The distinction of the above mentioned conditions may be impossible until laparotomy is performed.

Other bizarre and rare variants such as metastizing leiomyoma or intravenous leiomyomatosis⁽⁴⁾ should be distinguished during the laparotomy. Metastizing leiomyoma is an unusual entity that consists of multiple intraperitoneal myomas and sometimes distant benign metastasis of myomas⁽⁴⁾. Intravenous leiomyomatosis

is defined as the extension into venous channels of smooth muscle tumors arising either from a uterine myoma or from the wall of the vessel itself⁽⁴⁾. Leiomyosarcoma is an important differential diagnosis, since it influences the intraoperative management. The diagnosis of leiomyosarcoma may be suspected preoperatively when a rapid growth is evident and at surgery when metastatic spread is present⁽⁴⁾.

REFERENCES

- 1) Zalondeck C., Norris H.: "Mesenchymal tumors of the uterus". In: "Blaustein's Pathology of the Female Genital Tract", 3rd ed., Kulman R. J., ed. Springer-Verlag, New York, p. 373, 1987.
- 2) Mercill J.A., Creasman W.Y.: "Lesions of the corpus uteri". In: "Obstetrics and Gynecology", 5th ed. Danforth D.N., Scott J.R., eds. J.R. Lippincott Company, Philadelphia, p. 1068, 1986.
- 3) Battarm V.C., Reiter R.C.: "Uterine leiomyomata: etiology, symptomatology and management". *Fertility Sterility*, 36, 433, 1981.
- 4) Baggish M.S.: "Mesenchymal tumors of the uterus". *Clin. Obst. Gyn.*, 17, 51, 1974.