Case Reports

THE DANGEROUS SUBMUCOUS UTERINE MYOMA


Although the least commonly encountered group, submucous uterine myomata attract early attention clinically because of encroachment on the uterine cavity. Symptoms include menorrhagia, intermenstrual bleeding and discharge and, because they may become polypoidal and be extruded from the uterus, pain may be a prominent feature. The ease of entry of microorganisms from the genital tract makes this form of myoma prone to infection, particularly after pregnancy or abortion.

Earlier-sought advice, diagnosis and treatment mean that the more severe cases will nowadays be less commonly encountered. Nevertheless, the complications of extrusion, infection, necrosis and bleeding may occur at any age, both after delivery or apart from pregnancy, as the following cases illustrate:

Case No. 1. Submucous myoma complicating pregnancy, labour and the puerperium.

Mrs. G.P., aged 28 years, gravida 4, para 2, was referred to the ante-natal clinic with a persisting oblique breech lie of the foetus at 35 weeks gestation. There was no relevant medical or obstetric history.

In the present pregnancy there had been a severe degree of anaemia (haemoglobin 7.1 g./100 ml.) and investigation had revealed a minor degree of iron deficiency, the bone marrow biopsy being normal. There was no evidence of chronic renal tract infection. Treatment with oral iron and, later, with folic acid had resulted in some improvement but this was not complete and at the time of her referral to the clinic, the haemoglobin level was 10.8 g./100 ml.

Abdominal examination confirmed the period of gestation and, although the foetus could be turned to the oblique vertex position, it quickly reverted to its original position. Because of the possibility that the malpresentation resulted from a low-lying placenta, the patient was advised admission; she was admitted in premature labour before this could be arranged. The foetus was at this time presenting by the breech; labour proceeded rapidly, an assisted breech delivery being performed. The total blood loss at delivery was 200 millilitres.

The infant, a live male, weighted 2.3 kg. (5 pounds) and was limp and cyanosed at birth. Although showing initial improvement, a pan-systolic precordial murmur, maximal in the left second interspace, was present and the femoral pulses were not palpable. Congestive cardiac failure developed and the infant died 42 hours after delivery, the clinical diagnosis being coarctation of the aorta. Autopsy revealed atresia of the aortic valve and hypoplasia of the ascending aorta.

The patient was discharged home to the care of her general practitioner 48 hours after delivery only to be re-admitted 15 days later with a history of continuing vaginal loss and associated abdominal pain. On examination, the patient was febrile (temperature 39° C; 102° F), pale and in pain. Abdominal examination showed the uterus to be tender and palpable halfway between pubis and the umbilicus and vaginal examination revealed the cervix to be three fingers dilated, a mass being felt through the cervix on the left posterolateral surface of the uterus. A diagnosis of a degenerating submucous uterine myoma was made.

Investigations: Blood group 'O': Rh +, Hb. 7.9 g./100 ml., WBC 14,000 cu. mm. (polys. 10,500). Chest X-ray normal. Blood culture negative. High vaginal swab—coiform organisms, sensitive to tetracycline and chloramphenicol.

Treatment: The patient was given tetracycline, 250 mg. 6-hourly for five days and was transfused with two pints of blood. The temperature settled but the abdominal pain persisted and became more severe four days after admission. Vaginal examination at this time showed the cervix to be widely dilated with the myoma protruding into the upper vagina. Operative removal was undertaken. Vaginal enucleation was attempted but the myoma was found to have a sessile attachment to the uterus and the attempt was abandoned; abdominal hysterectomy with ovarian conservation was performed, operation being uneventful. The post-operative course was uneventful and the patient discharged from hospital on the sixteenth post-operative day. Subsequent follow-up at the out-patient clinic revealed no abnormality and she was discharged from the care of the hospital.

Histological report: Projecting into the cavity of the uterus is a large ragged mass of partly necrotic and haemorrhagic tissue some 12 x 10 x 7 cm. which has the consistency of a fibromyoma. Microscopical examination shows extensive areas of necrosis, haemorrhage and edema with polymorpho-nuclear infiltration. There is no evidence of malignancy. The endometrium shows an endometritis.

Comment

Although pregnancy is not infrequently encountered in patients with intramural or subperitoneal myomata, it is rare with the submucous variety. Parks and Barter (1952) emphasised that the latter will produce major problems both from the point of diagnosis and of treatment. The occurrence of tumour degeneration and infection after abortion may necessitate hysterectomy; prolonged bleeding and pyrexia in the puerperium in a patient with uterine myomata indicate infection of a submucous form and may require abdominal hysterectomy. Cody and Wall (1956) reported a case of an infected submucous myoma which extruded from the uterus three weeks after delivery, vaginal enucleation being successfully
BUCKLE: Dangerous Submucous Uterine Myoma

The present episode of vaginal bleeding had occurred 26 days after a normal period, the loss being heavy with the passage of clots but there had been no pain.

On examination the patient was febrile (temperature 39.2° C; 102.4° F) and extremely pale. The blood pressure was normal and there was a soft systolic murmur at the apex. The chest was clear and there was no abnormality on abdominal examination. Vaginal examination revealed the cervix to be two fingers dilated and a sessile mass was palpable on the left side of the cervical canal, some 4 cm. in width; the upper edge could not be reached. A steady bright red blood loss was occurring from the cervical canal. A diagnosis of an infected extruding submucous myoma of the uterus or upper part of the cervical canal was made.

Investigations: Blood group 'A'; Rh. +, Hb. 4.6 g./100 ml. WBC 11,000/per cu. mm. Chest X-ray normal. High vaginal swab grew diphtheroids and scanty streptococcus faecalis.

Treatment: A slow intravenous infusion of blood was commenced and, after 4 pints had been given, the haemoglobin had risen to 9.6 g./100 ml. The vaginal loss ceased after 24 hours. Two further pints of blood were given prior to operation. Examination in the operating theatre confirmed the presence of a large sessile submucous myoma on the left posterior wall of the cervix and lower part of the body of the uterus, although it was not possible to feel the upper edge. After incision through the capsule, the myoma was enucleated in several fragments. Limited access made it impossible to identify bleeding points in the capsule of the myoma so recourse was had to packing the bed of the tumour with ribbon gauze.

The post-operative course was uneventful and no undue loss followed the removal of the pack some 48 hours after operation. The patient was discharged from hospital 10 days after operation. Follow-up in the out-patient clinic showed a return to normal in the size of the cervix and there was a return to normal menstrual cycle. Stool examination was carried out for gastro-intestinal bleeding, with a negative result; a barium meal showed a characteristic ulcer deformity of the duodenal cap. At the time of discharge from the out-patient clinic, the haemoglobin was 11.5 g./100 ml.

Histological report: The tumour pieces are part of a benign myoma, the total weight being 114 g. There is no evidence of malignancy.

Comment

Heavy vaginal bleeding of the degree encountered in this instance may well have resulted from surface necrosis of the tumour with the subsequent rupture of vessels. Tumours of this type are rarely encountered, especially at this age, and vaginal enucleation was attempted as it appeared to be accessible from the vaginal route. Had it not been possible to arrest hemorrhage from the tumour bed, an abdominal approach would have been necessary to display the affected area. It is of interest that the patient had at no time had abdominal pain, despite the dilatation of the cervix.

Case No. 3. Submucous myoma: previous symptoms referable to myomata.

Mrs. G.L., aged 47 years, para 3, was admitted complaining of a heavy and offensive blood loss per...
THE SPLENIC FLEXURE SYNDROME

J. Shafar, M.D., M.R.C.P., D.P.H.
Consultant Physician,
Burnley and District Group of Hospitals

The splenic-flexure syndrome would appear to have received inadequate attention as judged by the paucity of reports in the literature and by its infrequent inclusion in textbooks of general medicine and even of disorders of the alimentary tract. Familiarity with the condition is important not only in elucidation of the nature of some examples of upper abdominal pain, but also by reason of its simulation of pain of cardiac or pulmonary origin. Palmer, Deutsch and Scott (1955) were impressed by the common diagnostic error of coronary artery disease; in many instances the subjects had become cardiac invalids as a consequence of ill-directed medical advice. These
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A. E. R. Buckle

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