Case Report

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Acquired Gynaetresia following treatment of uterine fibroid: Case report

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Abstract:

Objective: The aim of this case report is to highlight harmful practice in treatment of fibroid with local herbs with consequent acquired gynaetresia. **Method:** This is a case report of a woman with uterine fibroid. The relevant information was obtained from her case file. **Results:** This is a case of a woman who was diagnosed of having uterine fibroid and was to have surgical management. She initially opted for treatment with local herbs and suffered acquired gynaetresia as a result of vaginal application of the herbs. She also had respiratory distress consequent to giant size of the tumor as a result of undue delay in receiving appropriate treatment. She eventually had abdominal total hysterectomy and bilateral salpingo-oophorectomy. **Conclusion:** Harmful practices in the treatment of uterine fibroid could result in disastrous consequences. Therefore, community enlightenment as regards appropriate treatment of fibroid should be undertaken to curtail the unwarranted consequences of harmful treatment.

Key words: Fibroid, acquired gynaetresia, local herbs, treatment, harmful practice

Introduction:

Uterine fibroids are a benign tumor of the uterus. They arise from the smooth muscle cells of the myometrium [1]. They vary widely in size from as small as a coin to the size of a large melon. A very large fibroid can cause the uterus to enlarge to a size of 6 or 7 month pregnancy. Fibroids can form as one single dominant fibroid or as a cluster of many fibroids. The uterus is about 7.5cm long and pear-shaped, and weighs about 70grams.

Many cases of uterine fibroids are asymptomatic. Symptoms of uterine fibroids depend on size and site of the fibroids. A small fibroid may not cause any symptom, so the woman may not even know that she has fibroid. A larger fibroid may make the uterus to enlarge, and the affected woman may develop symptoms [1]. Common symptoms of uterine fibroids include abdominal mass/swelling, menorrhagia, dysmenorrhea, dyspareunia, pelvic pain or pressure, pressure on the bladder which leads to

frequency of micturition, urinary incontinence or retention, pressure on the bowel which can lead to constipation or bloating, and oedema of the lower limbs. Diagnosis can be made from clinical and ultrasonic findings. Where available, magnetic resonance imaging is also used to confirm the diagnosis [2].

Treatment modalities include follow-up for small fibroids, medical and surgical treatment [2]. Medical treatment includes the use of drugs such as non-steroidal anti-inflammatory drugs, for example mefenamic acid, to ameliorate dysmenorrhea; use of anti-thrombotic drugs such as transnemic acid to reduce menorrhagia; use of gonadotropin-releasing hormone analogues, for example, sereline, gorsipol, to reduce tumor size. Mifepristone has also been reported to be effective in the tumor size reduction. Surgical methods include myomectomy, hysterectomy, bilateral ligation of internal iliac arteries and uterine artery embolization [3].

Until recently, hysterectomy was the preferred option for treating large fibroids. Now, however, there are a number of uterine fibroids treatment options including the noninvasive outpatient Magnetic Resonance guided Focused Ultrasound treatment for ablating fibroids of different sizes [2].

Despite the availability of most of these modern treatment options, a substantial number of women in developing countries including Nigeria still seek alternative treatment options, which are not only ineffective but also cause unwarranted delay in receiving modern treatment. Therefore, the aim of this case report is to highlight harmful practice in treatment of fibroid with local herbs with consequent acquired gynaetresia and the depreciation in the quality of life that may result from delay in receiving appropriate treatment.

Case Report

Patient was a 50 year-old Para 0^{+3} caterer who was first seen at Olabisi Onabanjo University Teaching Hospital (OOUTH) gynaecological clinic on the 29th of July 2011 on account of abdominal swelling, weight loss and easy fatigability of 5 years, 2 years and 3 months duration respectively. Her last menstrual period was 6th of May, 2011.

She had been in her usual state of health until about 5 years prior to presentation at OOUTH gynaecological clinic when she noticed lower abdominal swelling which was firm. It had been progressively increasing in size with no associated pain but with prior history of menorrhagia. She presented at the Island Maternity Hospital, Lagos 3 years prior to presentation at OOUTH, where she was diagnosed of having uterine fibroid and was subsequently scheduled for myomectomy but she defaulted.

She sought for traditional medical treatment of the uterine fibroid, and some concoctions were given to her to drink and had some inserted into her vagina with the aim of "melting" the fibroid but to no avail. She observed that she had developed narrowing of vagina with subsequent deterioration in sexual function a few weeks following the insertion of the concoction into the vagina.

About 2 years to presentation at OOUTH, she noticed she was losing weight and gradually developed difficulty in breathing. However, she had no history of cough or chest pain but there was history of leg swelling which gradually subsided on physiotherapy. She also noticed easy fatigability about 3 months prior to presentation, with occasional dizziness but no fainting attack or urinary symptoms. She was advised to come to OOUTH by her friend with similar problem but had received treatment.

She had spontaneous abortions at 8, 9 and 12 weeks in 1985, 1986 and 1993 respectively. She married her present husband who was a 52 year-old contractor, in a polygamous setting in 2003. She had never used any contraceptive method.

She was diagnosed to be hypertensive in 2010 and was on antihypertensives- Aldomet tablet and Nifedipine tablet. She was neither diabetic nor asthmatic. She had not had any surgery or blood transfusion.

On examination, she was chronically ill-looking, moderately pale, afebrile to touch, anicteric with mild pitting ankle oedema and hirsuitism. She was dyspnoeic but not tachypnoeic. The lungs were clinically clear. Her pulse was 106 beats per minute while her blood pressure was 160/70 mmHg. The heart sounds were normal. The abdomen was grossly distended with a firm, non-tender mass occupying the whole of the abdomen, making palpation of organs difficult.

On vaginal examination, the vulva was normal. The vagina was moist and short, about 3cm long and ended midway with fibrotic tissues and a hole measuring 1cm by 1cm and 2 other dimples. The cervix, adnexae and pouch of Douglas were difficult to access.

A diagnosis of uterine fibroid was made, with differential diagnoses of ovarian malignancy and leiomyosarcoma being entertained.

Results of Investigations:

Full blood count

Packed cell volume: 18.2%
Red cell morphology: hypochromic microcytosis.
White cell count: total- 6500/mm^3,
Differentials: neutrophils- 65%, lymphocytes- 33%, basophils- 1%, eosinophils- 1%
Platelets: grossly raised.
Electrolytes- within normal range, urea- 78mg/dl
Blood group: A Rhesus positive
Haemoglobin genotype: AA
Urinalysis: sugar- negative, protein- ++
Abdominopelvic ultrasound revealed a huge complex echoic mass with solid and cystic component, suggestive of huge ovarian cyst,? mucinoid cystadenoma
Chest X-ray: normal findings
Electrocardiography: showed ventricular tachycardia with left axis deviation
Radiologist declined carrying out intravenous urography on the patient.

Treatment

She was resuscitated and had 3 units of packed cells transfused while the 4th unit of blood was discontinued due to transfusion reaction. The post-transfusion packed cell volume was 28.2% while the repeat electrolytes and urea results were within normal limits. She was reviewed by the general surgeon in view of the huge abdominal mass with possible intestinal involvement.

She had exploratory laparotomy, and abdominal total hysterectomy and bilateral salpingo-oophorectomy on the 16th August, 2011. She had 3 pints of blood transfused intra-operatively and fourth pint postoperatively. Findings at surgery were: clean peritoneum, huge solitary fibroid (with the tubes and ovaries) weighing 15kg, with estimated blood loss of 1.3 litres. The post-operative packed cell volume was 31%.

The post-operative period was satisfactory till 8th post-operative day when she complained of neck pain, relieved with methyl salicylate ointment topically. The wound stitches were removed on the 11th post-operative day. She was discharged home for subsequent follow-up at gynaecological clinic where the histology report of the surgical specimen was reviewed and was as follow:

Histopathology report (17/08/2011)

Macroscopy: received a huge hysterectomy specimen weighing 14.1kg, measures 30.4 x 30.2 x 27cm. It is ovoid in shape, the two ovaries are identified with their ipsilateral Fallopian tubes, and the cervix is neither seen nor identified.
Right ovary and tubes: weighs about 25gm
Left ovary and tube: weighs about 25gm
Uterus: cut surface shows an endometrial cavity filled with serosanguineous and muco-purulent substance and necrotic masses of tissue arising from endometrium. Estimated quantity of the substance is about 8 litres.
Microscopy: histologic section of uterine masses show interlacing fascicles of smooth muscle cells with spindle-shaped nucleic arranged in haphazard pattern. Extensive areas of hyalinization and cystic degeneration are seen. Section of the ovaries and Fallopian tubes are unremarkable.
TAH/BSO SPECIMEN: DEGENERATING UTERINE LEIOMYOMATA

Discussion

Despite the availability of many modern treatment options for fibroid, a substantial number of women in developing countries including Nigeria still seek alternative treatment options, which are not only ineffective but also cause unwarranted delay in receiving modern treatment. More worrisome is the use of corrosive native medications, which are usually prescribed to be used vaginally with subsequent vaginal fibrosis and resultant stenosis and atresia of the vagina as it occurred in this case [4]. Sexual function becomes impaired. In addition, the infertility experienced by many of these patients is made worse by dyspareunia and more often than not, cervical stenosis which are inevitable consequences of vaginal insertion of the corrosive substances [4]. The diagnosis of uterine fibroids was made from clinical findings (though not confirmed with ultrasonography) in this case. She was offered surgical treatment, but on the advice of acquaintances, opted for treatment with traditional medicine. She was given a medication which she inserted into the vagina, with the hope that the fibroids would "melt". However, the medication did not only cause vaginal stenosis but caused a delay in receiving surgical treatment with a resultant increase in the tumor size and attendant respiratory difficulty. The delay in receiving more effective modern treatment options often leads to resultant increase in tumor mass sometimes to enormous (giant) size, causing respiratory embarrassment [2].

There were at least two lessons to be learnt from this case. Firstly, the application of wrong treatment resulted in acquired gynaetresia. Secondly, the delay in treatment led to increase in tumor mass to enormous size with attendant respiratory distress and poor quality of life. The delay also denied her

possible fertility potential which she could have benefitted from if myomectomy was performed earlier.

This calls for public enlightenment on the dangers of wrong/delayed treatment of symptomatic fibroids. This can be achieved in the first instance by incorporating fibroid as part of health talk usually offered to antenatal patients during antenatal sessions as well as introducing a health talk on fibroids to gynaecological patients at gynaecological clinics. Posters on fibroids can be displayed in antenatal and gynaecological clinics. Secondly, a wider dissemination of information on fibroids can be achieved by having health talks in the print and electronic media.

Conclusion

Harmful practices in the treatment of uterine fibroid could result in disastrous consequences. Therefore, community enlightenment as regards appropriate treatment of fibroid should be undertaken to curtail the unwarranted consequences of harmful treatment.

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