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Case Report

Case Report: Management of a 39-Year-Old Female with Heavy Vaginal Bleeding, Cervical Fibroids, and Suspected Cervical Malignancy

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Abstract

This case report details the presentation, diagnostic evaluation, and management of a 39-year-old female patient with a history of heavy menstrual bleeding (HMB), irregular vaginal bleeding, and fainting episodes. The patient has a past medical history, including bipolar disorder, asthma, and iron deficiency anemia. She was admitted following a syncopal episode and ongoing menorrhagia. Imaging and histological assessments revealed large prolapsing fibroid with a suspicion of a malignancy. The patient underwent a subtotal hysterectomy and postoperatively had a wound infection, which was managed by vacuum dressing. The case underscores the challenges in diagnosing and managing atypical presentations of gynecological conditions.

Keywords: Heavy Menstrual Bleeding (HMB); Tranexamic Acid (TXA); Lower Segment Cesarean Sections (LSCS)

Introduction

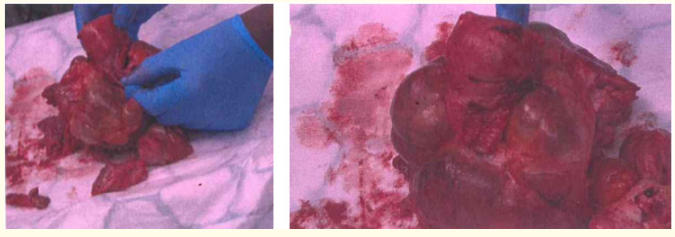
Heavy menstrual bleeding (HMB) is a common gynecological complaint that can negatively impact a patient's quality of life. When coupled with other symptoms such as fainting and chronic anemia, the clinical picture may suggest more severe underlying pathology, one of them could be uterine fibroid. This case highlights the diagnostic complexities and management strategies employed in a patient with HMB caused by a large prolapsing cervical fibroid.

Case Presentation

A 39-year-old female presented to the emergency department following a fainting episode at a supermarket. She reported a three-week history of significant vaginal bleeding, necessitating the use of 10 pads per day. The bleeding was accompanied by symptoms of anemia, for which she had been on tranexamic acid (TXA) and ferrous sulfate. The patient had a longstanding history of irregular vaginal bleeding, worsening over the last six months, and had received multiple blood transfusions (2 units of RBC in the past two months) to manage her anemia (Hemoglobin levels improved from 52 to 73 g/L following transfusion).

The patient also had a history of urinary retention managed with a long-term catheter since December 2023. She reported episodes of blood in the catheter but denied fever, chest pain, or palpitations. There was no history of hemoptysis, hematemesis, cuts, or bruises. Her past medical history included bipolar disorder, iron deficiency anemia, uterine fibroids, and previous lower segment cesarean sections (LSCS). She was allergic to erythromycin and penicillin.

On vaginal examination, a bluish, suspicious looking mass was noted. The patient had been under the care of a benign gynecology team and had undergone a hysteroscopy on January 11, 2023, which was incomplete due to inadequate tissue sampling. Histology revealed fragments of autolyzed tissue with no viable tissue for full assessment. An endometrial biopsy showed proliferative endometrium without evidence of hyperplasia or malignancy. A hysterectomy was planned, but the patient missed several appointments.

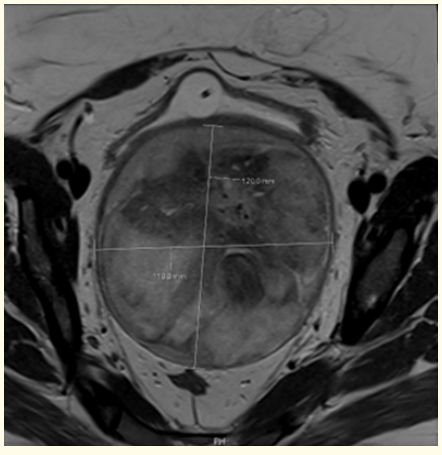


Picture 1: Specimen.

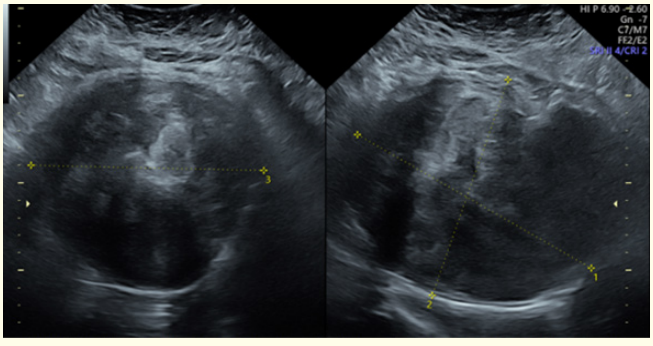
Investigations

During her hospital admission, several investigations were performed:

- **Ultrasound:** Poor quality scan due to body habitus and fibroid; large centrally located fibroid mass noted measuring 156 x 131 x 135mm, unable to visualize the endometrium.
- **CT Abdomen and Pelvis:** Demonstrated a progressive increase in the size of a heterogeneous cervical lesion. Further assessment recommended via MRI.
- **MRI:** Showed a large necrotic mass lesion exophytic into the endovaginal cavity, suspicious for cervical malignancy. Differential diagnoses included lymphoma, sarcoma, or an exophytic degenerating fibroid.
- **CT Thorax:** Multiple tiny left lung infiltrates suggestive of an infective or inflammatory process; no definite metastatic disease.
- **Histopathology:** Post-subtotal hysterectomy specimen showed benign leiomyomas of the uterus with secondary coagulative necrosis and hyaline degeneration, without evidence of malignancy.



Picture 2: MRI Images.



Picture 3: Ultrasound images.

Management

The initial management included analgesia, Tranexamic acid, norethisterone, iron supplements, and a blood transfusion. Antibiotics were administered due to infection concerns, and a unit of packed red blood cells (PRBC) was transfused. The patient underwent laparotomy and subtotal hysterectomy. Midline or Pfannenstiel incision was given. Subtotal hysterectomy was performed as the fibroid was arising from the endometrial cavity prolapsing into endocervicx and vagina. Cervix was normal and hence it was preserved. Postoperatively, she developed a wound infection, managed with VAC dressings by the Tissue Viability Nurse (TVN) team and antibiotics. The patient was subsequently discharged with plans for outpatient follow-up in 4 weeks times.

Discussion

Histologically fibroids are composed of smooth muscle and fibrous connective tissue, so named as uterine leiomyoma, myoma or fibromyoma [2]. A large prolapsing fibroid can lead to menstrual irregularities, urinary retention, urinary frequency, constipation, dyspareunia and post coital bleeding depending upon their location [3]. They give rise to greater surgical difficulty especially when they are large as they can distort anatomy [4]. The problems an-

ticipated during hysterectomy for large prolapsing fibroid are due to distortion of normal anatomy of ureter and uterine vessels and sometimes due to pulled up bladder anteriorly. Therefore, there are more chances of injury to ureter, bladder and uterine vessels [2].

Conclusion

Patients with heavy menstrual bleeding and abnormal pelvic findings require thorough investigation to rule out malignancy. In this case, a combination of imaging, histology, and surgical intervention was necessary to manage the patient's complex condition. The case highlights the importance of a multidisciplinary approach in managing gynecological malignancies and complex fibroid cases.

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