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Case Report

A Rare Case of Anterior Vaginal Wall Myoma Mimicking Gartner's Cyst

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Abstract

Myoma are the common gynecological problem, mostly occur in body of uterus, cervix and broad ligament. But vaginal leiomyoma remain a rare entity with only few hundred cases reported yet. This parous lady clinically presented like Gartner's cyst initially. The mass was excised after proper evaluation. But surprisingly, the histopathological report of excisional specimen was consistent with leiomyoma. Histopathological examination was the only confirmatory means to reach definite diagnosis. Surgery by vaginal route is modality of treatment. Post-operative period was uneventful and she was followed up at OPD without any complaints.

Keywords: Dyspareunia; Gartner's cyst; Myoma

Case Presentation

A 31 years Para 2 lady, presented to Outpatient Department (OPD) with complains of something coming out per vaginum since 1 year. Initially it was small in size which gradually increased and reached the present day size. It could be easily felt outside vagina and was causing discomfort and was non reducible. She presented with pain and dyspareunia.

Per vaginal examination revealed a mass about 2 cm below the urethra (Figure 1). On Per speculum examination, the cervix was seen separately from the mass.

Ultrasonography showed normal sized uterus and unremarkable bilateral adnexa. It mentioned anterior vaginal wall cyst, well defined hypoechoic lesion, devoid of vascularity. It was in the anterior vaginal wall just inferior to the cervix, measuring 42 mm × 31 mm × 29 mm without any connection with urethra. There was no other abnormality noted (Figure 2).

Patient was counseled for surgery and relevant investigations were performed. Consent was taken for photography and publication. Urosurgical consultation was sought.

Removal of mass was planned vaginally. A foley's catheter was introduced into the urethra to prevent any urethral injury. Mass was removed by blunt dissection. The vaginal mucosa was separated from the mass, the mass was easily enucleated. Excess vaginal mucosa was excised.

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Gross examination of the specimen revealed 4 cm × 4 cm, firm solid mass, with smooth outline. And cut section showed whorled appearance (Figure 3).

The excisional specimen was sent for Histopathologial Examination (HPE). Histopathology report was consistent with leiomyoma.

Microscopy revealed encapsulated tumor composed of interlacing bundles of smooth muscle cells with elongated nuclei and acidophilic fibrillary cytoplasm with foci of myxoid areas with interspersed acute and chronic inflammatory infiltrates and blood vessels (Figure 4).

Postoperative period was uneventful and she was discharged on 2nd postoperative day. On 9th post operative day, patient followed up at OPD with no complaints.

Discussion

Vaginal leiomyoma remain an uncommon entity with only about 300 cases reported in world literature [1]. It was first detected in 1733 by Denys de Leyden. Bennett and Erlich found only nine cases in 50,000 surgical specimens and only one case in 15,000 autopsies reviewed at Johns Hopkins Hospital [2]. Leiomyoma in female genital tract are common in the uterus and to some extent in the cervix followed by the round ligament, utero-sacral ligament, ovary, and inguinal canal [1]. Occurrence in vagina is very rare.

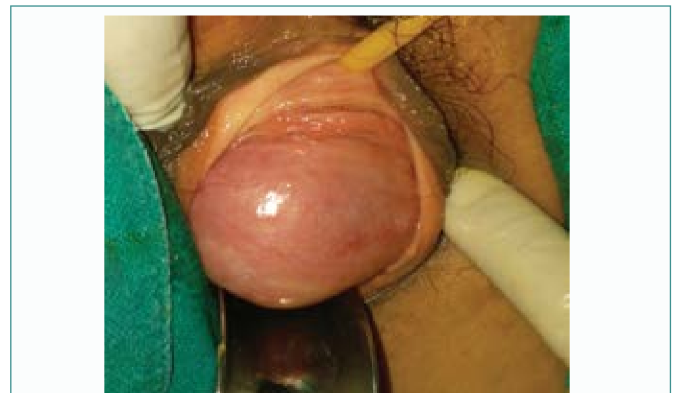

Figure 1: Per speculum examination.

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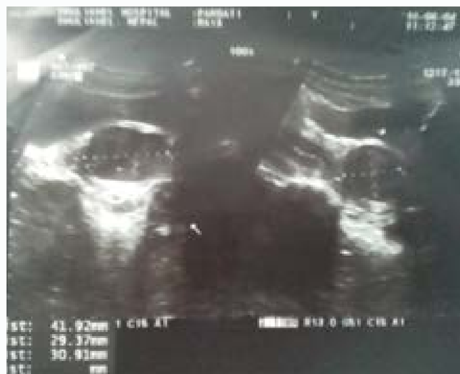

Figure 2: Ultrasonographic findings.

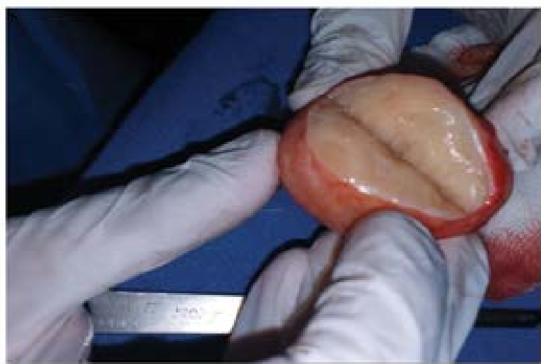

Figure 3: Cut section of excisional mass.

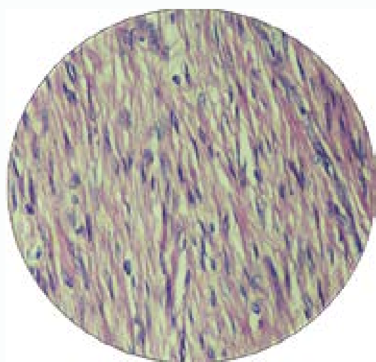

Figure 4: Microscopic appearance of excisional mass (40X).

They are slowly growing, and generally asymptomatic, but may give rise to cyclic urinary [3-5] retention, dyspareunia [6,7], gluteal swelling with vaginal purulent discharge, obstruction in birth passage if along with pregnancy [7], or simply a feeling of mass in vagina [4,6,7].

Preoperative diagnosis by ultrasound may be difficult and may need MRI. In magnetic resonance imaging, they appear as well-demarcated solid masses of low signal intensity in T1 and T2 weighted images, with homogenous contrast enhancement, while leiomyosarcoma and other vaginal malignancies show characteristic high T2 signal intensity with irregular and heterogeneous areas of necrosis or hemorrhage [8,9]. However, histopathological confirmation is the gold standard of diagnosis and also beneficial to rule out any possible focus of malignancy.

Surgery by vaginal route is modality of treatment taking in care of urethral injuries [6,7,10]. Cases of large tumors may require abdominoperineal approach [5,7,11]. Follow up are required for chances of recurrence.

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