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Case Report

Large Pedunculated Submucosal Fibroid Delivered Through the Cervix

Diassana Mahamadou[1,7]*, Macalou Ballan[1,7], Dembele Sitapha[1,7], Sidibe Alima[2], Goita Lassina[3,7], Diarra Samou[4,7], Dao Seydou Z[9,7], Haidara Mamadou[5,7], Kane Famakan[6,7], Camara Fantamady[8], Traore Soumaila[10,7]

[1]Department of Gynecology and Obstetrics of the Fousseyni Daou Hospital in Kayes, Mali
[2]Kayes Reference Health Center, Mali
[3]Anesthesia and Intensive Care Department of the Fousseyni Daou Hospital in Kayes, Mali
[4]Management of Fousseyni DAOU Hospital, Mali
[5]Kalabancoro Reference Health Center, Mali
[6]Bla Reference Health Center, Mali
[7]National Center for Scientific and Technological Research of Bamako, Mali
[8]Kayes Regional Health Directorate, Mali
[9]Reference Health Center of the Commune II, Mali
[10]Gynecology and Obstetrics Department of Sikasso Hospital, Mali

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***Corresponding author:** Diassana Mahamadou
Department of Gynecology and Obstetrics of the Fousseyni Daou Hospital in Kayes, Mali

Abstract

Fibrous polyp: it is a fibroid, endocavitary, pedunculated and delivered through the uterine cervix with a pedicle arising from the uterine fundus or one of the walls of the uterine cavity. Their treatment is surgical and requires skill and a suitable technical platform. To our knowledge, no cases have been published in Mali. We report a fibrous polyp occurring in a 41-year-old patient, multi-gesture 5th procedure 5th parous with 5 living children, evacuated from a community health center located 60 km away, who presented episodes of metrorrhagia. The gynecological examination shows the presence of a "fibroid" delivered through the cervix. She was surgically managed vaginally for lumpectomy. It was a mass composed histologically of uterine leiomyofibroma remodeled by inflammation.

Keywords: Fibrous polyp, delivered through the cervix, Kayes (Mali).

INTRODUCTION

Fibrous polyp: it is a fibroid, endocavitary, pedunculated and delivered by the cervix with a pedicle arising from the uterine fundus or one of the walls of the uterine cavity. It can sometimes reach 5-6 cm or more. Sphacele delivered by the cervix: the sphacele is a piece of necrotic tissue. Sometimes, certain pedunculated tumors evolving in the uterine cavity can, under the effect of uterine contractions, be partially expelled outside the uterine cavity towards the vagina; then the extension of its pedicle and its exposure to the infection favored by its presence in a non-sterile environment which is the vagina, lead to its necrosis (it is said to be sphacelate). Uterine sphaceles are often endocavitary fibroids (uterine submucosal), pedunculated and delivered by the cervix, but they can also be large pedunculated polyps [1]. The endometrial polyp: results from a localized hyperplasia of the endometrial mucosa, that is to say a focal growth of the glands and stroma around one or more spiral arterioles with thick walls resulting in the formation of a protruding, pedunculated mass, which can dilate the uterine cavity and sometimes occupy it entirely and protrude through the cervix into the vagina. The endometrial polyp is a sign of hormonal imbalance (dysovulation, hyperestrogenism, luteal insufficiency, etc.). This imbalance is the cause of several phenomena that can give rise to the polyp. These phenomena are: the absence of monthly cyclical involution of the spiral arterioles of the endometrium; the loss of progesterone receptors and the persistence of estrogen receptors. The frequency of endometrial polyps is around 6% of curettages and uterine surgical specimens. The age of onset is between 12 and 81 years with a maximum between 30 and 59 years. Clinically, the endometrial polyp can manifest itself by

metrorrhagia, menorrhagia, leukorrhea, but it can remain latent, asymptomatic and discovered fortuitously during hysterosalpingography, hysteroscopy and ultrasound, or during a gynecological examination in the event of protrusion through the cervix. Its size is less than 0.5 cm up to 12 cm, but on average, it measures 2 to 3 cm, often solitary, multiple in 22% of cases; pedunculated or sessile (wide implantation base); its location is most often in the bottom of the uterine cavity, but all endometrial locations are possible including the uterine isthmus; of soft consistency, but in some cases, it can be firm simulating leiomyomas (fibroids), uterine endocavitary fibrous polyp, benign. Histologically we find a connective stroma occupied in its center by one or more arterioles with thickened walls; the surface is covered by a glandular endometrial mucosa (sometimes in simple secretory phase). The endometrial polyp can be the focal site of a simple or complex endometrial hyperplasia with sometimes cytological atypia. The endometrial polyp can be isolated, or associated with other abnormalities such as adenomyosis, fibroids Mucous endometrial polyp, benign on myomatous uterus (associated hydrorrhea) and endometrial hyperplasia without or with atypia; Adenocarcinoma is seen in 0.36–0.55% of cases. Endometroid adenocarcinoma of the endometrium may take the form of exophytic endometrial polyps projecting into the uterine cavity [2-4].

PATIENT AND OBSERVATION

Mrs. K S, aged 41, married, housewife, multiparous 5th procedure 5th parous with 5 living children (last child at 15 months), evacuated from a community health center located 60 km away, who presented episodes of metrorrhagia (hypermenorrhea) which motivated treatments in rural structures without success. The current episode dates back to January 4, 2025 marked by pelvic pain and vomiting followed by protrusion of a mass between the thighs.

Image 1: Large pedunculated submucosal fibroid delivered through the cervix

On admission on January 9, 2025, on physical examination, the general condition was preserved but with slight pallor and asthenia, the facies was infectious. The temperature was 38.5 degrees Celsius, the pulse 94 beats per minute, the blood pressure 90/66 millimeters of mercury and the respiratory rate 24 cycles per minute. The abdomen was soft and painless. Hydro-aeric sounds were present. The gynecological examination revealed on inspection a large mass exteriorized to the vulva resembling a polyp delivered through the cervix or a uterine inversion (Image 1). Given this picture, she was conditioned for surgery. She is blood group O, rhesus positive. The surgical management by the lower route consisted of an excision (lumpectomy) with an electric scalpel at the base of the fibrous pedicle (Image 2); under local anesthesia and a blood transfusion of 500 milliliters of whole blood iso-group and iso-rhesus O rhesus positive on a hemoglobin level of 9 grams/deciliter, under antibiotic therapy.

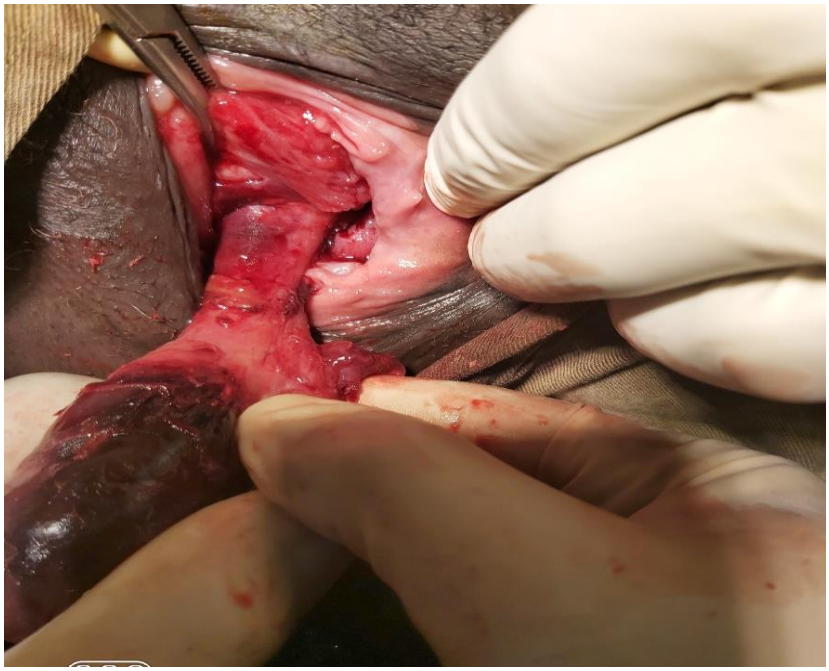


Image 2: Visualization of the fibrous pedicle

Image 3: Appearance of the vagina after vaginal excision of the pedunculated submucous fibroid

It was a mass composed histologically of uterine leiomyofibroma remodeled by inflammation (fasciculated tumor proliferation made of leiomyocytes and fibroblasts without atypia, elsewhere it is an inflammatory infiltrate made of lymphoplasmocytes and polymorphonuclear neutrophils with sometimes congested vessels and hemorrhage). Hemostasis was satisfactory at the end of the operation (Image 3). The postoperative course was simple. The surgical specimen (Image 4) sent for anatomo-pathological examination gave the histological nature of the mass (Image 5).

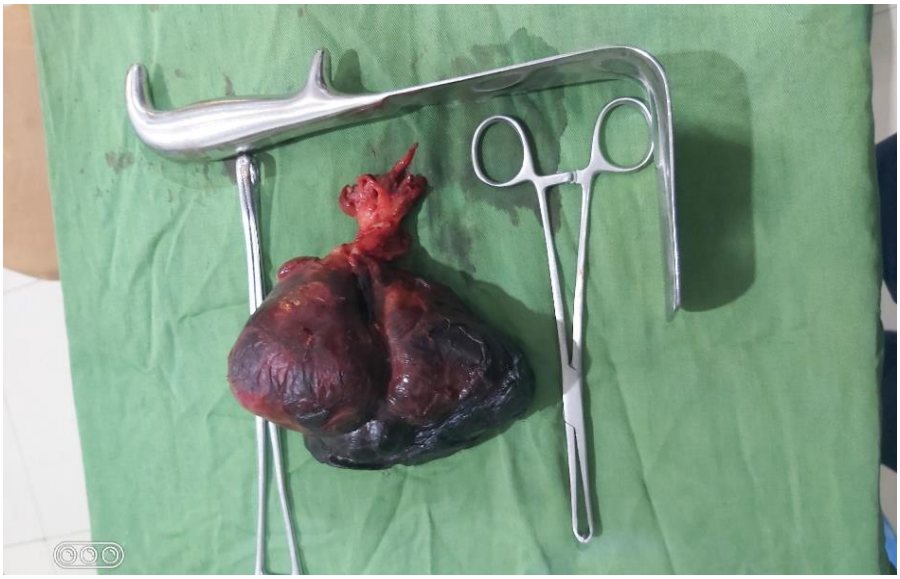
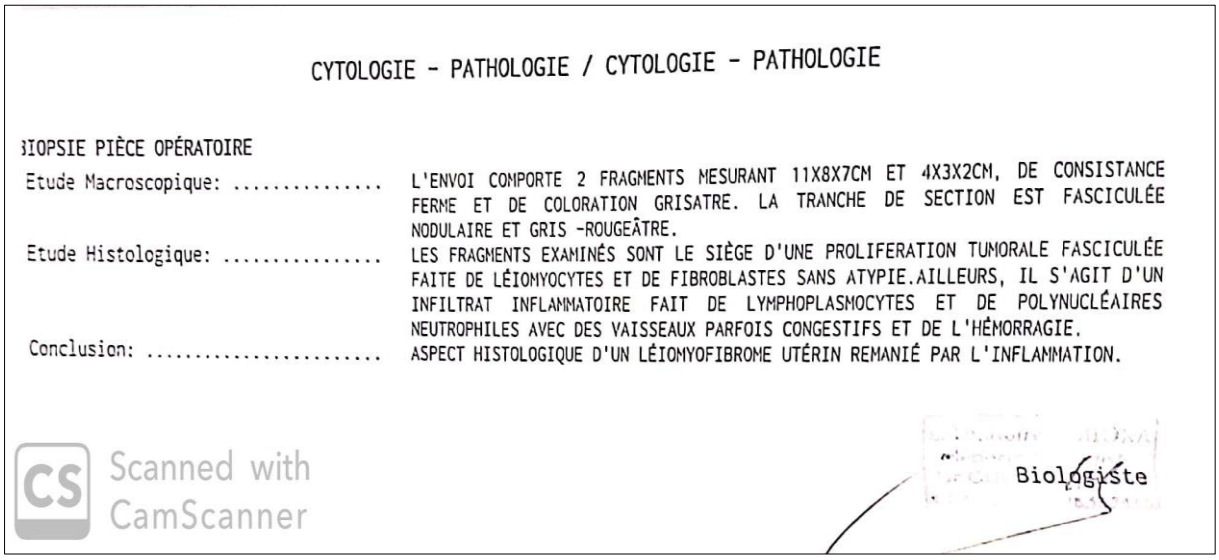


Image 4: Surgical specimen of the pedunculated submucous fibroid after excision



CYTOLOGIE - PATHOLOGIE / CYTOLOGIE - PATHOLOGIE

BIOPSIE PIÈCE OPÉRATOIRE

Etude Macroscopique: ..... L'ENVOI COMPORTE 2 FRAGMENTS MESURANT 11X8X7CM ET 4X3X2CM, DE CONSISTANCE FERME ET DE COLORATION GRISATRE. LA TRANCHE DE SECTION EST FASCICULÉE NODULAIRE ET GRIS -ROUGEÂTRE.

Etude Histologique: ..... LES FRAGMENTS EXAMINÉS SONT LE SIÈGE D'UNE PROLIFERATION TUMORALE FASCICULÉE FAITE DE LÉIOMYOCYTES ET DE FIBROBLASTES SANS ATYPIE.AILLEURS, IL S'AGIT D'UN INFILTRAT INFLAMMATOIRE FAIT DE LYMPHOPLASMOCYTES ET DE POLYNUCLÉAIRES NEUTROPHILES AVEC DES VAISSEAUX PARFOIS CONGESTIFS ET DE L'HÉMORRAGIE.

Conclusion: ..... ASPECT HISTOLOGIQUE D'UN LÉIOMYOFIBROME UTÉRIN REMANIÉ PAR L'INFLAMMATION.

Biologiste

Image 5: Result of the histology of the surgical specimen (uterine leiomyofibroma remodeled by inflammation)

DISCUSSION

Uterine polyp is a focal hypertrophy of the endometrium containing glands, stroma and vessels. It can be mucous or fibrous, sessile or pedunculated, single or multiple, and of variable size. Its frequency is 10-15 to 50% of women with bleeding, 10 to 30% of infertile women and 6 to 36% in postmenopause. It is estimated that approximately 30% of uterine polyps of less than 1cm regress spontaneously in 1 year during the period of genital activity. The main clinical sign is metrorrhagia, more than menorrhagia. The diagnosis is made visually after if the polyp is delivered by the cervix [5]. In our patient, the gynecological examination revealed a large mass exteriorized to the vulva resembling a polyp delivered through the cervix or a uterine inversion (Image 1). The etiology of uterine polyps is multifactorial. They are estrogen-dependent but also resistant to the effect of progesterone (by modification of their progesterone receptors). Thus, obesity, a long genital life and estrogen agonists (such as tamoxifen) promote the occurrence of uterine polyps. Within the polyp there is a decrease in apoptosis [5]. Regarding the case described in this observation, she was not obese and was not taking any medication based on estrogen or tamoxifen. As reported in the literature, the clinical picture in our patient was dominated by episodes of metrorrhagia (hypermenorrhea) which led to treatments in rural structures without success. The current episode dates back to January 4, 2025, marked by pelvic pain and vomiting followed by protrusion of a mass between the thighs. The treatment consisted of a polypectomy (excision) with an electric scalpel at the base of the fibrous pedicle; under locoregional anesthesia as well as a blood transfusion and antibiotic therapy. The literature review reports several histological types of uterine polyp *(telangiectatic polyp "rich in dilated vessels", polyp of the matron "fibrous stroma", adenomyomatous polyp or pedunculated adenomyoma of Hertig and Gore,*

placental polyp, decidual polyp "retention of the decidua", endocervical polypoid pedunculated fibroma "myoma" [2, 6]; ours came in favor of uterine leiomyofibroma reworked by inflammation (fasciculated tumor proliferation made of leiomyocytes and fibroblasts without atypia, elsewhere it is an inflammatory infiltrate made of lymphoplasmocytes and polymorphonuclear neutrophils with sometimes congested vessels and hemorrhage) (Image 5). The postoperative course was simple.

CONCLUSION

Uterine leiomyofibroma is a rare entity that occurs most often in peri- or post-menopausal women. When it is externalized to the vulva, clinically it can be confused with uterine inversion. Uterine leiomyofibroma is a benign tumor and must be differentiated from more severe lesions including fibrosarcomas.

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