Case report

Acute urinary retention due to huge cervical myoma with abdomino-vaginal extensions

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Abstract: We happened to manage a case of acute urinary retention that was relieved by drainage of 2L of urine and was sent home to attend out patient Gynecology department next day after the ultrasound diagnosis of huge myoma. This came out to be cervical myoma that filled the vagina pushing the uterus up to the level of the umbilicus.

This is in reference to the general interest of everybody that any woman suffering acute urinary retention having gynecological bearing must be well evaluated before disposing them without inserting indwelling catheter.

Key words: acute urinary retention in gynaecolgy, cervical myoma

Introduction

Acute urinary retention often is an obstetric problem.[1] It is usually a problem of retroverted gravid uterus sometimes worsened by the presence of uterovaginal prolapse.[2] The latter condition could be a sole cause when it is associated with cystolithiasis in prolapsed incarcerated uterus in infectious background.[3] Apart from this, a huge collection in vagina, uterus or both from any causes is likely to produce urinary retention. Examples that can be cited are hydrocolpos, hematocolpos and pyomatra. [4-6] It may be a rarity, but at times, ovarian tumors deeply incarcerated into the pouch of Douglas by displacing the bladder neck and the uterine cervix in the anterocephalad direction have been found to cause urinary retention.[9,10] Same phenomenon can be acknowledged in a case of myoma arising from posterior lower uterine segment resulting bladder outlet obstruction.[11,12]

This case report intends to rememorize the etiologies of preoperative acute urinary retention met in gynecological practices, this case being an addition.

Case

A rural woman in the reproductive age in her early forties (43yrs) and low parity, ($P_{1;}$ para one) suffering from 4 episodes of acute urinary retention in the last 1½ years before, came with the same problem in the Emergency Unit of our hospital. She received same pattern of care that is immediate release of 2L urine, being told to attend the Gynecological Outpatient Department the next day. In the following morning, moderate anemia (8.3 gm% Hb) was noted. There was huge abdominal mass extending up to the umbilicus as well as protruding down into the vagina, short of introitus by 2 cms. She was admitted the same day and was readied for elective hysterectomy by transfusing four units of blood. Preoperative CT showed the huge mass underlying the lower portion of a small uterus (4cm x3 cm) that appeared exactly the same on opening the abdomen by lower midline incision, by the look of a small uterus surmounting huge cervical myoma *(Fig. 1)*.

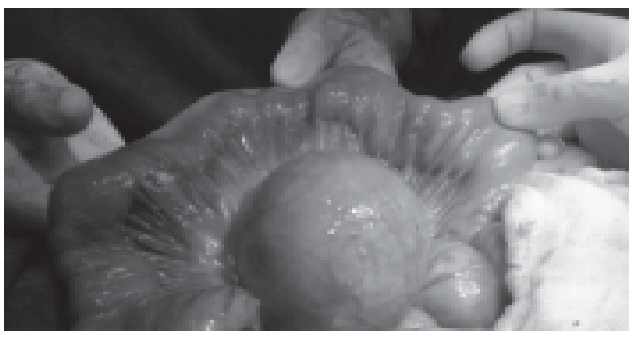

Fig. 1. The growth arising from the lower part of uterus (cervix)

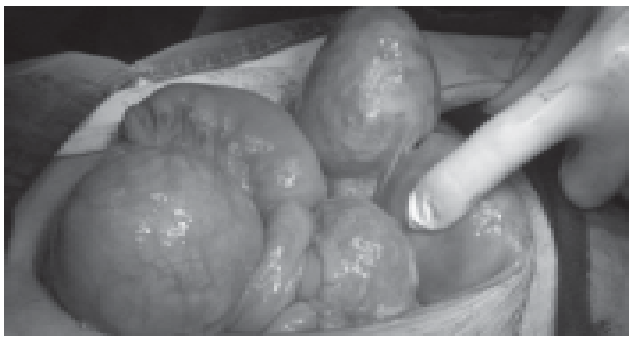

Fig 2. Polypoidal protrusion the myoma was tightly squeezed between sacral promontory and pubic bones, somewhat fixed towards the left side.

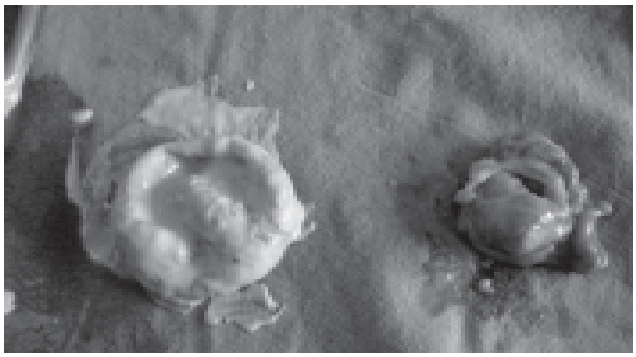

Fig. 3.

As in routine procedure, bilateral round ligaments, infundibulopelvic ligament were ligated and then cut. The bladder was pushed way below after cutting the pubovesical fold of peritoneum. The uterine arteries were ligated on either side, so were the Mackenrodts. A vertical cut inflicted below the level of the uterus helped to trace vagina which guided the application of curved artery forceps sequentially placed transversely through the opening all around. This eased us, in bringing out the cervical myoma from below, arising from posterior aspect of cervix. Uterus (4x3cms) along with cervical myoma (13x9x8 cms) was delivered out in toto (Fig. 3). Then the vaginal vault was reefed and pelvic peritonisation accomplished, keeping the entire pedicles extra peritoneal. The blood loss of 300ml; therefore one unit of blood was transfused intraoperatively. Urine was clear at the end of surgery.

Discussion

This case reported thus with an intention to disseminate the fact that a huge myoma arising from the cervix can be a cause of urinary retention in women of reproductive age. This case also indicates the importance of simple vaginal examination which can reveal findings of such a huge myoma almost filling the whole vagina even to an inexpert. Considering the painful nature of the condition, it must be realized that one and every women with pathology accountable for urinary retention must not be dismissed without an indwelling catheter as there is chance of retention any time giving similar emergency.

This lady was drained of the urine in several places but never once had a vaginal examination, not even in our hospital Emergency unit. Neither, she had been explained that she needs to see a specialist. Had she not developed retention when she came to visit her sister in Kathmandu, no one knows for how long she would have suffered from intermittent episodes of acute urinary retention. In her misery from acute urinary retention provoked by pelvic congestion usually arising during pre-menstrual period (this time just following period); all other symptoms like vaginal discharge, spasmodic dysmenorrhea and menorrhagia seemed trivial.

Conclusion

In any women of reproductive age group presenting with acute urinary retention the possibility of cervical myoma with bidirectional abdomino-vaginal extension may be remembered as an etiological predisposition, so that optimal care may be provided.

Very mobile mesenteric cyst like ours has been described in the literature, one of them was observed to changing its position during hospitalization. [6,7]

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