Case Study: The Elusive Vaginal Leiomyoma

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HPI: 31yo G3P3 with AUB-L and HMB. Previously tried OCPs, Lystedia, LNG-IUD without improvement. Also with significant dysmenorrhea

PMH: Obesity, OSA, Migraines without aura, Anxiety, Mild persistent asthma, GERD

Exam: Normal external genitalia and vagina, cervix nulliparous. Bimanual: 3-4cm mass palpated just anterior to cervix with moderate tenderness, uterus anteverted and approximately 7wk in size, no adnexal masses or tenderness

Labs: Hgb 11.9

Imaging:
CT - right hypodense adnexal lesion measuring 3.6cm
TVUS - uterus normal in size, unable to see hypodense mass seen on CT scan
MRI - 4cm mass in region of right-anterior cervix and right vaginal fornix c/w cervical or vaginal leiomyoma

Proceeded with LAVH, bilateral salpingectomy, cystoscopy

Operative Report Findings:
1. Slightly enlarged globular uterus without obvious evidence of fibroids on laparoscopy
2. 2-3 gunpowder lesions noted in posterior cul de sac c/w endometriosis
3. Extensive vesicouterine adhesions noted
4. Approx 2cm abdominal wall hernia at the umbilicus with omental adhesions to anterior abdominal wall at this hernia
5. Normal-appearing bilateral fallopian tubes
6. Left ovary with 1cm simple-appearing cyst, otherwise normal appearing. Normal-appearing right ovary
7. On vaginal exam, fullness noted in right vaginal fornix after removal of uterus - c/w what appeared to be a fibroid on imaging. On excision of this mass, appearance c/w leiomyoma

Pathology: Uterus 156g, benign cervix and endometrium, uterus with 0.6cm benign leiomyoma and no evidence of endometriosis or adenomyosis. Benign fallopian tubes. Vaginal mass c/w benign leiomyoma

Vaginal Leiomyomas:
Vaginal leiomyomas are rare and only about 300 cases have been reported in the literature. These benign tumors typically occur in females aged 30-50, most often appear on the anterior vaginal wall and are often asymptomatic. Given the rarity, they can often be mistaken for other masses such as cervical leiomyomas, vaginal cysts, or cytostome to name a few. Their final diagnosis is made by histopathology but pre-operative imaging and examination are key.

References

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