Postmenopausal Bleeding in A 60-Year-old Woman by Uterine Fibroids

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ABSTRACT

Uterine fibroid or leiomyoma is the most common benign uterine tumor which affects mostly women in reproductive age. However, its occurrence after menopause is very rare as the growth of a fibroid depends on the hormone of estrogen. There are several risk factors including nulliparity, obesity, black race, family history, and hypertension. Therefore, fibroid degeneration is rare after menopause. We are reporting a case of a post-menopausal woman of 60-year-old, menopausal for 10 years, with a history of bleeding for 2 years for whom the gynecological exam revealed a cervical budding lesion hypervascularized for which a previous cervico-vaginal smear revealed no suspicious cells. Then a biopsy was performed and also devoid of malignancy signs. The ultrasound has identified two fibroids classified 2-5 for the first corporeal-fundal myoma about 50/55 mm (myoma or sarcoma?) and a corporeal posterior myoma type 2 about 40/30 mm repressing the endometrium (8,5mm). The eventual diagnosis of sarcoma was not excluded till then. The RMI has not been realized. A total hysterectomy with bilateral adnexectomy was performed focusing on the two fibroids, and the histopathological, report confirmed the leiomyoma tumor diagnosis. Even if the fibroid degeneration is rare after the menopause, the association in this case with the cervical lesion and bleeding especially at the age of 60 had not absolved the malignancy till the last histopathological confirmation.

Keywords: uterine fibroid, leiomyoma, post menopause, bleeding, cervix

1. INTRODUCTION

Uterine fibroid or leiomyoma is one of the common tumors in women of reproductive age with an estimated incidence of 20%-40% \(^\text{(7,8)}\). The growth of the tumor is estrogen dependent \(^\text{(1)}\). Consequently, fibroids appear after menarche and reduce in size after menopause or after a course of GnRH agonists \(^\text{(2)}\). The enlargement of the fibroid in the post-menopausal age is rare, and it is considered as a potential malignancy symptom into the leiomyosarcoma which should not be excluded until histopathologically proven diagnosis. Fibroids continue likely to grow slowly as long as a patient still has menstruations. The gold standard diagnosis exam for uterine fibroids seems to be gray-scale ultrasonography, with magnetic resonance imaging being a close second option in complex clinical circumstances. The management of uterine fibroids can be approached medi-cally, surgically, and even by minimal access techniques. Actually, uterine artery embolization is well-recognized as a uterine-sparing (fertility-preserving) method of treating fibroids.

2. CASE REPORT

Mrs. N.F, a 60-year-old, menopausal for 10 years, menarche at the age of 13 years with regular menstruation subsequently, G3P2, 2 vaginal deliveries and 1 spontaneous abortum. She did not have any positive medical or surgical past history, family history too, or allergy history. She was not known to have ingested any medication, alcohol nor smoked cigarettes or illicit drugs. She was in a monogamous relationship with her husband.

No previous history of surgery. She has been complaining of postmenopausal minor bleeding of 2 years duration. There was no abdominal pain, bowel symptoms, contact bleeding, abnormal vaginal discharge, anorexia, weight loss, or urinary complaints.

The physical examination revealed an elderly woman afebrile, anicteric, a little pale, in no distress. Her height and weight were respectively 150 cm and 89 kg, with a body mass index (BMI) of 39.55 kg/m². Her blood pressure was 130/80 mm Hg; pulse rate was 80/min, respiratory rate was 20/min. The chest radiography was normal. The pelvic examination revealed an aspired uterine cervix with a polyp located at the axe of 03h hypervascularized and minor vaginal bleeding. The vaginal touch associated to the abdominal palpation revealed the top of the uterus above the pubic bone about two fingers-width. The patient had benefited from a cervicovaginal smear which was devoid of suspicious cells. The polyp has been biopsied, and the histopathological report revealed no malignancy signs. Endovaginal ultrasound revealed an enlarged uterus with regular contours, dented at the anterior corporeal-fundus level, heterogeneous echo structure by the presence of 2 large masses: one anterior hypoechoic heterogeneous of 50/55 mm (large fibroid type 2-5), the other is Posterior corporeal of 40/30 mm in contact with the endometrium (measuring 8.5 mm) which was repressed, ovaries were not seen, absence of adnexal mass. The magnetic resonance imaging was not realized. The patient has been fully informed of hysterectomy, and she requested it. A total hysterectomy with bilateral adnexectomy was performed by laparotomy, and the histopathological report confirmed the diagnosis of 2 fibroids which have been responsible for the bleeding (Fig 1 + Fig 2).

Fig 1 + Fig 2: Uterus after hysterectomy halved through the antero- fundal myoma (1+2) of 5 cm and showing the second posterior fibroid (3) repressing the uterine cavity (4).

3. DISCUSSION

Uterine leiomyomas or fibroids are the most common uterine tumors. They are estrogen dependent (1). Thus, they rarely appear before menarche (11) and they regress after the menopause (4), in the absence of postmenopausal estrogen replacement therapy (3). The incidence of fibroids after the menopause is not lower than the premenopausal incidence, though postmenopausal leiomyomas are smaller and fewer (4).

Uterine fibroids are benign, present in 20% to 30% of women, with clinical manifestations in women over 30 years old of age (5,6). They are considered as monoclonal tumors of the uterine smooth muscle cells containing a large rate of extracellular matrix composed of collagen, fibronectin, and proteoglycan (9,10). Fibroid degeneration in a postmenopausal woman is extremely rare (12,13). They are classified by their location relative to the uterus layers (as subserous, intramural, or submucous) and may be single or multiple. Often asymptomatic, fibroids may be a source of multiple symptoms including abnormal uterine bleeding, pelvic pressure, urinary retention or incontinence, and even pain. Also, their existence can lead to infertility and...
miscarriage\(^{(14)}\). The reported symptoms are important to decide on the appropriate treatment. To define the adequate strategy, we rely on the severity of the symptoms, the accurate location and size of the leiomyoma/leiomyomas, the patient’s age, the proximity to menopause, and the desire of fertility\(^{(15)}\). The accurate mapping of uterine fibroids including location, size, characterization and number of myomas is based on sonography, saline-infusion-sonography, and MRI. Thus, this mapping assessment permits to select patients for medical therapy, non-invasive procedures or surgery\(^{(10)}\). Hysterectomy is the definitive procedure with a good outcome and ensures complete stopping of periods with no risk of fibroid recurrence. Hysterectomy can be realized through the classical abdominal, vaginal, or laparoscopic (total or assisted vaginal) procedure. Each method has advantages and disadvantages\(^{(16)}\).

4. CONCLUSION

Fibroids or leiomyomas are commonly benign tumors which occur essentially in women of reproductive age and rarely before menarche or after menopause. Their symptoms may be several as well as bleeding which is considered as a warning signal. The caregivers should always be aware from malignancy, especially in postmenopause. The diagnosis is mostly based on gray-scale ultrasonography, which is actually supported by others as MRI. The surgical procedure is still the approach especially on post-menopausal women by myomectomy or hysterectomy. Nowadays, women who want to preserve uterus and fertility could benefit from vascular embolization and novel techniques. Finally, only the histopathological report may relieve the uterus from any malignancy.

ACKNOWLEDGMENTS

Authors have no potential conflict of interest regarding the publication of this paper.

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