

## An Unusual Case of Huge Cervical Fibroid with Tubercular Aortic Nodes in Case of Aortic Occlusion

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**Abstract**

*We report a 29-year-old female who had coexistence of huge cervical fibroid with aortic nodes of tubercular origin with aortic occlusion due to chronic thrombus of lower abdominal aorta.*

**Keywords:** Fibroid Uterus, Malignant/Tubercular Aortic Node, Aortic Occlusion, Chronic Thrombus of Lower Abdominal Aorta with Collaterals.

**1. Introduction**

Herein, we report a case of 29-year-old woman who presented the symptoms of frequency of urination and burning urination since 10 days she also complained of abdominal pain since 15 – 20 days H/O exhaustion after work and pain in legs after walking since 1-month examination showed pallor, no edema feet respiratory system was clear and cardiovascular system was normal on per abdominal examination mobile pelvic mass felt.

On pervaginal examination 10 x 12 cm mobile mass felt in pouch of douglus and Rt adenexa.

Lab reports were done – HB 14gm/dl W.B.C -10,800

Urine Analysis: - Ketones+ Occult Blood +++ Pus Cells 20-25/HPF RBC 50-55/HPF EC 8-10/HPF Bacteria+ HIV, HBSAG, HCV was Negative LFT and KFT was normal To r/o malignancy I/v/o aortic nodes Ca 125 done which was normal X-ray chest – Normal ECG –Normal USG –Left adnexal Solid hyperechoic mass lesion 10 x 8 cm MRI was done to find the size of and nature of adnexal mass to our surprise we found large aortic thrombus with collaterals.

**2. MRI Report**

Large well defined homogeneously enhancing soft tissue lesion seen in the left adnexa. Lesion causes mass effect in the form of displacement of the uterus anteriorly and to the right side. Lesion also displaces the left ovary anterosuperiorly. Lesion indents the left lower ureter laterally without significant proximal

hydroureteronephrosis. Findings represent left adnexal subserosal /broad ligament fibroid.

Multiple varying size hypo enhancing lymph nodes are seen in the retro peritoneum involving the portacaval, pre Para aortic, aorticaval, precaval as well as long the bilateral iliac vessels. Some of the lymph nodes show calcific foci within. Findings represent active infective etiology such as Koch's with partial healing. Suggest clinico-labatory correlation.

High grade /complete luminal occlusion with narrow caliber seen evolving the lower abdominal aorta from below the level of the origin of the renal arteries up to the bifurcation. The inferior mesenteric artery is not visualized- concerning for high grade/ near complete occlusion. Re-canalization by collateral circulation of bilateral common iliac vessels with mildly reduced caliber and normal opacification of the contrast. Findings represent chronic thrombosis of the lower abdominal aorta as described.

Physician opinion, 2D echo, was normal. Further hematologist opinion done i/v/o aortic arteritis case was diagnosed to be aortic takayasu arteries and further investigations were done. It was put on ecosprin 75 mg by hematologist which was shifted preop heparin.

Electrolytes :- Sodium – 139.30 Normal ; Potassium – 2.96 ; Chloride -98.60 Normal ; Protein- 7.00 Normal ; Albumin -3.30 ; Globulin -3.70 A/G ratio – 0.89

Pro-BNP (N-terminal pro brain natriuretic peptide) -Observed value is 85.81: units- pg/ml Bleeding Time (BT)-Normal, Clotting Time (CT)- Normal

Prothrombin Time Test – 14.0; Mean Normal Prothrombin Test – 14.0; Prothrombin Ratio – 1.00; Prothrombin Index – 100.0; INR – 1.00

Beta-2-Glycoprotein 1 –IgM: NEGATIVE

Beta -2-Glycoprotein 1 –IgG: NEGATIVE

Cardiolipin AntibodyACL –IgM: NEGATIVE

Cardiolipin AntibodyACL –IgG: NEGATIVE

Protein C Activity – 87%

Protein S Activity - <8%

Protein S Antigen – 81 %

Anti-Thrombin III Activity – 110 %

Anti-Thrombin III Antigen, plasma –94 %

ACPR-132.6 sec

Protein C Antigen- 94.14%

LAC- Absent

DRVV Screen – Normal

aPTTSL- Decrease

Factor VIII Activity – 109 %

Homocysteine – 16.78

Factor V Leiden, Mutant Detection – Negative

PET CEET was done to rule out other arterial involvement

There is significant narrowing of infrarenal abdominal Aorta (Maximum Diameter – 6mm) and bilateral common iliac arteries. There is significant narrowing of the inferior mesenteric artery. Increased FDG uptake in multiple retrocausal, aortocaval and left paraaortic nodes, largest measuring 2.8x2.7cm, SUV max 3.61 in aortocaval node.

### 3. Pelvis

Uterus appears normal.

Large non-FDG avid left adnexal lesion measuring 7x 8.5x 9 cm seen.

Urinary bladder appears partially distended.

Increased FDG uptake in bilateral in common iliac, right internal iliac and right external iliac nodes, largest Measuring 1.3x2cm, SUV max 8.33 in right external iliac region. Rest of the whole body scan appears unremarkable and shows physiological tracer distribution.

CT Aortogram with contrast was done – Mild (about 30 %) short segment luminal narrowing seen involving the abdominal aorta below the level of the origin of the superior mesenteric artery High Grade (about 80%)short segment luminal narrowing seen involving the infrarenal abdominal aorta Complete luminal occlusion with narrow caliber seen involving long segment of rest of the lower abdominal aorta up to the level of aortic bifurcation. re-canalization by collateral circulation of bilateral common iliac vessels with mildly reduced caliber and normal opacification of

the contrast. Rest of the distal external and internal iliac vessels appear remarkable Complete occlusion with narrow caliber seen involving short segment of inferior mesenteric artery at its origin. Recanalization by collateral circulation with normal caliber seen involving the rest of the inferior mesenteric artery and its branches.

Large well defined homogeneously enhancing soft tissue lesion seen in the left adnexa. Lesion causes mass effect in the form of displacement of the uterus anteriorly and to the right side. Lesion also displaces the left ovary anterosuperiorly . Lesion indents the left lower ureter laterally without significant proximal hydroureteronephrosis. Findings represent left adnexal subsersosal /broad ligament uterine fibroid.

Small corpus luteal cyst seen in the left ovary.

Multiple varying sized hypo enhancing lymph nodes are seen in the retroperitoneum involving the portacaval, pre paraaortic, aortocaval, precaval as well as the bilateral iliac vessels. Some of the lymph nodes show calcific foci within. Above findings are concerning for infective etiology such as Koch's partial healing.

### 4. Mild hepatomegaly

Focal cortical scarring seen along the posterior aspect of the upper pole of the left kidney.

### Images Showing Aortic Occlusion



**Figure 1:** showing aortic occlusion on aortogram [original aortogram picture of patient]

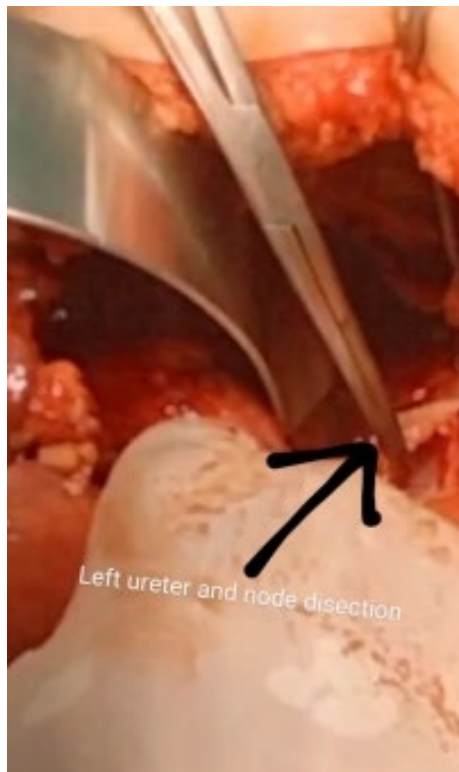
Case was decided to open up with oncosurgeon and urosurgeon standby with team of anesthetist i/v/o lymph node dissection and? ureteric involvement. High risk consent and hysterectomy consent and need of ICU i/v/o TIA or Coronary angina.

Wertheims was done leaving right ovary in situ . pelvic node dissection was done Intraoperative frozen section adnexal mass and pelvic nodes was done which were as follows:

Adnexal mass – cervical lipoleiomyoma fibroma

Lymph nodes – tubercular origin

Drain was kept and abdominal incision closed



[pulse diagnostics]

Patient was put on postop heparin, higher antibiotic and ICU monitoring was done for 1 day.

AS Pt was vitally stable and recovery was very good. we shifted the patient to ward on 2 postop day stitch removal was done on day 10. Pt discharged on ecosprin Discussion -> young female 29 years with two full term normal deliveries with no symptoms of arteritis and no complication aortic thrombus during her normal label diagnosed on ultrasound with large adnexal mass 12x14 cm left adnexa with aortic nodes? malignant? tubercular origin with large aortic thrombus with collaterals developed.

In view of LN we first thought R/o malignancy did her investigation accordingly to R/O malignant R/O. Initially laparoscopic procedure was planned but due to involvement of aorta we thought it was

prudent to do open surgery and save time of surgery, CO2 retention and need of general anesthesia for long time.

Diagnosis of left adnexal mass? kochs abdomen? takayasu arteritis or protein s deficiency was kept.

Physician and hematologist and hemato oncologist were involved to diagnosed arteries likely to be takayasu arteries, features of claudication were conspicously absent and and only symptom of exhaustion on walking and pain in legs after walking were present PET CET gave a green signal for surgery ruling out no other artery involvement.

To R/O minutest possibility of TIA / brain embolus or coronary embolus.

Team of anesthetist were involved. General anesthesia was given keep 2OPCV ready. Intraoperative frozen section of adnexal mass & pelvic nodes was done to decide extent of surgery to aortic nodes as due to collaterals the surgery was bloody . We used cautery whenever necessary. ureter was freed from fibroid and as we proceed the origin of fibroid was from cervix which made the surgery all the way more difficult. Intraoperative and postop anesthetist support and ICU backup was taken [1-9].

However patient withstood procedure well intraoperative and postoperatively and was shifted to ward on day 2 itself with no major postop complications, except one episode of fever on day 3 up to 100 Celsius which settled. Postop – hematologist put on ecosprin after which drain removed on day 5 and SIR on day 8 with oral tablets including antibiotic, painkiller, iron, ecosprin.

## 5. Conclusion

There have been few case reports of association of large adnexal mass with tubercular LN and large aortic thrombus due to takayasu arteries which was chronic thrombus with collateral development.

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