

Images in endoscopy

Parasitic myoma under the diaphragm

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A 40-year-old patient came to our clinic in August 2003 complaining of menorrhagia for 1 year. She had undergone 2 previous cesarean sections and a laparoscopic myomectomy at our center in 1998. Ultrasound examination revealed a large lobulated uterus with 5 myomas ranging from 5 to 9 cm in diameter, with the largest being a fundal subserosal one. The patient elected to undergo laparoscopic supracervical hysterectomy at our center.

During laparoscopic surgery, initial examination revealed multiple large, cystic, degenerated broad ligament myomas. Laparoscopic supracervical hysterectomy was performed. In addition, a large parasitic myoma (approximately 5 cm in diameter) was found under the right dome of the diaphragm (Figure 1). Myomectomy was performed by coagulating and then cutting the base of the diaphragmatic myoma. A small second parasitic myoma (approximately 3 cm in diameter) was found attached to the rectovaginal septum, which was also removed laparoscopically.

The surgery was uneventful. Pathologic study confirmed that both the diaphragmatic and rectovaginal septum myomas were indeed benign leiomyomas. The patient was discharged on the second postoperative day with hemoglobin of 12.5 g%.

The patient had an uneventful recovery and was asymptomatic until 6 months after surgery, when she developed a leiomyoma of the colon. Further study is being carried out at our center in a paper on posthysterectomy leiomyomatosis.

Laparoscopic myomectomy is feasible and safe irrespective of the size, number, or location of the myomas.¹ There are very few references of parasitic myomas in the literature.^{2,3} Although a recent paper has discussed implantation of retained fragments after the use of morcellation during laparoscopic surgery,⁴ the size of the diaphragmatic myoma as well as the fact that our patient was seen almost 8 years after the laparoscopic myomectomy negate this as a reason for the development of the diaphragmatic myoma. During the laparoscopic myomectomy in 1998,

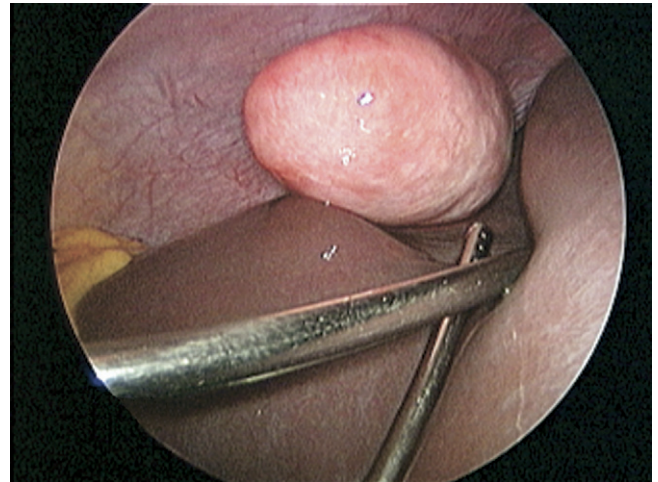


Figure 1 Parasitic myoma under the diaphragm.

the entire abdomen, including the diaphragmatic area, was surveyed immediately after the insertion of the laparoscope to rule out other intraabdominal pathologies. Also after the removal of the myoma by morcellation, the upper abdominal area near the liver and the diaphragm were drained of collected fluids by means of suction cannula. In both instances, the diaphragmatic myoma was not seen, negating the possibility that the myoma was present in the diaphragmatic region during the laparoscopic myomectomy. An ultrasound examination performed 3 months after the laparoscopic myomectomy also confirmed that there were no residual myomas in the uterus. When the patient presented at our clinic in 2003, the uterus also had myomas and hence the probability of it being a parasitic myoma, which had lost its attachment to the uterus, is increased.

References

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Submitted May 30, 2006. Accepted for publication August 12, 2006.