Parasitic leiomyoma in the abdominal wall after laparoscopic myomectomy

Hwa Sook Moon, M.D., Ph.D., Ja Seong Koo, M.D., Sea Hee Park, M.S., Gun Sik Park, M.D., Jin Guk Choi, M.D., and Sang Gap Kim, M.D.

Department of Obstetrics and Gynecology, Center for Minimally Invasive Surgery, Good Moonhwa Hospital, Busan, Korea

Objective: To report a case of parasitic leiomyoma of the abdominal wall after laparoscopic myomectomy.

Design: Case report.

Setting: Large medical center.

Patient(s): A 31-year-old woman with a newly developed palpable mass in the abdominal wall near the trocar site of a previous laparoscopic myomectomy.

Intervention(s): Excision of the mass.

Main Outcome Measure(s): Histopathologic examination of the mass.

Result(s): A mass measuring 3.2 × 2.2 × 2.0 cm was excised. The lesion was located in the subfascial area of the abdominal wall, near the trocar site of a previous laparoscopic myomectomy. Histopathologic examination confirmed leiomyoma.

Conclusion(s): This result shows that myoma fragments sometimes are found to be scattered in the abdominal cavity after laparoscopic myomectomy, suggesting that all myoma fragments, however small they may be, must be completely removed. (Fertil Steril 2008;90:1201.e1–e2. ©2008 by American Society for Reproductive Medicine.)

Key Words: Parasitic leiomyoma, laparoscopic myomectomy

Laparoscopic myomectomy is a popular treatment for symptomatic uterine myoma. Although laparoscopic myomectomy has gained acceptance among patients who wish to save their uterus, as well as gynecologists, this technique brings about a risk of complications that usually are not encountered in conventional myomectomy through laparotomy. Reports of such complications will help gynecologists to be cautious during the procedure to prevent future complications. We report a case of parasitic leiomyoma of the abdominal wall in a 34-year-old woman who had undergone laparoscopic myomectomy 3 years before.

The patient revisited our clinic 3 years later with a palpable mass on the left lower quadrant of the abdomen, and diagnostic transabdominal ultrasound revealed a 2.7 × 1.7-cm round mass in the abdominal wall (Fig. 1). No other abnormalities of the pelvic organs were noted.

While the patient was under sedation and being given local anesthesia with 1% lidocaine, a mass measuring 3.2 × 2.2 × 2.0 cm was excised (Fig. 2). The lesion was located in the subfascial area of the abdominal wall, near the trocar site of the previous laparoscopic myomectomy. It grossly appeared as a solid, round encapsulated mass and was confirmed as a leiomyoma on histopathologic examination.

DISCUSSION

Laparoscopic myomectomy has become a promising alternative surgical technique to classic laparotomy by lowering postoperative morbidity and cost (1). However, since the introduction of laparoscopic techniques in the gynecologic field, there have been concerns about the risk of incomplete removal of myoma fragments (2–4). Because retrieval of the excised uterine myoma through a small abdominal incision in laparoscopic surgery requires morcellation of the mass, there is an increased possibility that fragments of myoma may be left behind unintentionally and implant into normal tissue.

Morcellation is a method that is widely used to aid in removal of large specimens in laparoscopic myomectomy.
The risk of incomplete removal is increased because the use of a morcellator produces smaller fragments.

In addition, the option of laparoscopic supracervical hysterectomy recently has resurfaced because of the extremely low incidence of cervix cancer in the screened population and several benefits of the procedure, including shorter recovery period, improved sexual function, and fewer postoperative complications (5). However, this technique also requires morcellation, and thus there is always a risk of incomplete removal of myoma fragments. Hutchins and Reinoehl (6) reported a case of abdominal pain caused by a retained myoma during a previous laparoscopic supracervical hysterectomy that required further surgical intervention. Donnez and Nisolle (7) described two patients with postoperative dyspareunia that most likely was caused by a piece of morcellated myoma tissue that remained in the pouch of Douglas after laparoscopic supracervical hysterectomy. These reports emphasize the importance of identifying and removing all fragments, regardless of size, after morcellation.

In our case, a fragment of myoma is thought to have remained in the abdominal wall after laparoscopic myomectomy. We speculate that this was a result of the attempt to simultaneously remove the last fragment of the myoma and the trocar while the entire fragment was not completely placed inside the trocar. Consequently, the fragment may have been trapped somewhere along the trocar tract in the abdominal wall.

We recommend that the trocar be removed after it is confirmed that the last piece of myoma has been removed. In addition, we suggest that surgeons and nurses check the number of morcellated myoma fragments, the way that the number of pieces of surgical gauze used in an operation is checked. In addition, when there are several myomas to be enucleated, placing an optimal-sized endobag in the operation field before enucleation will be helpful for collecting all specimens without missing any of them.

Myoma fragments sometimes are scattered in the abdominal cavity during morcellation. All morcellated myoma fragments, however small they may be, must be completely removed. To do so, it is necessary to meticulously examine the surgical field without changing the position of the patient, and as a final step, it can be helpful to irrigate with normal saline, with the patient in a reverse Trendelenburg position.

Acknowledgment: The authors sincerely thank Bo Sun Joo, Ph.D., of the Center for Reproductive Medicine, Good Moonhwa Hospital, for data management.

REFERENCES