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A Case Report

Fibromyoma: A Clinical Dilemma

Rajeshwari L Khyade[1], Chandrajeetsingh Tale[2], Poonam Rayaskar[3]

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ABSTRACT

Background: Fibromyoma, or uterine leiomyoma, is the most common benign tumor of the female reproductive tract, affecting 50-80% of women by age 50. Despite its benign nature, it poses a significant clinical dilemma due to its variable presentation, impact on quality of life, and complex management decisions.

Aim: This article discusses the diagnostic and therapeutic dilemmas associated with fibromyoma, focusing on challenges in clinical decision-making for symptomatic women.

Discussion: The dilemma arises from several factors. First, most fibroids are asymptomatic, yet 25-30% cause menorrhagia, pelvic pain, pressure symptoms, or reproductive issues. Second, treatment must balance symptom relief with fertility preservation. Options include expectant management, medical therapy with GnRH agonists or SPRMs, minimally invasive procedures like uterine artery embolization and HIFU, and surgical approaches such as myomectomy or hysterectomy. Each has distinct risks, benefits, and recurrence rates. Third, differentiating benign fibroids from the rare leiomyosarcoma (<1%) preoperatively remains challenging. Fourth, fibroids in pregnancy can lead to red degeneration, preterm labor, and postpartum hemorrhage, yet many women have uneventful outcomes.

Conclusion: Managing fibromyoma requires individualized care based on age, symptoms, fertility desires, and fibroid characteristics. A multidisciplinary approach with thorough counseling is essential. Further research is needed for reliable biomarkers to rule out malignancy and long-term fertility data for newer modalities.

Author's Affiliation:

[1]Senior Consultant and DNB Teacher, KB Bhabha Hospital, Bandra, Mumbai, Maharashtra, India.

[2]Clinical Associate, Department Obstetrics and Gynecology, Gleneagles Global Hospitals, Mumbai, Maharashtra, India.

[3]Resident, Department Obstetrics and Gynecology, KB Bhabha Hospital, Maharashtra, India.

Corresponding Author:

Rajeshwari L Khyade, Senior Consultant and DNB teacher, KB Bhabha Hospital, Bandra, Mumbai, Maharashtra, India.

E-mail: krajeshwari2@yahoo.co.in

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KEYWORDS

• Fibromyoma • Uterine Fibroids • Leiomyoma • Gynecological Dilemma • Menorrhagia • Myomectomy • Hysterectomy • Infertility • Treatment Options • Women's Health

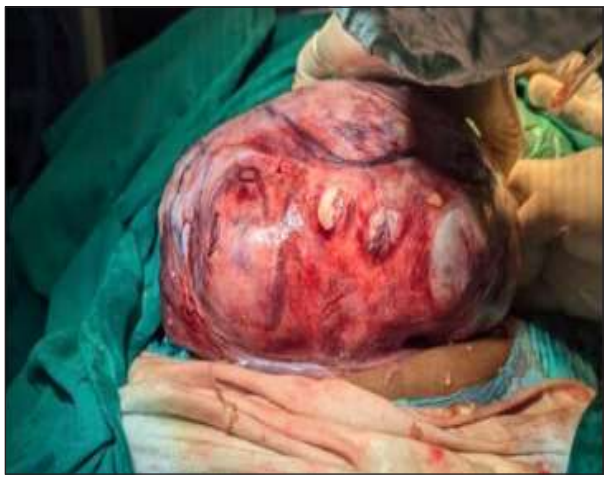
INTRODUCTION

Leiomyosarcoma accounts for 10% to 20% of all newly diagnosed STS. In recent years, advancements in molecular diagnostics have enhanced the accuracy of diagnosis. Leiomyosarcoma most commonly occurs in the retroperitoneum, followed by the uterus, extremities, and trunk. Uterine sarcomas comprise about 3% to 7% of all uterine malignancies, with leiomyosarcoma being the most common subtype, accounting for nearly 80% of all uterine sarcomas.

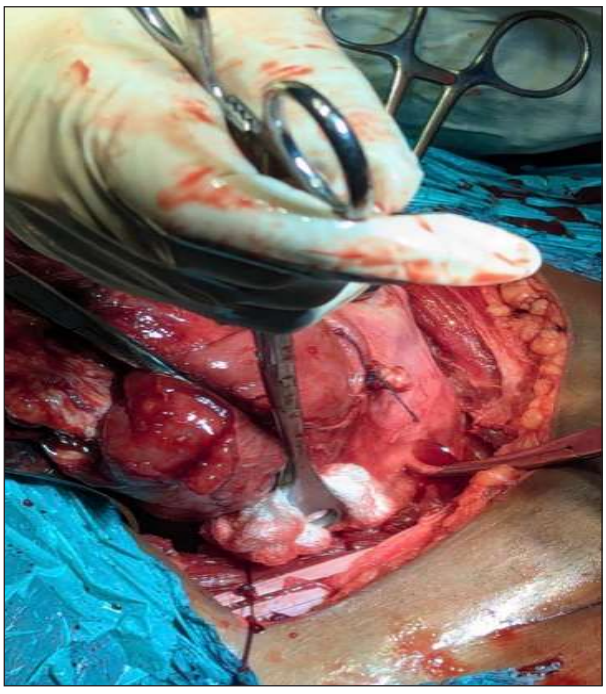
The incidence of leiomyosarcoma increases with age, reaching its peak in the seventh decade of life. The exception to this is uterine leiomyosarcoma, which occurs most commonly in perimenopausal women.

Uterine leiomyosarcoma is a rare and aggressive malignant smooth muscle tumour that is often difficult to distinguish from benign uterine leiomyomas prior to surgery. It is particularly uncommon in women presenting with infertility, posing significant diagnostic and therapeutic challenges. We present the case of an infertile woman who was found to have a large uterine mass initially suspected to be a benign leiomyoma based on clinical and radiological evaluation. The patient underwent surgical management, and definitive diagnosis of leiomyosarcoma was established on histopathological examination. Histology revealed features consistent with malignancy, including marked cellular atypia, high mitotic activity, and tumour necrosis. This case highlights the limitations of preoperative imaging in differentiating benign from malignant uterine smooth muscle tumours and underscores the importance of histopathology in establishing a definitive diagnosis. Early recognition is crucial, as leiomyosarcoma carries a poor prognosis and requires prompt oncologic management. Reporting such rare presentations in infertile women is essential to increase awareness and guide clinicians in counselling, management, and fertility-related decision-making.

CASE DESCRIPTION

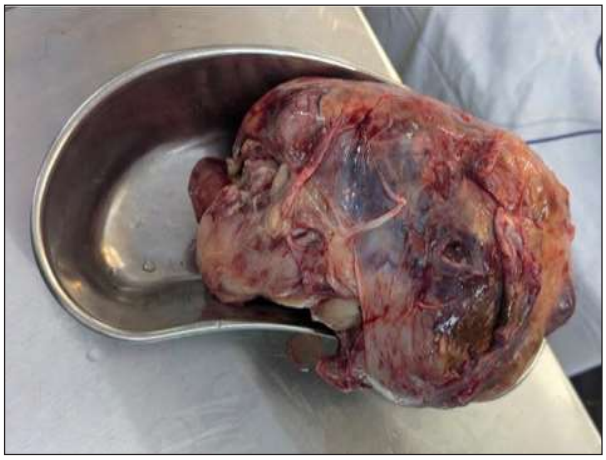


A 35-year-old P0A2 presented with chronic pelvic pain since 6 months (Gradual onset, mild, dull aching, generalized, continuous, non-radiating, no aggravating factors) Abdominal Distension since 6 months (Progressive heaviness, more in lower abdomen) Constitutional Symptoms since 7-8 months (weight loss of 5 kg, lethargy, fatigue, Decreased appetite).



On inspection: Distended abdomen noted (hypogastric & infraumbilical), umbilicus everted, no scars/sinuses Palpation: Mass ~22-24 weeks size (2 cm above umbilicus), firm, smooth margins, minimally mobile side-to-side no guarding, rigidity, or tenderness.

Percussion: Dullness over mass, tympanic note over surrounding bowel, no shifting dullness. On per speculum examination vulva and vagina appeared health. The cervix was pulled up. healthy with no altered discharge. On p/v examination **Uterus**: 22-24 weeks, regular contour, Consistency: Firm to hard, Mass: Movable with cervical movement, not separable from uterus, Right fornix: Full, non-tender|Left **fornix:** Free, non-tender|Cervix: Displaced left, pulled up P/R Confirmed P/V findings.Ultrasound suggestive of Large, well-defined, heterogeneous, vascular mass in pelvis/my ometrium, Size: 12.8 × 18.1 × 14.5 cm, Left ovarian hemorrhagic cyst: 3.3 cm, suggestive of Posterior uterine wall fibroid with bilateral ureteric compression causing bilateral mild hydronephrosis. MRI suggestive of Heterogeneously T2 hyperintense, Heterogeneously T1 hypointense, Few T1 hyperintensities (hemorrhage), Patchy areas of restricted diffusion, Heterogeneous post-contrast enhancement, Attached to right lateral uterine wall, via pedicle with flow voids Mass causes levo-rotation of uterus•Right ovary not seen•Mild ascites present,T2 hypointense lesion in right lateral wall (3.5 × 3.5 cm) — likely intramural fibroid, Left ovary: 3.7 × 2.5 cm with hemorrhagic follicle (2.6 × 2.1 cm),Uterus, cervix, parametrium, vagina: Normal•No lymphadenopathy. Complete blood count and tumour markers were CA-125: 37 U/mL, (*mildly elevated*), CA 19-9 was 425 U/mL (significantly elevated). CEA: 1.79 ng/mL (normal) LDH: 29 Hb: 7.8 g/dL,WBC: 14,000/mm³, Platelets: 5.66 L,OT/PT: 29/16.



Surgical management-Uterus: Normal size. An approximately 18 × 14 × 12 cm multilobulated mass arising from the right posterior wall near the cornua. irregular in shape multilobed with smooth borders, friable, myxoid gelatinous fluid oozing from the mass while separating. The mass was separated from its capsule using sharp and blunt dissection. Redundant part cut and removed. Cavity obliterated, Right cornual part approximated and sutured. Left fallopian tube: Normal, Left ovary: Cystic, 4 × 5 cm. Right fallopian tube was Stretched over the mass, Right ovary was Not seen separately — ? stretched over mass. Uterus with both ovaries and tubes were conserved. Myoma removed and sent for histopathology. No enlarged lymph nodes were palpable. The mass weighed approximately 2 kg. Ascitic Fluid: Yellow, hazy, WBC: 220 cells/mm³, RBC: 550 cells/mm³, Neutrophils: 70%, No malignant cells seen. Histopathological examination suggested a sarcoma, with myxoid leiomyosarcoma as the differential diagnosis. Recommendation-Immunohistochemistry (IHC) for definitive diagnosis and subtyping.

DISCUSSION

Uterine Leiomyosarcoma are Extremely rare, aggressive malignant soft tissue tumors (1-2% of uterine malignancies). often seen in perimenopausal and postmenopausal women, They typically present as rapidly growing solid masses. difficult to distinguish from benign leiomyomas. Uncommon in young reproductive women presenting with infertility posing significant diagnostic and therapeutic challenges. It arises from smooth muscle of myometrium, classified under undifferentiated sarcomas. Myxoid variant: rare subtype with prominent myxoid stroma, often mimics benign lesions. The diagnosis is often mistaken for benign fibroids preoperatively. (after myomectomy or hysterectomy). Clinical Clues to Malignancy Rapid growth/large size at presentation, Constitutional symptoms (weight loss, fatigue), Post-menopausal growth seen in 7th decade of life (not in this case), Heterogeneous imaging with necrosis, Restricted diffusion on MRI, Elevated tumor markers, Ascites with pelvic mass. MRI Features of LMS: T2 heterogeneously hyperintense, T1 hyperintense foci (hemorrhage), Areas of restricted diffusion, Irregular margins/ill-defined borders, Central necrosis,

Heterogeneous enhancement, Size > 8-10 cm raises suspicion. Management Considerations: Surgical: Ideally Total abdominal hysterectomy with bilateral salpingo-oophorectomy is standard for confirmed LMS. Fertility-sparing surgery was performed because the patient wished to preserve fertility. since she was young and desired future fertility. And wish to conceive. The uterus and adnexa were preserved, and only a myomectomy was performed. Fertility sparing Surgery is a conservative reproductive management for gynecologic cancers in young women with low risk, with no metastasis and local spread. It is considered rare and experimental approach because of the rarity of the pathology. The uterus and adnexa were preserved, and only a myomectomy was performed. Strict need for follow up. On discharge asked her to see medical oncologist for further investigation and treatment. Staging: FIGO staging; peritoneal cytology, lymph node assessment based on findings done. Adjuvant: Role of chemotherapy (doxorubicin ± ifosfamide) and radiation varies; often recommended for Stage I-IV. Not required here. Prognosis: Poor overall; 5-year survival 25-75% depending on stage; high recurrence rate. After completion of childbearing Hysterectomy with bilateral salphingo oophorectomy can be done. Follow-up every 3 months for the first 3 years, followed by every 6 months thereafter.

CONCLUSION

Uterine sarcomas are rare but carry high mortality; maintain clinical suspicion in rapidly growing masses with constitutional symptoms. MRI features like heterogeneous T2 signal, T1 hyperintensities (hemorrhage), and restricted diffusion should raise suspicion for malignancy. Pre-operative differentiation from benign fibroids remains challenging; diagnosis often made post-operatively. Avoid morcellation in suspicious cases — can lead to tumour dissemination and upstaging. Definitive diagnosis requires histopathology with IHC; myxoid LMS is a rare variant that can mimic benign conditions. Fertility sparing surgery should be considered in all young childbearing women in early stages although it is rare and experimental approach in a low-risk patients without evidence of metastasis or local spread.

Abbreviations

STS - Soft Tissue Sarcoma

P/R - Per Rectum

P/V – Per Vaginal

LMS - Leimyosarcoma

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