

UNUSUAL CLINICAL PRESENTATION OF UTERINE MYOMAS

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Although the presence of myomas is almost never associated with mortality, myomas may cause morbidity and affect the quality of life [1]. However, a recent publication by Su and colleagues on the topic of internal bleeding from a ruptured serosa vein covering the myoma surface mimicking upper gastrointestinal bleeding calls attention to the alarming possibility of this unusual clinical presentation of the uterine myomas, which might result in a life-threatening status [2]. In fact, there are many reports on unusual clinical presentation of uterine myomas [3–6]. Herein, we review the symptomatology of uterine myomas.

Most women with myomas are asymptomatic; therefore, an observation is expected and follow-up is often recommended. Only the following conditions call for definite treatment: severe menstrual symptoms, pelvic pain, pressure complaints, subfertility, and pregnancy-related complications [7–9].

Disturbance of menstruation is the most frequent presenting symptom in women with myomas and the leading reason for therapy [10]. The exact proportion of abnormal bleeding related to myomas is difficult to determine because of the difficulty in assessing myoma prevalence and the differing criteria for abnormal uterine bleeding. A randomized study involving a sample of 878 non-care-seeking urban women found that the prevalence of myoma was 65% [10]. Forty-six percent of the women with myomas had an increased risk of self-reported “gushing-type” bleeding. However, another population-based cohort study with a myoma prevalence rate of 21.4% found no statistically significant relationship between the presence of myomas and menstrual cycle characteristics [11].

There is no abnormal bleeding pattern specific to myomas. Women with myomas may develop menorrhagia or metrorrhagia, or both. The probable mechanism of myoma-related bleeding had been attributed to the expanded surface area of the endometrium or local compression of veins in the interior uterine layers [12]. Results from several recent studies weighed against these hypotheses but suggested the role of growth factor dysfunction [13]. The dysregulation of growth factor may be responsible for the observation of increasing venules and arterioles and venule ectasia in the myomatous uteri [13].

Gynecologic pain, such as dysmenorrhea, dyspareunia or non-cyclic pelvic pain, has been described as an associated symptom of myomas. A population-based, non-care-seeking cohort of women aged 20 to 50 years was evaluated by self-reported gynecologic pain on a visual analog scale and by ultrasound to determine the presence, size, volume and location of myomas [14]. Of the 635 women screened, myomas were detected in 96 (15%). The presence of myoma was related to dyspareunia (odds ratio [OR], 2.8; confidence interval [CI], 0.9–8.3) and non-cyclic pelvic pain (OR, 2.6; CI, 0.9–7.6), rather than dysmenorrhea (OR, 1.1; CI, 0.5–2.6) [13]. Neither the number nor the total volume of myomas was related to pain.

Myomas may be associated with pressure effects, leading to urinary symptoms. Studies assessing the treatment effect on myomas found that urinary frequency and urgency improved after reduction of uterine volume [15]. These results support the notion that increased uterine volume caused by myomas may lead to urinary symptoms.

This summary of the symptomatology of uterine myomas shows that, although they are still not well understood, much has been learned about them.

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