Astana Medical Journal
e2790-1203

Original article

Gigantic size leiomyoma in a patient with pulmonary embolism

Received: 14.05.2026
Accepted: 05.06.2026
Published: 30.06.2026

Citation: Zhannur Torebek, Balkenzhe Imankulova. Gigantic size leiomyoma in a patient with pulmonary embolism. Astana Medical Journal, 2026, 126 (3), amj027. https://doi.org/10.54500/2790-1203-2026-3-126-amj027

Zhannur Torebek [1], Balkenzhe Imankulova [2*]

[1] Obstetrics and Gynecology Resident, Nazarbayev University School of Medicine, Astana, Kazakhstan. E-mail: zhannur.torebek@nu.edu.kz
[2] Associate Professor, Obstetrician and Gynecologist, Clinical and Academic Department of Women's Health, Corporate Fund «University Medical Center», Astana, Kazakhstan. E-mail: imanbalken@mail.ru

*** Corresponding author:** imanbalken@mail.ru

Abstract

Introduction. Uterine fibroids or leiomyoma is a frequent diagnosis in women of reproductive age. They originate from monoclonal proliferation of smooth muscle cells of myometrium. Around 75% of women are diagnosed with fibroids by the age of 50. Depending on the location it can be classified as: subserosal, intramural, submucosal or pedunculated. Many cases might be asymptomatic, but the most common presentation of uterine fibroids is heavy menstrual bleeding, pelvic pressure and lower abdominal pain. The diagnosis is made by transvaginal ultrasound. Magnetic Resonance Imaging (MRI) can be used for detailed mapping in some rare cases. The acute complications of uterine leiomyoma are not common and include thromboembolism, urinary retention, vaginal or intraperitoneal hemorrhage and torsion of pedunculated polyps. Even if acute complications such as deep vein thrombosis (DVT) and pulmonary embolism (PE) are very rare they are associated with significant morbidity and mortality.

We represent a case of a 48-year-old gravida 2, para 2 woman who came to the Clinical and Academic Department of Women's Health, Corporate Fund «University Medical Center» (UMC) in Astana with a past medical history of pulmonary embolism because of large leiomyoma. She was successfully treated with supracervical hysterectomy. The actuality of this case is that this patient did not have any other risk factors of thromboembolic disease such as prolonged immobilization, hospitalizations, surgery, history of oral contraceptive pills use, etc. Her thromboembolism was mainly caused by mechanical obstruction of pelvic veins by a large fibroid.

We aim to emphasize the importance of thorough evaluation of patients with uterine fibroids that are assumed to be mostly benign disease. By presenting the case of a patient with a history of deep vein thrombosis followed by pulmonary embolism secondary to gigantic size leiomyoma, we aim to increase physician's awareness of rare complications of fibroids and present available multimodal treatment strategies, prophylactic measures and prevention methods.

Keywords: leiomyoma, venous thromboembolism, pulmonary embolism, venous thrombosis.

1. Introduction

Uterine leiomyoma, otherwise called fibroids belong to the most common type of benign tumors of the uterus. They arise from myometrial smooth muscle cells. The lifetime prevalence of leiomyoma is around 75% and depends on different factors like age, race, and environmental factors [1]. Clinically, they cause excessive or heavy menstrual bleeding, pelvic or lower abdominal pain, bulk symptoms (urinary urgency/frequency, pelvic pressure, back discomfort), dysmenorrhea, and problems with fertility [2]. Risk factors include early menarche, late menopause, nulliparity, obesity or high body mass index (BMI), family history of leiomyoma, and African descent, etc. The diagnosis is usually made by transvaginal ultrasound. MRI can be used for detailed mapping in some rare cases [1].

The acute complications of uterine leiomyoma are not common and include thromboembolism, urinary retention, vaginal or intraperitoneal hemorrhage, and torsion of pedunculated polyps [3]. DVT followed by PE is a severe and rare complication of uterine leiomyoma. Basically, venous thromboembolism can be explained by a blood clot otherwise called a thrombus, that forms in veins, particularly deep veins of the legs. Then this thrombus can dislodge and migrate in the vasculature and become an embolus. If this embolus gets trapped in the pulmonary vasculature, it causes PE and might be fatal.

According to the American Heart Association, the risk factors of venous thromboembolism include cancer diagnosis, major surgeries, hospitalizations, prolonged immobilization, smoking, use of oral contraceptive pills, obesity, age over 40, etc. [4]. Most cases of thrombosis are due to known risk factors. However, large uterine leiomyomas can lead to rare cases of thrombosis [5]. Even if thromboembolism is a rare acute complication of uterine leiomyomas, it can lead to significant morbidity and mortality [3].

We report a case of a 48-year-old gravida 2, para 2 woman who came to elective supracervical hysterectomy after acute submassive bilateral pulmonary embolism treatment. The aim of this case report is to highlight the importance of timely treatment of leiomyoma in patients with a risk of venous thromboembolism. Moreover, we aim to increase physicians's awareness of rare complications of fibroids and discuss available multimodal treatment strategies, prophylactic measures, and prevention methods.

Case presentation:

A 48-year-old gravida 2 para, 2 woman presented to Clinical and Academic Department of Women's Health, Corporate Fund «UMC» in Astana for a planned surgical treatment on October 20, 2025. Her chief complaint was heavy menstruation and lower abdominal pain. The patient described her lower abdominal pain as aching pain. Quantitatively rated as 5-6 out of 10 on a pain scale. The onset of pain was insidious, and it bothered the patient from February 2025. It was not relieved by nonsteroidal anti-inflammatory drugs (NSAIDs). An exacerbating factor was physical activity. The associated symptoms included urinary frequency every 1.5 hours and lower back pain. She reported heavy menstruation for more than eight days with intermenstrual bleeding episodes. A patient also reported using urological pads due to excessive menstruation and a history of anemia treated with iron supplements. She was diagnosed with leiomyoma nine years ago and did not receive any specific treatment.

Her past medical history was significant for acute submassive bilateral PE because of migratory femoropopliteal venous thrombosis of the left lower extremity in February 2025. She was immediately treated with anticoagulation therapy, and the treatment course was uneventful. She was discharged on rivoroxaban 15 mg twice daily for twenty-one days and 20 mg once daily for six months. At the time of treatment, she was recommended to undergo elective surgical treatment for her leiomyoma. On repeat computed tomography (CT) of the chest with contrast from October 9, 2025, CT signs of pulmonary embolism were excluded. Otherwise, her past medical history was not significant: no previous surgeries, no chronic illnesses and no major hospitalizations. She had an allergy to rheopolyglucin that presented as angioedema. She had a mild myopia corrected with glasses.

From obstetric and gynecological history, her menarche was at the age of twelve. Prior to the leiomyoma diagnosis, her periods were regular, not painful, and lasted five to six days with a frequency of twenty-eight to thirty days. She had two term pregnancies that ended with two normal vaginal deliveries in 1998 and 2006. She denied any history of

sexually transmitted infections, oral contraceptive pill use, and other gynecological illnesses.

Her social history was unremarkable. Denied smoking, drinking alcohol, and use of recreational drugs. Family history was positive for myoma in two sisters and mother that might show the genetic risk factor for leiomyoma development. Review of organ systems was unremarkable.

On physical examination, her vital signs were normal. She was oriented to time, place, and person without signs of acute distress. On abdominal examination, the abdomen was increased up to the size of a 20-week gestation pregnancy due to a gigantic-sized leiomyoma. On speculum examination, her cervix was clear, cylindrical, and with scars from previous old cervical lacerations at 3 and 9 o'clock positions. Bimanual examination revealed that the uterus was immobile, fixed, and enlarged up to the level of the umbilicus, corresponding to a mid-term pregnancy. A myomatous nodule measuring up to 15.0 cm of dense consistency was noted. Adnexa were not palpable.

Her regular blood examinations before surgery, including common blood count, biochemistry, coagulation profile, human immunodeficiency virus, Hepatitis B and C screening, and Treponema Pallidum testing were all normal. Urinalysis was unremarkable. Electrocardiogram showed a sinus rhythm with a heart rate of 80 beats per minute. Lower extremity duplex ultrasound and chest CT angiography were done prior to surgery, and both excluded thromboembolic disease. Preoperative consultation with an angiosurgeon was obtained, who excluded contraindications to supracervical hysterectomy.

Her last transvaginal ultrasound from October 16, 2025, showed an enlarged uterus (18.9 x 15.6 x 17.5 cm) with irregular myometrium and with interstitial-subserous myomatous lesion of size 14.0 x 4.2 x 2.4 cm that distorted the uterine cavity. Pelvic magnetic resonance imaging (MRI) with contrast, performed on April 3, 2025 (presented in *Figure 1*), revealed a markedly enlarged, spherical uterus in anteversion and anteflexion, measuring 18.6 × 11.8 × 17.8 cm. The anterior uterine wall measured 1.5 cm in thickness, whereas the posterior wall measured up to 10.5cm. A large interstitial leiomyoma was identified in the right anterolateral uterine wall, measuring 14.4 x 10.9 x 14.1 cm. Additionally, two smaller interstitial leiomyomas were noted along the posterior wall, measuring 4.0 x 1.9 x 4.3 cm and 1.1 x 0.75 cm respectively.

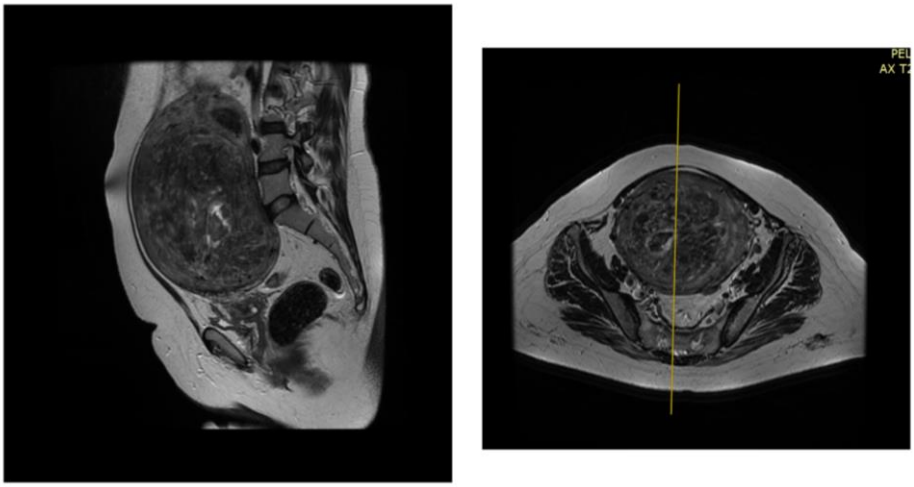

Figure 1 - Pelvic MRI with contrast of the patient; coronal and sagittal views showing the uterus with the biggest myoma - 14,4 x 10,9 x 14,1 cm

She underwent supracervical hysterectomy of the uterus with uterine tubes on October 21, 2025. A lower median laparotomy incision was made. On gross examination, the uterus was 28.0 x 30.0 cm and presented with centripetally located intramural leiomyoma up to 13.0-14.0 cm. The uterus with uterine tubes was sent to histological examination that confirmed the diagnosis of uterine leiomyoma, bilateral chronic salpingitis, and endometrium in the early proliferation stage. Total blood loss intraoperatively was 500.0 ml. She was transferred to the Intensive Care Unit department due to the amount of blood loss and hemodynamic instability and transferred back to our department on post-op day two. The post-surgical treatment of a patient included pain control,

antibiotic treatment with Cefazolin 1.0 gram three times a day for five days, and low molecular weight heparin (LMWH) 0.4 g once a day for five days. She was successfully discharged home on post-op day seven in a stable condition. After four months of follow-up, the patient remained stable and healthy without signs of thromboembolism. Verbal and written informed consent for writing and publication of a case report was obtained from the patient.

2. Discussion

Typically benign and prevalent uterine fibroids can cause rare acute complications, including DVT and PE. Patients diagnosed with thromboembolic disease secondary to massive uterine fibroid require an extensive and multimodal treatment strategy. This combined modality treatment includes thrombus management and further fibroid excision, which is critical to prevent the recurrence of thromboembolic events. The gold standard of surgical treatment for those patients is hysterectomy, but conservative myomectomy can be offered to patients who wish to preserve their fertility [6]. Inferior Vena Cava (IVC) filters and anticoagulation agents can be used as a complementary therapy. For example, Satti *et al.* [3] report two cases of thromboembolic disease due to uterine leiomyoma successfully treated with placement of IVC filters and subsequent hysterectomy. Moreover, aspiration mechanical thrombectomy for DVT can also be applied in some cases [6]. One of the biggest limitations of this method is that it requires specific equipment and skilled surgeons that may not be attainable in all hospital settings. Currently there is no standardized protocol designed for the management of uterine fibroids with DVT or PE [6]. The definitive treatment strategy should be individualized depending on the age, patient's preferences, comorbid conditions, and functional status of a patient. In our case, due to the age, parity of a patient and the large size of the symptomatic leiomyoma, supracervical hysterectomy was performed after confirming that the patient recovered from PE and excluding DVT diagnosis.

Literature search showed several similar case reports and case series that were published in accordance with the findings of this patient [3, 6, 7, 8]. In all cases, the pathogenesis of venous thromboembolism is explained by Virchow's triad that consists of three factors: hypercoagulable state, either local or systemic; endothelial injury of vessel walls; and venous stasis. One of the possible reasons for the development of DVT in patients with gigantic-sized leiomyomas without significant risk factors is supposed to be venous stasis due to compression of inferior vena cava and iliac veins. Additionally, venous stasis can result from decreased mobility during heavy and severe pain due to fibroids [8]. Among all the most frequent sites of venous compression is the common iliac vein, either left or right or both. After established DVT of veins, thrombus is predisposed to dislodge, embolize, and cause PE [9]. In addition to mechanical causes, upregulation of the expression of type 1 basic fibroblast growth factor is also observed in fibroids. It promotes platelet adhesion and coagulation, which further enhances thrombosis formation [8].

There are larger studies that explored the relationship between thromboembolism and uterine fibroids. For example, in a nationwide population-based case-control study that utilized the National Health Insurance Research Database (NHIRD) and was conducted on 2,282 cases with DVT/PE and 392,635 participants without DVT/PE, a strong association between uterine leiomyoma and DVT was found [10]. Before matching, the Odds Ratio (OR) of VTE in women diagnosed with leiomyoma was 1.547 with $p<0.0001$. Additionally, patients with anemia who were receiving treatment with iron supplementation tablets were more likely to develop VTE as compared to those not receiving (OR=1.996, $p<0.003$, CI: 1.27-3.15). In a subgroup analysis, those who are older than 45 years of age had a lower significant risk of VTE (OR=0.498, $p=0.009$, CI: 0.29-0.84) [10]. Subsequently, our patient is 48 years old and received a long treatment for anemia caused by symptomatic uterine leiomyoma. Similarly, a correlational descriptive study conducted by Saab *et al.* [11] in Riyadh, Saudi Arabia, showed that there is a significant correlation ($r=0.115$, $p<0.001$) between symptomatic fibroids and VTE history, especially with larger and multiple fibroids [11].

The weight of the uterus is also associated with the risk of DVT [11]. Estimation of uterine weight before surgery might be challenging, but imaging methods like ultrasound and MRI can be used to approximate the weight. For example, MRI has options of 3D reconstructions for volume and subsequent mass assessment.

As a method of prophylaxis, some authors suggest the use of prophylactic anticoagulation therapy with LMWH in patients with large fibroids undergoing planned surgery to reduce the risk of VTE [3, 6]. For those who have contraindications to anticoagulation prophylaxis, mechanical ways of prophylaxis can be

offered. For example, elastic compression stockings, electric stimulation devices, and sequential compression devices [11]. However, some high-risk groups of patients might require both pharmacologic and mechanical prophylaxis, and the choice of treatment depends on cost, local hospital guidelines, and accessibility [11].

A recent review of literature on the association of fibroids and acute and chronic venous thromboembolism conducted by Afaq *et al.* [12] on nine case series and fifty-seven case reports, three single-center and one population-based study, showed that around 60% of patients lacked major risk factors of VTE [12]. As stated before, our patient also did not have any significant risk factors for venous thromboembolism. Analysis of case reports and case series indicated the mean largest diameter of fibroids to be 13.5 ± 6.0 cm, which is consistent with our patient's findings. The mean gestational age of the uterus was 21.6 ± 4.5 weeks [12], again in accordance with our patient's uterus size that corresponded to approximately 20 weeks of gestation. The main treatment strategy was through anticoagulation (73%); an IVC filter was used in 35% of cases. Regarding the management of fibroids, 62% had hysterectomy, 13% had conservative myomectomy, and the remaining 5% had uterine artery embolization as an alternative method of treatment [12].

The last important point to note is that this patient did not receive any treatment for leiomyoma from the initial diagnosis nine years ago, which might have contributed to the development of DVT and subsequent PE. It highlights the role of timely treatment of leiomyoma and patient education. The timely management of symptomatic fibroids is important to minimize their acute complications like DVT and PE.

3. Conclusion

In conclusion, the causal relationship between uterine fibroids or leiomyoma and venous thromboembolism cannot be identified solely based on case reports and small observational studies [8]. More prospective cohort studies should be designed in the future research. Identifying groups of populations with high thrombotic risk might be useful to define screening methods and recommend prophylactic treatment strategies [11]. As it was mentioned in the aim of this case-report, timely treatment of patients with uterine leiomyoma is paramount to decrease the risk of mortality and morbidity from venous thromboembolism.

Conflict of interest: The authors declare no conflict of interest.

Acknowledgements: The authors gratefully acknowledge «University Medical Center» Corporate Foundation, Astana, Kazakhstan.

Funding: No funding was received for preparation of this case-report.

Author's contributions: All authors equally contributed to this case-report. Zhannur Torebek - getting an informed consent from a patient, conceptualization, writing original draft, literature review. Balkenzhe Imankulova - performed a hysterectomy, clinical management of a patient, conceptualization, final review, and editing.

References

1. Lakabi, R., Harth, S., Meinhold-Heerlein, I., Olsthoorn, A. V., Munro, M. G., & Murji, A. (2025). Diagnosis and classification of uterine fibroids. *International Journal of Gynaecology and Obstetrics, 171*(2), 566–573. https://doi.org/10.1002/ijgo.70538

2. Donnez, J., & Dolmans, M. M. (2016). Uterine fibroid management: From the present to the future. *Human Reproduction Update, 22*(6), 665–686. https://doi.org/10.1093/humupd/dmw023

3. Satti, M. A., Paredes Saenz, C., Raju, R., Cuthpert, S., Kanzy, A., Abhari, S., Hebert, J. A., & Rocha, F. G. (2016). Should prophylactic anticoagulation be considered with large uterine leiomyoma? A case series and literature review. *Case Reports in Obstetrics and Gynecology, 2016*, Article 9803250. https://doi.org/10.1155/2016/9803250

4. American Heart Association. (n.d.). Risk factors for venous thromboembolism. Retrieved February 23, 2026, from https://www.heart.org/en/health-topics/venous-thromboembolism/risk-factors-for-vte

5. Gil, J., Klingensmith, J., Hendrix, L., Stocker, P. J., & Oyesanmi, O. (2025). A complex case of a large fibroid uterus compressing the inferior vena cava causing recurrent deep vein thrombosis and pulmonary embolisms. *HCA Healthcare Journal of Medicine, 6*(4), 345–347. https://doi.org/10.36518/2689-0216.1942

6. Qammar, A., Raja, S., Raja, A., Chaulagain, A., Moshayedi, P., & East, C. (2024). Large uterine fibroid causing DVT and PE: Successful management with mechanical aspiration thrombectomy and hysterectomy: A case report and literature review. *Medicine, 103*(49), e40862. https://doi.org/10.1097/MD.0000000000040862

7. Lacharite-Roberge, A. S., Raza, F., Bashir, R., Dass, C. A., Moser, G. W., Auger, W. R., Toyoda, Y., Forfia, P. R., & Vaidya, A. (2019). Case series of seven women with uterine fibroids associated with venous thromboembolism and chronic thromboembolic disease. *Pulmonary Circulation, 9*(1), 2045894018803873. https://doi.org/10.1177/2045894018803873

8. Brown, D., Ghalib, N., Wu, J., Shahzadi, A., Simpson, T., Sharma, A., Bejugam, V. R., Soodhan, K., & Thachil, R. (2024). Uterine fibroid-associated massive pulmonary embolism: A report of two cases. *Cureus, 16*(6), e62436. https://doi.org/10.7759/cureus.62436

9. Wang, K. L., Kao, Y. T., Chang, W. T., Chang, H. Y., Huang, W. C., Hsu, P. C., Hsu, C. H., Huang, C. L., Hsieh, L. C., Wang, C. Y., Lin, Y. H., Lin, T. H., Chiu, K. M., Hwang, J. J., & Chu, P. H. (2020). Management of venous thromboembolisms: Part II. The consensus for pulmonary embolism and updates. *Acta Cardiologica Sinica, 36*(6), 562–582. https://doi.org/10.6515/ACS.202011_36(6).20200917A

10. Huang, H. K., Kor, C. T., Chen, C. P., Chen, H. T., Yang, P. T., Tsai, C. D., & Huang, C. H. (2018). Increased risk of venous thromboembolism in women with uterine leiomyoma: A nationwide, population-based case-control study. *Acta Cardiologica Sinica, 34*(1), 66–76. https://doi.org/10.6515/ACS.201801_34(1).20170901B

11. Saab, S. M., Algarni, A. M., Saab, M. A., Daowd, R. A. A., Almograbi, M. A., Abdulkader, N. Y., Rakhil, K. A., Alrashed, N. M., Albusayyis, R. F., Bismar, B. K., Alyousef, Y. S., & Celestra, E. C. (2025). Association between symptomatic uterine fibroids and venous thromboembolism risk: A correlational descriptive study in Riyadh, Saudi Arabia. *Journal of Clinical Trials, 15*(3), 587. https://doi.org/10.35248/2167-0870.25.15.587

12. Afaq, M., Zlotshewer, B. A., Oliveros, E., Bauman, S. G., Vaidya, A., Lakhter, V., Forfia, P., Sadek, A. S., Hernandez, E., & Bashir, R. (2025). Uterine fibroids and their association with acute and chronic venous thromboembolic disease—An expert review of the literature. *Journal of Clinical Medicine, 14*(12), 4065. https://doi.org/10.3390/jcm14124065

Өкпе тромбоэмболиясы бар пациенттің гигант тық жатыр миомасы

Төребек Ж.К. [1], Иманқұлова Б.Ж. [2]

[1] Дәрігер-резидент, акушер-гинеколог, Назарбаев университеті Медицина мектебі, Астана, Қазақстан.
E-mail: zhannur.torebek@nu.edu.kz
[2] Қауымдастырылған профессор, Жоғары санатты акушер-гинеколог дәрігер, "Әйелдер денсаулығы" Клиникалық академиялық департаменті, «University Medical Center» Корпоративтік қоры, Астана, Қазақстан. E-mail: imanbalken@mail.ru

Түйіндеме

Кіріспе. Жатыр миомасы немесе лейомиома - репродуктивті жастағы әйелдерде жиі кездесетін диагноз. Олар миометрийдің тегіс бұлшықет жасушаларының моноклоналды көбеюінен пайда болады. Әйелдердің шамамен 75 пайызына 50 жасқа дейін жатыр миомасы диагнозы қойылады. Орналасуына байланысты оны субсерозды, интрамуральды, субмукозды немесе сабақты жатыр миомасы деп жіктеуге болады. Көптеген жағдайларда жатыр миомасы симптомсыз болуы мүмкін. Алайда жатыр миомасының ең көп таралған симптомдарына шамадан тыс етеккір қан кетуі, іш қуысының қысымы немесе іштің төменгі бөлігінің ауыруы жатады. Диагноз трансвагинальды ультрадыбыстық зерттеу арқылы қойылады. Кейбір сирек жағдайларда магнитті-резонанстық томография (МРТ) қолданылуы мүмкін. Жатыр миомасының жедел асқынулары жиі кездеспейді және оған тромбоэмболия, зәрдің іркілуі, қынаптан немесе құрсақ қуысынан қан кету және аяқшалы полиптің бұралуы жатады. Терең вена тромбозы (ТВТ) және өкпе эмболиясы (ӨЭ) сияқты жедел асқынулар өте сирек болса да айтарлықтай аурушаңдық және өліммен байланысты.

Біз Астанадағы «University Medical Center» (UMC) Корпоративтік қорының "Әйелдер денсаулығы" клиникалық академиялық департаментіне келіп түскен, үлкен жатыр миомасы салдарынан өкпе эмболиясымен ауырған 48 жастағы әйелдің кейсін ұсынамыз. Науқасқа супрацервикальды гистерэктомия сәтті жасалды. Бұл жағдайдың өзектілігі мынада: бұл науқаста ұзақ уақыт иммобилизация, ауруханаға жатқызу, хирургиялық

араласу, біріктірілген контрацептивтерді қолдану тарихы және тағы да басқа сияқты тромбоэмболиялық аурудың қауіп факторлары болмаған. Оның тромбоэмболиясы негізінен үлкен миомамен жамбас веналарының механикалық бітелуінен туындаған.

Осы кейс арқылы біз көбінесе қатерсіз ауру деп саналатын жатыр миомасы бар науқастарды мұқият бағалаудың маңыздылығын атап өтуге тырысамыз. Бұл кейсті ұсыну арқылы біз дәрігерлердің миоманың сирек кездесетін жедел асқынулары туралы хабардарлығын арттыруға және қолжетімді мультимодальды емдеу стратегияларын, профилактикалық шараларды және алдын алу әдістерін ұсынуға тырысамыз.

Түйін сөздер: жатыр миомасы, веналық тромбоэмболия, өкпе эмболиясы, вена тромбозы.

Гигантская миома матки у пациентки с тромбоэмболией легочной артерии

Торебек Ж.К. [1], Иманкулова Б.Ж. [2]

[1] Врач-резидент акушер-гинеколог, Назарбаев Университет Школа Медицины, Астана, Казахстан.
E-mail: zhannur.torebek@nu.edu.kz
[2] Ассоциированный профессор, Врач акушер-гинеколог высшей категории, Клинический академический департамент «Женское здоровье», Корпоративный фонд «University Medical Center», Астана, Казахстан. E-mail: imanbalken@mail.ru

Резюме

Введение. Миома матки - часто встречающийся диагноз у женщин репродуктивного возраста. Она возникает в результате моноклональной пролиферации гладкомышечных клеток миометрия. Примерно у 75% женщин миома диагностируется к 50 годам. В зависимости от локализации она может быть классифицирована как субсерозная, интрамуральная, подслизистая или на ножке. Во многих случаях миома может протекать бессимптомно, но наиболее распространенными проявлениями миомы матки являются обильные менструальные кровотечения, чувство давления в области таза или боли внизу живота. Диагноз ставится с помощью трансвагинального ультразвукового исследования. В редких случаях для детального картирования может использоваться магнитно-резонансная томография (МРТ). Острые осложнения лейомиомы матки встречаются нечасто и включают тромбоэмболию, задержку мочи, вагинальное или внутрибрюшное кровотечение и перекрут полипов на ножке. Даже если острые осложнения, такие как тромбоз глубоких вен (ТГВ) и легочная эмболия (ЛЭ), встречаются крайне редко, они связаны со значительной заболеваемостью и смертностью.

Мы представляем случай 48-летней пациентки, обратившейся в Клинический академический департамент «Женское здоровье» Корпоративного фонда «University Medical Center» (UMC) в Астане с анамнезом легочной эмболии, развившейся вследствие крупной миомы матки. Пациентка была успешно пролечена супрацервикальной гистерэктомией. Особенность этого случая заключается в том, что у пациентки не было других факторов риска тромбоэмболических заболеваний, таких как длительная иммобилизация, госпитализации, хирургические вмешательства, история приема оральных контрацептивов и так далее. Ее тромбоэмболия была вызвана главным образом механической обструкцией тазовых вен крупной миомой.

Мы стремимся подчеркнуть важность тщательного обследования пациенток с миомами матки, которые в большинстве случаев считаются доброкачественными заболеваниями. Представляя случай пациентки с анамнезом тромбоза глубоких вен, за которым последовала легочная эмболия вследствие гигантской лейомиомы, мы стремимся повысить осведомленность врачей о редких осложнениях миомы и представить доступные стратегии мультимодального лечения, профилактические меры и методы профилактики.

Ключевые слова: миома матки, венозная тромбоэмболия, легочная эмболия, тромбоз вен.