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Case Report

Uterine myoma in a perimenopausal woman: A case report of abnormal uterine bleeding following amenorrhea

Abitmer Gultom[1], Niluh Erin Kusuma[1], Silphia Novelyn[2]

From [1]Specialist in Obstetrics and Gynecology, MARS, Department of Obstetrics and Gynecology, Faculty of Medicine, [2]Master of Biomedicine, Department of Anatomy, Faculty of Medicine, Universitas Kristen Indonesia, Jakarta, Indonesia

ABSTRACT

Uterine leiomyoma, or uterine fibroid, is a common benign tumor arising from the smooth muscle of the uterus. Although many fibroids are asymptomatic, symptomatic patients may present with heavy menstrual bleeding, pelvic pain, or other pressure-related symptoms. A 42-year-old woman presented to the Emergency Department with severe lower abdominal pain and heavy vaginal bleeding after 3 months of amenorrhea. Approximately 12 h before admission, she passed dark reddish-black blood accompanied by tissue and required frequent sanitary-pad changes. The patient reported nausea but no vomiting, fever, vaginal discharge, or fluid leakage. On examination, she was hemodynamically stable, with suprapubic tenderness. Gynecological examination demonstrated tissue at the external genitalia, although speculum and vaginal examinations were not performed. Laboratory evaluation showed a hemoglobin level of 10.7 g/dL, hematocrit of 33%, leukocyte count of 6.6 thousand/µL, and platelet count of 288 thousand/µL. Pelvic ultrasonography demonstrated a hypoechoic, round, well-defined uterine mass measuring 7.12 × 7.94 cm. Based on the clinical presentation and imaging findings, a uterine fibroid was diagnosed. The patient was managed conservatively with intravenous fluids, analgesic/anti-inflammatory therapy, norethisterone, and medication to control bleeding, followed by outpatient follow-up with an obstetrician-gynecologist. This case illustrates a symptomatic uterine fibroid presenting with heavy vaginal bleeding and severe pelvic pain following a period of amenorrhea. Because pregnancy testing, characterization of the passed tissue, and histopathological examination were not documented, the relationship between the amenorrhea and the passed tissue cannot be definitively established.

Key words: Abnormal uterine bleeding, Amenorrhea, Pelvic pain, Ultrasonography, Uterine leiomyoma, Uterine myoma

Uterine fibroids (uterine myomas) are benign tumors that develop in the uterine muscle and surrounding connective tissue. This condition is also commonly referred to as uterine fibromioma, uterine leiomyoma, or uterine fibroids. Epidemiological data indicate that 70% of cases occur by the age of 50 years, with 30–40% of cases occurring during the perimenopausal period and 20–25% among women of reproductive age. Uterine fibroids require attention because most cases are asymptomatic [1]. The etiology of uterine fibroids remains unclear; however, their growth is strongly associated with estrogen production. Fibroids exhibit maximum growth when estrogen levels are high. Therefore, they tend to grow during puberty and the reproductive period, enlarge during pregnancy, and shrink when women enter menopause [2]. Based on epidemiological data, uterine fibroids occur in 20–25% of women of reproductive age and in 40–50% of women over 40 years of age. Black women are more likely to develop uterine fibroids than White women. The prevalence of uterine fibroids increases to more than 70% when assessed by pathological examination of the uterus, demonstrating that many women have asymptomatic fibroids, while only approximately 30% of cases are symptomatic. Fibroids are rare, or almost never found, before menarche; after menopause, only approximately 10% of fibroids continue to grow [3]. In Indonesia, national statistical data on uterine fibroids are currently unavailable, and epidemiological studies on leiomyoma remain very limited. A retrospective study conducted in Manado found that the highest proportion of cases occurred among women aged 36–45 years, with a predominance of nulliparity [4].

Access this article online	
Received - 30 August 2026 Initial Review - 14 September 2026 Accepted - 10 October 2026	Quick Response code
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CASE REPORT

The patient was a 42-year-old woman who presented to the Emergency Department of Rumah Sakit Umum

Correspondence to: Abitmer Gultom, Jl. Mayjen Sutoyo No. 2 Cawang, Jakarta Timur, Jakarta, Indonesia. E-mail: abitmer.gultom@uki.ac.id

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Universitas Kristen Indonesia with lower abdominal pain that had begun approximately 1 day before admission. The pain was continuous and described as a squeezing sensation, accompanied by a burning sensation extending to the back. Approximately 12 h before admission, she developed dark reddish-black vaginal bleeding accompanied by passage of tissue. The bleeding was described as heavy, requiring a change of sanitary pad approximately every 3 h; by the time she arrived at the Emergency Department, she had changed six pads. The patient had no history of hypertension, diabetes mellitus, heart disease, or asthma. She reported several medication allergies, including an allergy to tranexamic acid. Menarche occurred at 13 years of age, followed by regular monthly menstrual cycles lasting approximately 7 days, with approximately four pad changes per day. The patient had previously given birth vaginally in 2008. She had used an intrauterine device for 1 year after delivery, followed by an implant for 2 years because of an infection, and subsequently did not use contraception. A family history of similar symptoms and uterine fibroids was reported in her grandmother.

The patient attempted to relieve the pain with paracetamol purchased independently, but the pain persisted, with a Visual Analog Scale (VAS) score of 8/10. The pain was somewhat relieved when she stood. She reported that this was her first episode of vaginal bleeding after 3 months without menstruation. She had experienced a similar 3-month menstrual delay the previous year and reported that a pregnancy test at that time was negative; menstruation subsequently resumed. However, the current episode was associated with substantially more severe pain. She also reported nausea but denied vomiting, fever, vaginal discharge, bloody mucus, or fluid leakage. Bowel movements and urination were normal.

Because the patient had experienced 3 months of amenorrhea followed by heavy vaginal bleeding and passage of tissue, pregnancy should have been excluded as part of the initial diagnostic evaluation. However, a urine pregnancy test or serum beta human chorionic gonadotropin (β-hCG) result was not documented in the available medical record. Therefore, the episode should not be retrospectively characterized as either a menstrual episode or a miscarriage without additional evidence.

On admission, the patient was moderately ill-appearing but conscious and hemodynamically stable. Blood pressure was 119/75 mmHg, pulse rate was 75 beats/min, respiratory rate was 20 breaths/min, temperature was 36.5°C, and oxygen saturation was 99% on room air. Suprapubic tenderness was present. Gynecological examination showed tissue at the external genitalia. There was no active bleeding at the time of examination. Speculum examination and vaginal examination were not performed.

Laboratory examination on May 23, 2025 showed a hemoglobin level of 10.7 g/dL, hematocrit of 33%, leukocyte count of 6.6 thousand/µL, and platelet count of 288 thousand/µL. Urinalysis demonstrated hematuria, with blood +2 and 45–50 erythrocytes per high-power field. Leukocytes were 3–4 per high-power field, with negative leukocyte esterase and nitrite.

Pelvic ultrasonography performed on May 23, 2025 demonstrated a hypoechoic, round, well-defined mass arising from the uterine wall, measuring 7.12 × 7.94 cm. These findings were considered consistent with a uterine fibroid (Fig. 1). The patient was diagnosed clinically with a uterine fibroid based on the presenting symptoms and ultrasonographic findings.

On May 24, 2025, her abdominal pain had improved from a VAS score of 8/10 to 2/10. However, she continued to experience dark reddish-black spotting and passage of tissue through the birth canal. She continued to report heavy bleeding and had changed approximately five sanitary pads. The hemoglobin concentration remained 10.7 g/dL, with a hematocrit of 33%, leukocyte count of 6.6 thousand/µL, and platelet count of 288 thousand/µL. The patient received intravenous Ringer's lactate, Cefobactam, Fetik, Primolut N, and ondansetron.

The patient was discharged for outpatient management on May 26, 2025, at 17:00 Western Indonesian time. Discharge medications included Primolut N 5 mg once daily and tranexamic acid 500 mg 3 times daily, with follow-up planned with an obstetrician-gynecologist on June 02, 2025.

DISCUSSION

Uterine leiomyoma is a benign tumor arising from the smooth muscle cells of the uterus. Fibroids may vary in number, size, location, and clinical presentation. Many patients remain asymptomatic, whereas symptomatic patients may experience heavy menstrual bleeding, pelvic pain, pressure symptoms, or reproductive problems [5,6].

In the present case, the most clinically significant manifestations were heavy vaginal bleeding and severe lower abdominal pain. The patient reported 3 months of amenorrhea before the current episode. However, because no pregnancy test or serum β-hCG was documented, the amenorrhea cannot be definitively attributed to uterine fibroids. In a reproductive-age woman presenting with amenorrhea followed by heavy vaginal bleeding and passage of tissue, pregnancy-related causes, including early pregnancy loss, should be considered and excluded



Figure 1: Ultrasound examination findings (May 23, 2025)

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before attributing the episode solely to a fibroid [7-9].

The patient's leukocyte count was 6.6 thousand/µL, which is within the reported laboratory range and does not demonstrate leukocytosis [10]. There was also no documented fever or other systemic evidence of infection at presentation. The patient was afebrile at 36.5°C. The ultrasonographic finding of a hypoechoic, round, well-defined uterine-wall mass measuring 7.12 × 7.94 cm supports the diagnosis of uterine fibroid.

The patient's symptoms may reasonably be considered compatible with a symptomatic fibroid, particularly because heavy vaginal bleeding and pelvic pain are recognized manifestations of uterine fibroids. However, because the patient also presented with 3 months of amenorrhea and passed tissue, the bleeding episode should not automatically be attributed entirely to the fibroid without excluding pregnancy-related pathology. The issue of fertility is also relevant to treatment planning. The patient had previously delivered one child, but the available record does not document whether she desired another pregnancy. Consequently, no conclusion regarding fertility preservation can be made from the present case. At follow-up, reproductive goals should be specifically assessed because they may influence the choice among medical therapy, myomectomy, uterine artery embolization, or hysterectomy.

The management of uterine fibroids depends on symptom severity, fibroid characteristics, patient age, reproductive goals, and treatment preferences. In this case, initial conservative management was undertaken because the patient was hemodynamically stable and the pain subsequently improved. Continued assessment is warranted because she had ongoing vaginal bleeding and passage of tissue at follow-up [11-15].

The patient's peripheral leukocyte count was 6.6 thousand/µL, and no clinical evidence of systemic infection was documented. If antibiotic therapy was administered for another clinical reason, that indication should be explicitly stated based on the treating physician's documentation [16].

An important limitation of this case is the absence of characterization of the tissue passed vaginally. Because the patient had amenorrhea for 3 months, passage of tissue raises the possibility of pregnancy-related tissue, but this cannot be established without pregnancy testing and/or pathological examination. Conversely, although a large uterine fibroid was identified, there is insufficient evidence to conclude that the passed tissue represented necrotic or prolapsed fibroid tissue [5,17,18].

CONCLUSION

This case describes a 42-year-old woman with a large uterine-wall mass consistent with a uterine fibroid who presented with severe lower abdominal pain and heavy vaginal bleeding following 3 months of amenorrhea. Ultrasonography demonstrated a hypoechoic, round, well-defined uterine mass measuring 7.12 × 7.94 cm. The case emphasizes the importance of evaluating alternative causes of abnormal uterine bleeding when amenorrhea precedes the bleeding episode. In particular, pregnancy should be excluded with urine pregnancy testing or serum β-hCG, and passed tissue should be appropriately characterized when available. In this patient, neither pregnancy testing nor histopathological examination of the passed tissue was documented, preventing definitive determination of its nature.

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Funding: Nil; Conflicts of interest: Nil.

How to cite this article: Gultom A, Kusuma NE, Novelyn S. Uterine myoma in a perimenopausal woman: A case report of abnormal uterine bleeding following amenorrhea. Indian J Case Reports. 2026; October 16 [Epub ahead of print].

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