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Caesarian Myomectomy in a Case of Precious Pregnancy with Adherent Placenta

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Abstract: ***Background****: Uterine fibromyomas affect a large number of women accounting for significant morbidity and health care costs during reproductive age. Conventionally, obstetricians are trained to defer myomectomies during caesarean sections as severe hemorrhages can occur, which may often impose hysterectomies. Recent literatures states that, however, studies and meta - analyses have been carried out signifying that caesarean myomectomy is a safe surgical procedure with careful patient selection and it doesn't add to any additional post - operative morbidity. Here's a case report of one such patient encountered where caesarean myomectomy was rather unavoidable.*

Keywords: Uterinefibroid, Caesareansection, Myomectomy

1. Introduction

Uterine leiomyoma is the most common uterine neoplasm of women of reproductive age. Uterine leiomyomas are benign clonal tumors arising from the muscle cell of the uterus. The latest statistics confirm that uterine leiomyomas are present in 20 - 50% women of reproductive age.1 Indeed, they are found in up to 77% of women if the uterus is examined closely at autopsy.2 The incidence of uterine leiomyomas in pregnancy varies from 1.6% to 10.7% according to the trimester of assessment and the size threshold.3 The impact of uterine myomas on pregnancy depends on the size, location and number of myoma.

Myomas with diameter more than 5 cm have been associated with preterm labor, premature rupture of membranes and post partum hemorrhage.4

During pregnancy leiomyoma usually remain asymptomatic, but they may be associated with increased risk of spontaneous abortion, premature rupture of membranes, preterm labour, antepartum hemorrhage, abruptio placenta, mal presentation and high incidence of caesarean delivery. Sometimes it may undergo red degeneration usually during second trimester of pregnancy. If it is located in lower uterine segment or cervix, it can lead to obstructed labour or cervicaldystocia. It can also cause postpartum endomyometritis, sub involution of uterus, retained placenta and post partum haemorrhage[5, 6].

Management of myoma during caesarean section remains a debatable issue. Myomectomy during cesarean section had no place in obstetrics literature until recently and it was widely suggested to postpone the myomectomy and perform it later before the next pregnancy[7]. The most common reason for deferring myomectomy has been prevention of unwanted hysterectomy due to uncontrolled hemorrhage that adds to post - operative morbidity and mortality and increased hospital stay.7, [8]. Many sources still discourage routinely performed myomectomy during caesarean section for these reasons. Recent literatures states that, however, studies and meta - analyses have been carried out signifying that caesarean myomectomy is a safe surgical procedure and that positive results may be obtained for subsequent pregnancy outcomes. It also reduces the risk of anesthetic complications, multiple surgeries, adhesions and intra or postoperative hemorrhage, exorbitant costs of operative procedures, and hospital stay.

Here authors report an interesting case of elderly pregnant patient with previous 1 lower segment caesarean section with IVF conception with adherent placenta and a large subserous fibroid in the right lateral uterine wall where myomectomy was done during caesarean section.

2. Case Report

A 37 years old elderly gravida 2 with previous caesarean with Rh negative pregnancy with precious conception presented with 9 months amenorrhea. On examination her vitals were stable with auterus of larger than term size with irregular contour. Her 3rd Trimester Ultrasound revealed BreechpresentationwithPlacentaAnteriorevidenceofplacental adherence. Liquor was adequate with fetal heart rate 149bpm and estimated fetal weight of 2732kg. A large subserous fibroid of 11.6 X 9.1cm was seen in the right lateral wall. Patient was posted for Elective lower segment caesarean section at term.

Intra- Operative Findings: A lower segment caesarean section was done and baby delivered by breech presentation. On expulsion of placenta it was noticed that Placenta was adherent on fibroidsite. On removing placenta, capsule of fibroid was traced. Decision to do myomectomy from inside without incision on serosa was made. Additional 2 - 3 deep box stitches through n through thickness of uterus was taken to obliterate the dead space & then prophylactic bilateral internal iliac ligation was done. Proper hemostasis was achieved. Abdomen was closed in layers. Skin closed with subcuticular stitches with Monocryl no3 - 0.

Figure 1: Fibroid seen anterior to the uterine cavity

Figure 2: Fibroid capsule bring removed from the inside

Figure 3: Intactmyomae nucleated

Figure 5: Sutures taken from inside to obliterate fibroid bed

3. Discussion

Uterine myomas are being observed in pregnancy more frequently now than in the past, because of many women delaying their child bearing till their late thirties, which is the time for the greatest risk of the fibroid growth.

Caesarean myomectomy has traditionally been discouraged due to fear of intractable hemorrhage, postoperative morbidity and possibility of hysterectomy. If performed in carefully selected patients, it saves the patient, the ordeal of second admission to hospital. Recent studies have shown that caesarean myomectomy can be performed safely and successfully by an experienced obstetrician in carefully selected patients. Ehigiegba et al, conducted successful caesarean myomectomy on 25 patients and no patient required caesarean hysterectomy[9].

Some literatures suggested that caesarean myomectomy could be performed when specific factors such as the size and location of the uterine leiomyomas were considered. Song, et al. assessed the safety of myomectomy performed during caesarean section, the results showed hemoglobin levels dropped more in the caesarean myomectomy group versus the caesarean section group, but the difference was not significant.1[0]. In 2015 Topcu et al, found the size of leiomyomas alone did not seem to have a significant impact on hemorrhage since the mean hemoglobin change and frequency of blood transfusions were similar in patients with or without myomectomy during caesarean section when they were grouped by the sizeofleiomyoma[11].

Additionally, according to data from one survey, changes in fibroid size ranged from 89% shrinkage to 138% growth, with a median of 9% change in volume in a 6 - month period, moreover, fibroids can have growth spurts.1[2, 13]. In this case also the fibroids increased in size as the pregnancy continued, hence large fibroids were removed. If the myomas was left in place during caesarean section, the possibility of repeat operation for increasing growth myomas was higher in future.

4. Conclusion

Myomectomy during caesarean section is a safe procedure. The old dictum discouraging caesarean myomectomy should be reassessed. Although myomectomy during pregnancy should not be done, but during caesarean section, it is a successful undertaking[14].

Understanding hemostasis achievements, techniques, expertise, availability of blood components and expert anesthetist are some of the critical requirements for undertaking caesarean myomectomy. It is also gratifying to the patient as she is relieved of stress and displays satisfactionandsenseofwellbeingonknowingthatanextralifeti mesurgicalprocedure has been minimized.

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