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Case Report

Pregnancy complicated by myoma: a case report

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ABSTRACT

Leiomyomas are the most common benign tumor of the uterus and affects 40% to 50% of women. Most of them are asymptomatic (70-80%) but 5% are symptomatic. Fibroid in pregnancy affects its outcomes. Fibroid in pregnancy can be managed conservatively or surgically in the form of myomectomy or hysterectomy. Fibroids when present are associated with complications in 10-40% of pregnant patients like abdominal pain, spontaneous abortion etc.

Keywords: Leiomyomas, Benign tumor, Myomectomy, Hysterectomy, Abortion

INTRODUCTION

Uterine fibroids are the most common benign tumor of female reproductive system. It develops from smooth muscle of the uterus. The incidence of fibroids in pregnancy is 0.1-10.7% of all pregnant women and incidence increases with increasing maternal age.¹ Despite, most of fibroids show no change in size during pregnancy, few may increase in volume due to elevated vascular supply to uterus and increased level of steroid hormone.² Ultrasound's ability to detect fibroid in pregnancy is much lower, owing to difficulties in distinguishing fibroid from normal myometrial thickness. Fibroids affects the fertility and pregnancy outcomes.

CASE REPORT

39 years old G3P2L2, married since 21 years with previous 2 full term normal delivery, one male 19 years old and one female 17 years old with non tubectomised came with 7 months amenorrhoea with history of contraceptive failure came with complaints of pain in abdomen on -off since 2 month which was radiating from front to back, not relieved on rest. She also has a history of increased frequency of micturition. Then on ultrasound there was evidence of single live intrauterine pregnancy of 28.6 weeks of

gestational age along with 13.4×15 cm of large fibroid of anterior wall of uterus which is extending up to cervix. Then patient was hospitalized and kept under observation. Steroids were given for lung maturation of fetus. Even after analgesics and tocolytics her pain was not relieved. Then at 29.2 weeks of gestational age she had acute pain in abdomen which was suspicious of red degeneration of fibroid. On examination, her vitals were stable, mild pallor was present.

Per abdomen-uterus size 28-30 weeks, irritable, a separate hard mass of size 16-18 weeks palpated in lower segment, tenderness++, PV-cx patulous os. Her all-blood investigations were done all were within the normal range. Then decision of emergency LSCS was taken. A high-risk informed consent with arrangement of 2-pint PCV blood products and SOS chances of bilateral internal iliac ligation, obstetrics hysterectomy, chances of ICU admission, fetal risks were explained. Then patient was taken for emergency LSCS under aseptic precautions.

After detailed examination of patient, decision of pfannenstiel incision after spinal anesthesia taken. Abdomen opened in layers, there was evidence of 12×15 cm of lower uterine segment fibroid which was hard in consistency and with increased vascularity. There was

dilemma in taking decision whether to take vertical incision or transverse incision on uterus. Decision of intra cesarean myomectomy taken as fibroid was large anterior and extending till cervix. Considering difficulty in delivering baby with classical incision and need to deliver baby within 3 min, lower segment transverse incision taken on uterus. Excision of fibroid (myomectomy) done within 2 minutes and cautery was used to minimize the bleeding. A preterm male baby delivered of weight 1.8 kg. Baby cried after birth and handed over to NICU. Placenta and membranes are removed completely.

Even after oxytocic, uterus was atonic then decision of bilateral internal iliac ligation was taken through posterior approach to immediately minimize bleeding. Also, there were 2 more fibroids in upper segment of uterus of size 3×2×1 cm and 2×1×1 cm approximately, myomectomy done and then closed the lower segment of uterus in double layers. Still uterus was atonic then bilateral uterine artery ligation and B-lynch compression sutures were taken to preserve the uterus.



Figure 1: Pre operative photo of uterus 28 weeks of pregnancy with fibroid.



Figure 2: Pfannenstiel incision on suprapubic region.



Figure 3: Myomectomy.



Figure 4: A preterm male baby delivered.

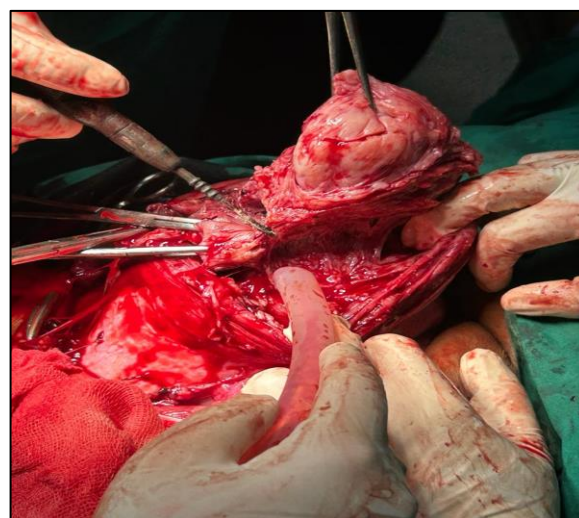


Figure 5: Another fibroid in upper segment of size 3×2×1 cm.

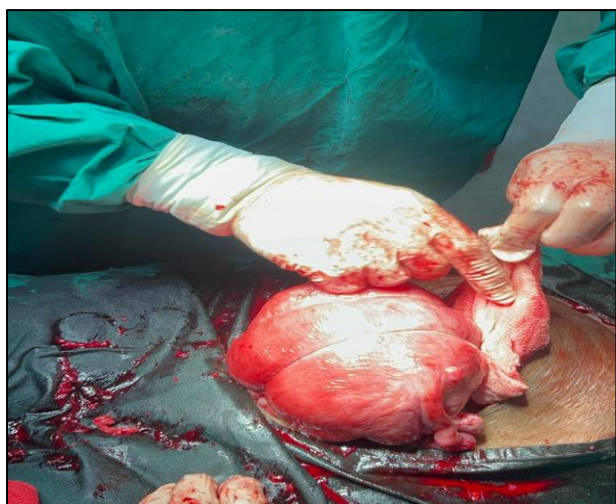


Figure 6: B-Lynch compression sutures.

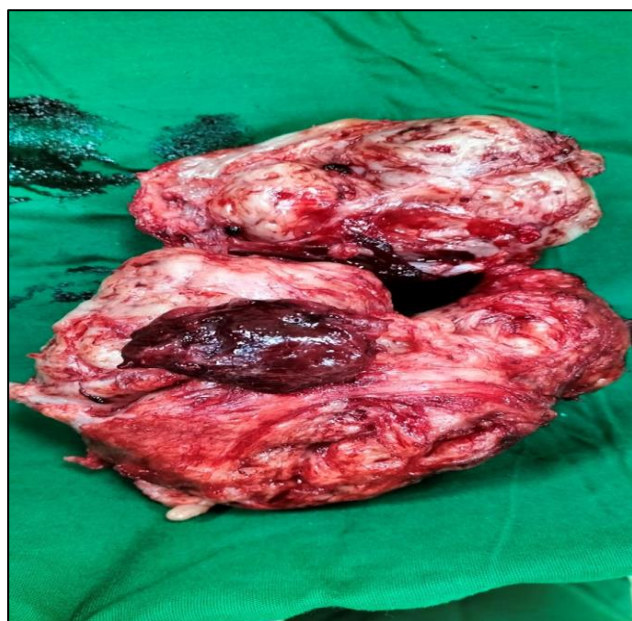


Figure 7: Total fibroid of size 12×15 cm.

Hemostasis confirmed uterus was well contracted then. At last scar was so clean and looks like LSCS scar. Overall estimated blood loss was 500 ml, intraoperative 2-pint pcv transfused post operatively prophylactically condom catheterization done in posterior vaginal fornices. Higher antibiotics were given. Intraoperatively and post operatively there were no complications. Postoperatively USG findings were bulky postpartum status with postoperative changes noted in anterior myometrium. Patient was discharged after 10 days. Patient was under regular follow up.

DISCUSSION

The incidence of pregnancy with fibroid uterus increases because of delay in conception and rising maternal age. Size and location of fibroid are two important things which

predict morbidity in pregnancy. Many fibroids remain asymptomatic. Pain is the most common complication in pregnancy with myoma. This is due to red degeneration of fibroid mostly in 2nd and 3rd trimester. Three main theories have been proposed to explain the severe pain associated with red degeneration. First, that rapid fibroid growth results in the tissue outgrowing its blood supply leading to tissue anoxia, necrosis, and infarction.⁴ Second, that the growing uterus results in a change in the architecture (kinking) of the blood supply to the fibroid leading to ischemia and necrosis even in the absence of fibroid growth.⁵

Third, that the pain results from the release of prostaglandins from cellular damage within the fibroid. This is supported by the observation that ibuprofen and other prostaglandin synthetase inhibitors effectively and rapidly control fibroid pain.⁴ Sometimes symptoms can be managed conservatively if size of fibroid is less than 5 cm but in this case as fibroid is of large size and it was present along the whole suture line decision of myomectomy along with EMLSCS was taken and it became possible as patient was in experienced hands. This case also shows that myomectomy can be done along with C-section if managed properly by anticipating PPH rather than conservative management. A successful myomectomy in India was reported by Jhalta et al in which a woman with a large abdominopelvic mass was operated during early stages of pregnancy.⁶

It describes laparotomy performed at the 13 weeks and 2 days of gestation age. It was deemed necessary due to the large size of the abdominopelvic mass. This pregnancy ended in the delivery of a healthy fetus validating the appropriateness of the early myomectomy. There are also reports on late myomectomy.⁶ An example is a report from Singapore that signifies the importance of myomectomy during cesarean section.⁷ In our case, myomectomy was inevitable as the myoma was in the incision line, making wound closure impossible. Every possible effort should be made to reduce the blood loss. Bilateral ligation of uterine arteries immediately after delivery of the fetus significantly reduces both intraoperative and postoperative blood loss and risk of peripartum hysterectomy.⁸ It also reduces the recurrence of myomas and minimizes the need for future surgery, with no apparent effect on fertility.⁹

This was a key step in our case which prevented the dreaded complications. Also, the postpartum uterus is better adapted physiologically to control bleeding than in any other phase of a woman's lifetime. The patient and relatives should be properly counseled and informed that removal of myoma is possible, and a final decision can be taken at the time of cesarean based upon the size, number, and location of the fibroid.

CONCLUSION

Myomectomy seems safe during cesarean section if those pregnancies complicated by symptomatic fibroids but

should be done at tertiary care hospital with experienced surgeon. Size and location of myoma is to be considered while doing myomectomy. Large and lower segment myomas removal is beneficial as they can prevent PPH and sepsis.

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