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Original Research Article

Success rate of peripartum myomectomy during cesarean delivery: a hospital-based study

Shamsun Nahar Shapna[1]*, Sakti Das[2], Shahida Akter[3]

[1]Department of Obstetrics and Gynecology, Railway General Hospital, Dhaka, Bangladesh
[2]Department of Gynecology, Sir Salimullah Medical College, Mitford Hospital, Dhaka, Bangladesh
[3]Salauddin Specialized Hospital, Dhaka, Bangladesh

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***Correspondence:**
Dr. Shamsun Nahar Shapna,
E-mail: shamsunnaharshapna19@gmail.com

ABSTRACT

Background: Although cesarean myomectomy was traditionally avoided because of hemorrhage risk, recent evidence suggests that it may be feasible in carefully selected women with appropriate surgical expertise and hemostatic support. Therefore, this study aimed to determine the success rate and short-term maternal outcomes of peripartum myomectomy performed during cesarean delivery.

Methods: This hospital-based observational study included 150 consecutive women with sonographic and/or intraoperative uterine fibroids undergoing cesarean delivery with planned peripartum myomectomy under spinal anesthesia at Salauddin Specialized Hospital, Dhaka, Bangladesh, between 2023 and 2025. The primary outcome was successful myomectomy without hysterectomy or abandonment. Secondary outcomes included postpartum hemorrhage, hemoglobin drop, transfusion, uterine atony, infection, hospital stay and in-hospital mortality.

Results: Mean maternal age was 31.2±5.4 years and mean gestational age was 38.1±1.7 weeks. Previous cesarean section was present in 52.0% of cases, while 58.7% were emergency procedures. Post-delivery myomectomy was performed in 96.7%. Mean operative time was 78.5±19.6 minutes and median blood loss was 850 mL (IQR 650–1100). Single fibroids occurred in 61.3% of patients, with a median size of 6.5 cm, mainly subserosal or intramural. Procedural success was achieved in 92.0%; hysterectomy and abandonment each occurred in 2.7%. Postpartum hemorrhage occurred in 12.0%, transfusion in 14.7%, fever in 10.7% and wound infection in 6.0%. Median hospital stay was 4 days, with no maternal deaths.

Conclusions: Cesarean myomectomy achieved a 92.0% success rate, with low hysterectomy rates and no maternal mortality. With careful patient selection, experienced surgeons and adequate hemorrhage-control measures, the procedure may be a feasible option for avoiding subsequent surgery.

Keywords: Cesarean myomectomy, Peripartum myomectomy, Postpartum hemorrhage, Uterine fibroid

INTRODUCTION

Uterine fibroids or leiomyomas, are the most common benign tumors of the female reproductive tract and affect women of reproductive age. Their prevalence varies by age, ethnicity, diagnostic method and study population and cumulative prevalence may reach approximately 70% by 50 years of age.[1] Although many fibroids remain asymptomatic, their presence during pregnancy may be clinically important because hormonal stimulation, increased uterine vascularity and uterine enlargement can alter their size and anatomical effects. Depending on their number, size and location, fibroids may contribute to pain, malpresentation, dysfunctional labor, obstruction of the birth canal, cesarean delivery and postpartum hemorrhage.[2] Recent evidence has shown that pregnancies complicated by uterine fibroids are associated with increased risks of preterm birth, miscarriage, placenta

previa, placental abruption, fetal malpresentation, cesarean delivery and postpartum hemorrhage.[2] These risks are not uniform. Larger, multiple, intramural, cervical and lower-segment fibroids may produce greater distortion of the uterine cavity or interfere with uterine contractility and delivery. Management should therefore be individualized according to fibroid burden, symptoms, placental relationship and potential obstruction of fetal delivery or uterine incision. Cesarean delivery has increased substantially worldwide, accounting for more than one-fifth of births, with marked regional variation.[3] A similar trend has occurred in South Asia and Bangladesh, where cesarean utilization has risen rapidly, particularly in institutional and private-facility deliveries.[4,5] As cesarean delivery and antenatal ultrasonography become more common, obstetricians increasingly encounter fibroids before or during surgery. Consequently, deciding whether to remove a fibroid during the same operation has become a recurring clinical issue.

Traditionally, cesarean myomectomy was discouraged because the gravid uterus is highly vascular and myometrial incision may result in severe hemorrhage, transfusion, uterine atony, emergency hysterectomy or maternal death. Removal was therefore often postponed until uterine involution after childbirth. However, delaying treatment may expose women to persistent symptoms, repeat hospitalization, repeat anesthesia, additional surgery and greater financial burden. In some cases, myomectomy may also be necessary when a fibroid obstructs fetal delivery, lies across the uterine incision, prevents adequate closure or is pedunculated and readily accessible. During the past decade, observational studies and meta-analyses have challenged the traditional view that cesarean myomectomy should be avoided in all cases. Available evidence suggests that the procedure may cause modest increases in operative time, blood loss, postoperative hemoglobin reduction, transfusion or hospital stay, without a consistent increase in catastrophic maternal complications when patients are carefully selected and managed by experienced teams.[6-10]

Recent studies have also suggested that transfusion risk may be influenced more by fibroid burden, emergency surgery, baseline anemia and obstetric complexity than by myomectomy alone.[11-13] Nevertheless, the 2025 Cochrane review assessed the certainty of evidence regarding hemorrhage, transfusion, major surgery, operative duration and hospitalization as very low because most studies were observational and were affected by selection bias, confounding and inconsistent outcome definitions.[14] Cesarean myomectomy should therefore be regarded as a systems-dependent procedure requiring appropriate case selection, experienced surgeons, uterotonic agents, blood-product availability and access to hemostatic measures such as tranexamic acid, vasopressin, uterine artery ligation, compression sutures and topical agents.[12,13,15] These requirements are important in resource-constrained settings, where hemorrhage may have greater consequences because access to transfusion, intensive care and specialist surgical support may be limited. Evidence from Bangladesh remains scarce regarding procedural success, reasons for failure, hemorrhage-related morbidity, transfusion, infection, hospitalization and maternal mortality after cesarean myomectomy. Therefore, this study aimed to determine the success rate of peripartum myomectomy performed during cesarean delivery and to describe its short-term maternal outcomes, including postpartum hemorrhage, hemoglobin reduction, transfusion, uterine atony, postoperative infection, length of hospital stay, conversion to hysterectomy and in-hospital mortality.

METHODS

This hospital-based observational study evaluated the success rate and short-term maternal outcomes of peripartum myomectomy performed during cesarean delivery in 150 consecutive eligible patients under spinal anesthesia. The study was conducted over 2 years, from 2023 to 2025, at Salauddin Specialized Hospital, Dhaka, Bangladesh. Eligible participants were pregnant women with uterine fibroids confirmed sonographically, intraoperatively or both, for whom the surgical team planned myomectomy at the time of cesarean section. Exclusion criteria included suspected uterine malignancy, placenta accreta spectrum requiring planned hysterectomy, uncorrected coagulopathy or incomplete perioperative records.

Baseline maternal variables recorded at admission included age, body mass index (BMI), gravidity, parity, gestational age at delivery, prior cesarean history, antenatal care status, comorbidities and preoperative hemoglobin level. Operative data collected comprised cesarean urgency (elective or emergency), primary indication for cesarean, type of uterine incision, timing of myomectomy relative to delivery, total operative duration, estimated blood loss and use of surgical drains. Fibroid assessment was standardized by documenting the total number of fibroids, identifying a dominant fibroid per case and recording the dominant fibroid's size (cm), type (subserosal, intramural, pedunculated, cervical or broad ligament), location (anterior, posterior, fundal or lateral), lower segment involvement and whether the fibroid obstructed delivery or the planned incision. Intraoperative hemostatic measures were recorded as non-mutually exclusive strategies, including routine oxytocin infusion, additional uterotonics, tranexamic acid and selective interventions such as Carbetocin injection, vasopressin injection, uterine artery ligation, compression sutures and topical hemostatic agents, as determined by the surgeon and bleeding severity. The primary outcome was 'successful peripartum myomectomy,' defined as the completion of fibroid removal during cesarean delivery without escalation events such as conversion to hysterectomy or abandonment of the procedure with the fibroid not removed. Any escalation event classified the case as unsuccessful, with the primary reason coded as mutually exclusive. Secondary outcomes included primary

postpartum hemorrhage, postoperative hemoglobin at 24–48 hours, hemoglobin drop, transfusion requirement and number of packed red blood cell units, uterine atony, postoperative infections, length of hospital stay and in-hospital mortality.

For data analysis, data were entered and analyzed using SPSS (v. 26.0). Normally distributed continuous variables were summarized as mean±standard deviation, while skewed continuous variables were presented as median and interquartile range. Categorical variables were reported as frequency and percentage. The primary success rate was calculated as the number of successfully completed procedures divided by the total number of women undergoing planned peripartum myomectomy.

RESULTS

Among 150 women undergoing peripartum myomectomy during cesarean delivery, the mean age was 31.2±5.4 years and mean BMI was 26.1±3.6 kg/m². The typical obstetric profile was gravida 2 (IQR 2–3) and parity 1 (IQR 1–2), with delivery occurring at a mean gestational age of 38.1±1.7 weeks. Over half had a previous cesarean (52.0%), most received regular antenatal care (82.7%), nearly one-third had any comorbidity (30.7%) and mean preoperative hemoglobin was 10.6±1.2 g/dl.

Regarding the cesarean and operative profile, 88 (58.7%) procedures were performed as emergency operations, while 62 (41.3%) were elective. The most frequent primary indication for cesarean delivery was previous cesarean delivery, reported in 58 (38.7%) cases, followed by fetal distress in 27 (18.0%) and cephalopelvic disproportion or failed progress in 23 (15.3%). A transverse lower-segment uterine incision was used in 146 (97.3%) cases and myomectomy was performed after fetal delivery in 145 (96.7%). The mean operative duration was 78.5±19.6 minutes, while the median estimated blood loss was 850 ml (IQR: 650–1100). A surgical drain was placed in 40 (26.7%) patients.

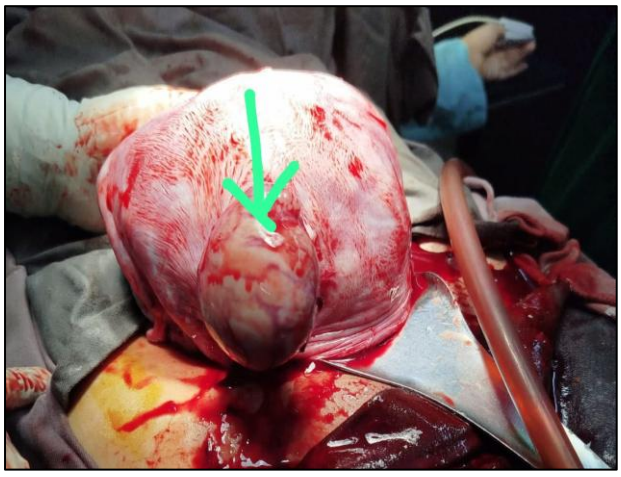

Figure 1: Myoma in the anterior aspect and also in the lateral aspect of the uterus.

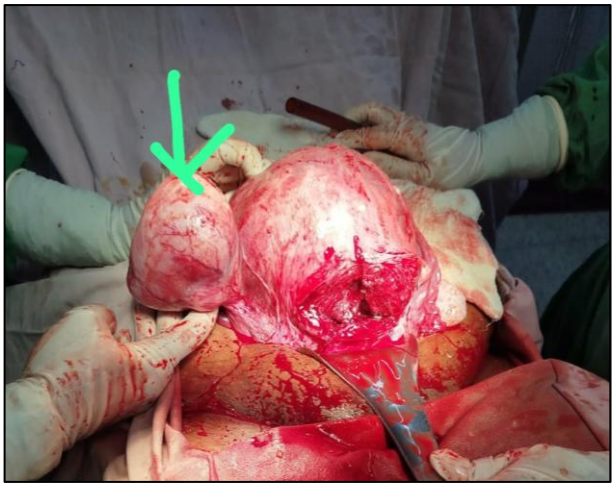

Figure 2: Myoma in the lateral aspect of uterus.

Figure 3: Myoma in the posterior aspect of uterus.

Regarding fibroid characteristics, a single fibroid was present in 92 (61.3%) patients, while 46 (30.7%) had two to three fibroids and 12 (8.0%) had four or more. The median diameter of the dominant fibroid was 6.5 cm (IQR: 5.0–8.0). Subserosal fibroids were the most common type, observed in 68 (45.3%) cases, followed by intramural fibroids in 57 (38.0%). The anterior uterine wall was the most frequent location, accounting for 74 dominant fibroids (49.3%). Lower-segment involvement was identified in 26 (17.3%) cases, while obstruction of fetal delivery or the planned uterine incision was documented in 19 (12.7%). According to the hemostatic management protocol, oxytocin infusion and carbetocin were administered in all 150 cases (100.0%). Tranexamic acid was administered in 120 (80.0%) cases, while additional uterotonic agents were used in 98 (65.3%). Vasopressin injection was used in 22 (14.7%) cases, compression sutures in 11 (7.3%), uterine artery ligation in 9 (6.0%) and topical hemostatic agents in 6 (4.0%). Because more than one hemostatic strategy could be used in each patient, the percentages were not mutually exclusive. Overall, peripartum myomectomy was successfully completed in 138 of 150 patients, resulting in a success rate of 92.0%. Among the 12 (8.0%) unsuccessful procedures, 4 (2.7% of

the total cohort) required conversion to hysterectomy, 4 (2.7%) were abandoned without removal of the fibroid and 4 (2.7%) resulted in incomplete or partial removal of the intended fibroid. Each category represented 33.3% of the unsuccessful procedures. Regarding maternal morbidity, primary postpartum hemorrhage occurred in 18 (12.0%) patients, while uterine atony occurred in 14 (9.3%). Blood transfusion was required in 22 (14.7%) patients. Among the transfused patients, the median number of packed red blood cell units was 2 (IQR: 1–2). The mean postoperative hemoglobin level at 24–48 hours was 9.0±1.3 g/dl, with a mean reduction of 1.6±0.9 g/dl from the preoperative level. Postoperative fever occurred in 16 (10.7%) patients, while wound infection occurred in 9 (6.0%). The median hospital stay was 4 days (IQR: 3–5) and no in-hospital maternal deaths were recorded.

Table 1: Baseline maternal characteristics (n=150).

Variable	Value
Age (in years), mean±SD	31.2±5.4
BMI (kg/m²), mean±SD	26.1±3.6
Gravida, median (IQR)	2 (2–3)
Parity, median (IQR)	1 (1–2)
Gestational age at delivery (weeks), mean±SD	38.1±1.7
Previous cesarean, n (%)	78 (52.0)
Antenatal care (Regular), n (%)	124 (82.7)
Any comorbidity, n (%)	46 (30.7)
Pre-op Hb (g/dL), mean±SD	10.6±1.2

Table 2: Caesarean and operative profile (n=150).

Variable	Category	N (%)
Cesarean type	Elective	62 (41.3)
	Emergency	88 (58.7)
Indication for cesarean (primary)	Previous cesarean	58 (38.7)
	Fetal distress	27 (18.0)
	CPD or failed progress	23 (15.3)
	Malpresentation	18 (12.0)
	Placenta previa or APH	9 (6.0)
	Hypertensive disorder	7 (4.7)
	Other	8 (5.3)
Uterine incision (LSCS transverse)		146 (97.3)
Timing of myomectomy (post-delivery)		145 (96.7)
Operation duration (minutes), mean±SD		78.5±19.6
Estimated blood loss (ml), median (IQR)		850 (650–1100)
Drain placed		40 (26.7)

Table 3: Fibroid characteristics (dominant fibroid per case (n=150).

Variable	Category	N (%)
Number of fibroids	1 fibroid	92 (61.3)
	2–3 fibroids	46 (30.7)
	≥4 fibroids	12 (8.0)
Dominant fibroid size (cm), median (IQR)		6.5 (5.0–8.0)
Dominant fibroid type	Subserosal	68 (45.3)
	Intramural	57 (38.0)
	Pedunculated	18 (12.0)
	Cervical or broad ligament	7 (4.7)
Dominant fibroid location	Anterior wall	74 (49.3)
	Posterior wall	43 (28.7)
	Fundal	22 (14.7)
	Lateral wall	11 (7.3)
Lower segment involvement		26 (17.3)
Obstructing delivery or incision		19 (12.7)

Table 4: Hemostatic strategies used (multiple responses possible (n=150).

Hemostatic strategy	N (%)
Carbetocin injection	150 (100.0)
Oxytocin infusion	150 (100.0)
Additional uterotonics (any)	98 (65.3)
Tranexamic acid	120 (80.0)
Vasopressin injection	22 (14.7)
Uterine artery ligation	9 (6.0)
Compression sutures	11 (7.3)
Topical hemostats	6 (4.0)

Table 5: Primary outcome, success rate of peripartum myomectomy (n=150).

Outcome component	Category	N (%)
Successful peripartum myomectomy (overall)		138 (92.0)
Unsuccessful (overall)		12 (8.0)
Unsuccessful, primary reason (mutually exclusive)	Conversion to hysterectomy	4 (2.7)
	Procedure abandoned, fibroid not removed	4 (2.7)
	Incomplete or partial fibroid removal	4 (2.7)

Table 6: Maternal morbidity and postoperative outcomes (n=150).

Outcome	Value
Primary postpartum hemorrhage, N (%)	18 (12.0)
Post-op Hb (24–48 h), g/dl, mean±SD	9.0±1.3
Hb drop (g/dl), mean±SD	1.6±0.9
Any transfusion, N (%)	22 (14.7)
PRBC units transfused, median (IQR)	2 (1–2)
Uterine atony, N (%)	14 (9.3)
Post-op fever, N (%)	16 (10.7)
Wound infection, N (%)	9 (6.0)
Length of hospital stay (days), median (IQR)	4 (3–5)
Maternal death, N (%)	0 (0.0)

DISCUSSION

Overall, peripartum myomectomy was successfully completed in 138 of 150 women, for a success rate of 92.0%. Among the 12 unsuccessful procedures, four required hysterectomies, four were abandoned without fibroid removal and four resulted in incomplete or partial removal. Primary postpartum hemorrhage occurred in 12.0%, transfusion was required in 14.7% and the mean hemoglobin reduction was 1.6±0.9 g/dl. No maternal deaths occurred and the median hospital stay was four days. These findings suggest that cesarean myomectomy was feasible in selected women, although bleeding-related morbidity remained important. Similar studies have shown that the procedure can often be completed without hysterectomy in experienced centers.[10,13-15] Although the 92.0% completion rate appears favorable, it should not be interpreted as proof of comparative safety. The study had no cesarean-only control group and defined success as completion without hysterectomy, abandonment or incomplete removal. Therefore, the sample represented women selected for myomectomy rather than all women with fibroids, reflecting a chosen subgroup rather than the broader population. In the cohort by Zhao et al outcomes were also influenced by case selection and fibroid characteristics.[10] Likewise, the 2026 case series by Brennan et al supported technical feasibility in selected higher-risk cases.[15]

The median estimated blood loss, defined as intraoperative blood loss, was 850 ml and was close to the 800 ml reported by Jarvi et al.[11] Although blood loss exceeded that of controls, cesarean myomectomy was not independently associated with transfusion after adjustment, while lower preoperative hemoglobin was more influential.[11] In the present cohort, mean preoperative hemoglobin was 10.6±1.2 g/dl, suggesting that pre-existing anemia may partly explain the 14.7% transfusion rate. Moreover, 58.7% of procedures were emergencies, limiting anemia correction, blood preparation and operative planning. Pooled evidence also indicates modest increases in bleeding-related outcomes. In the meta-analysis by Goyal

et al a higher transfusion risk was reported, with a relative risk of 1.45.[6] In the meta-analysis by Huang et al greater hemoglobin reduction, 46 ml additional blood loss, higher odds of hemorrhage and transfusion and about 10 minutes longer operative time were found.[7] Similarly, the meta-analysis by Pergialiotis et al reported longer surgery times and greater hemoglobin reductions, without a clear increase in major postoperative complications.[8] However, the 2025 Cochrane review judged evidence concerning these outcomes to be very uncertain because most studies were observational and vulnerable to bias.[14] Thus, the present findings should be regarded as descriptive rather than as confirmation of comparative safety or harm.

The mean operative duration, defined as time from incision to closure, was 78.5±19.6 minutes, similar to the 80.22±13.06 minutes reported by El-Refaie et al.[9] Their cesarean-only group required 56.67±8.85 minutes, although transfusion and postoperative hemoglobin did not differ significantly.[9] Similarly, the study by Lee et al reported an additional 13.5 minutes of operative time and 0.7 days of hospitalization.[16] Acceptable operative and postoperative outcomes in a tertiary hospital were also reported by Ramya et al.[17] Without a comparison group, the additional time attributable specifically to myomectomy cannot be determined. Nevertheless, the four-day median stay suggests acceptable short-term recovery.

Fibroid morphology probably influenced both hemorrhage and completion. The median dominant diameter was 6.5 cm; 38.0% were intramural, 17.3% involved the lower segment and 12.7% obstructed delivery or the planned incision. In the study by Dedes et al fibroids measuring at least 5 cm independently increased the likelihood of blood loss of at least 500 ml with an adjusted odds ratio of 2.7.[18] In the study by Kwon et al lower-segment location and increasing diameter were identified as independent predictors of operative hemorrhage.[19] These findings support careful assessment of fibroid size, depth, location, number and proximity to major vessels. Conversely, 61.3% of patients had a single fibroid, while 45.3% of dominant fibroids were subserosal. Solitary subserosal lesions are more accessible than multiple, deeply intramural, cervical or broad-ligament fibroids and require less dissection. This distribution may partly explain the high completion rate. Collectively, findings from previous studies indicate that outcomes depend on fibroid burden, surgical approach and operator experience.[10,12,13,16,17] Hemorrhage prevention was central to management. Oxytocin and carbetocin were administered to all patients, tranexamic acid to 80.0% and additional uterotonics to 65.3%. Vasopressin, compression sutures, uterine artery ligation and topical agents were used selectively. This approach may have contributed to the low hysterectomy rate and absence of mortality. Current evidence emphasizes surgeon experience, rapid recognition of bleeding, availability of blood products and access to vascular or compression techniques.[12,17,20] However, because these interventions were not randomly assigned, their individual effects cannot be determined. Postoperative fever, defined as fever during hospitalization, occurred in 10.7% and wound infection, defined as clinically diagnosed infection during the same admission, in 6.0%. Across comparative studies and meta-analyses, no consistent increase in postoperative fever after cesarean myomectomy has been demonstrated, although the certainty of evidence remains limited.[6,8,9,14] Because follow-up ended at discharge, later infections may have been missed.

Clinically, the findings support a selective rather than routine approach. Planning should include fibroid mapping, correction of antenatal anemia, cross-matched blood, experienced surgeons and counselling regarding transfusion, incomplete removal and hysterectomy.[12,20] In Bangladesh, avoiding a second operation may reduce the need for repeat anesthesia, hospitalization, travel, income loss and treatment costs. These benefits must be balanced against blood-bank capacity, critical care access, staffing and surgical expertise.

Several limitations should be considered. Because the study was observational, single-center and lacked a cesarean-only control group, causal conclusions and direct safety comparisons cannot be made. Because surgeons selected patients for myomectomy, selection bias may have increased the apparent success rate by excluding women with fibroids considered excessively difficult or dangerous. Furthermore, the estimated blood loss may have been subject to measurement error and transfusion decisions may have varied based on clinical judgment and baseline anemia. In addition, neonatal outcomes, intensive care admission, readmission, menstrual symptoms, adhesion formation, fibroid recurrence, fertility and subsequent pregnancy outcomes were not assessed.

CONCLUSION

Overall, peripartum myomectomy during cesarean delivery achieved a high procedural success rate of 92.0%, with a low hysterectomy rate and no maternal deaths. Although blood loss and transfusion requirements were not negligible, most complications were manageable with standardized uterotonic administration and selective hemostatic interventions. These findings indicate that, with appropriate patient selection, experienced surgical teams and preparedness for hemorrhage control, cesarean myomectomy may be a safe and effective option that could obviate the need for a subsequent planned surgery.

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