

MYOMECTOMY DURING PREGNANCY

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ABSTRACT

Uterine fibroids may be encountered with pregnancy and many obstetricians will inevitably confront the dilemma of how best to manage fibroids causing complications in a gravid uterus. We describe two cases of unavoidable caesarean myomectomy and myomectomy performed for the management of complications during pregnancy.

KEY WORDS: Uterine, Fibroid, Caesarean Section, Myomectomy, Pregnancy.

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INTRODUCTION

Fibroids are common benign tumours of the uterus found in nearly 30% of women over the age of 30 years.¹ They are more prevalent in negroid women and associated with 0.3 – 3% of pregnancies.²⁻⁴ Although most will not cause any problems during pregnancy, but 10-30% might present with a complication. These include first trimester losses, pressure symptoms, pain of red degeneration, torsion of pedunculated fibroids, premature rupture of membranes and premature labour. Other complications may be retained placenta, post partum haemorrhage and malpresentations.^{2,3} A lower segment or cervical fibroid may result in obstructed labour. Traditionally, myomectomy during pregnancy is discouraged due to the possibility of uncontrollable and life threatening haemorrhage. We present two cases whereby emergency myomectomy had

to be performed, due to failure of medical treatment.

CASE REPORT

Case-1: A 30 year old primigravida was referred at 14 weeks gestation with persistent lower abdominal pain of 21 days duration. The pain had become increasingly severe and was unresponsive to analgesics and other conservative measures. An ultrasound scan done earlier had revealed a single fetus coexisting with a large fundal fibroid of about 12cm in diameter. The fibroid had grown so much bigger since the onset of the pain. This was confirmed by a repeat scan done after admission which showed the fibroid to be 18cm in diameter. On examination, she was in agony and pale. The fundal height was 28 weeks with uterine tenderness. Haemoglobin was 6.4g/dl. A provisional diagnosis of a fibroid undergoing red degeneration or torsion was made. Exploratory laparotomy was performed under general anaesthesia. Findings included a very large fibroid of 16cm in diameter attached to the fundus by a broad vascular pedicle which had undergone torsion. Several other smaller fibroids were also noted. Myomectomy was performed with the removal of the large fibroid only. Two units of blood were transfused. Post-operative recovery was uneventful and she was discharged after seven days. The pregnancy progressed uneventfully until labour started at 38 weeks. Spontaneous vertex delivery (SVD)

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of a live male baby occurred without complications.

Case-2: A 28 year old woman, G₂P₁, was referred at 37 weeks with multiple fibroids and fetal malpresentation. Two years previously, she had an uncomplicated SVD of a live female baby. On abdominal palpation, multiple fibroids were felt; the lie of the fetus was longitudinal with breech presentation. An ultrasound scan confirmed both the presentation and presence of multiple fibroids and in particular, a large one in the lower segment close to the internal os. An elective caesarean section was performed at 38 weeks. The presence of multiple fibroids was confirmed with a large fibroid occupying the anterior wall of the lower segment. A low vertical incision was made in the lower segment and the baby delivered by breech extraction above the fibroid. The fibroid (20 x 18cm), which was now protruding through the incision, was shelled out easily. The fibroid cavity was closed in two layers with continuous locking sutures to obliterate the dead space. Placenta was delivered easily and complete. It was then carefully reperitonised. Oxytocin infusion was employed for 24 hours thereafter to maintain uterine contraction and retraction to further reduce blood loss. Prophylactic broad spectrum antibiotics were given. Blood was not transfused. Postoperative recovery was uneventful.

DISCUSSION

Traditionally, the management of fibroids in pregnancy is conservative but sometimes, myomectomy may be necessary when complications occur as shown by the two cases described. Severe abdominal pain unresponsive to conservative management is a leading indication. The pain could have resulted from torsion of a pedunculated subserous fibroid as in Case 1 or due to red degeneration. In others, an increase in the size of the fibroid could cause abdominal pain and discomfort.

The major complications of myomectomy during pregnancy include abortion and haemorrhage. If the abortion is incomplete,

sepsis may follow. This could be serious if a communication exists between the endometrial cavity and the recently enucleated fibroid bed.⁵ The risk of haemorrhage is real considering the increased vascularity of the pregnant uterus, though this was not demonstrated in some studies.^{6,7} The application of a tourniquet round the base of the broad ligament to compress both uterine arteries and vessels in the infundibulopelvic ligament has been suggested as a way of reducing blood loss during caesarean myomectomy.² Others prefer high dose oxytocin as was utilized in our second case. The oxytocin infusion is maintained for several hours postoperatively.²

It may however be safer to remove a pedunculated fibroid or a superficial subserous fibroid during pregnancy as illustrated by the cases described. More deeply embedded fibroids should be tackled through postpartum. The dangers are invariably increased if multiple fibroids are removed in the same operation. Haemorrhage and undue prolongation of operating time could pose serious problems. When a fibroid lies in the line of the uterine incision, myomectomy becomes unavoidable, as in case 2. Furthermore, closure of the uterine incision would have been difficult without enucleating the fibroid. Enucleation was quite straightforward due to looseness of the capsule, which occurs in pregnancy.⁵

An alternative to caesarean myomectomy in the second case would have been caesarean hysterectomy.^{1,5} The patient was quite young and in only her second pregnancy. In a society, such as ours which places high premium on child bearing, this could have been a huge calamity.

Since fibroids are so common in childbearing women, it is to be expected that many obstetricians will have to confront the dilemma of how best to deal with fibroids on a gravid uterus at laparotomy or fibroids preventing access to the site of uterine incision at caesarean section.²

Myomectomy may be justified during pregnancy and at caesarean section where the fibroids are causing complications or

preventing access to the site of the uterine incision at caesarean section as exemplified by the cases described. Our case reports and others.^{2-4,6,8} Highlight the safety of caesarean myomectomy and myomectomy performed for the management of complications during pregnancy.

REFERENCES

1. Lowe DG. Benign Tumours of Uterus. In: Dewhurst's textbook of Obstetrics & Gynaecology for postgraduates. (Edmonds. DK, Ed.) 6th Edition, Blackwell Scientific Publications, London 1999;552-8.
2. Omigbodun AO, Fawole AO. Myomectomy during Pregnancy and Delivery. Is it safe? – Commentary Trop J Obstet Gynaecol 2005;22(1):1-3.
3. Nwagha UI, Agu KA, Nwankwo TO, Egbuji CC. Emergency Myomectomy during Pregnancy: A Case Report Trop J Obstet Gynaecol 2005;2(1):79-80.
4. Agboghroma CO, Efetie ER, Umezulike AC. Unavoidable Caesarean Myomectomy: A Case Report. Trop J Obstet Gynaecol 2005;22(1):81-2.
5. Myerscough PR. Pelvic tumours, other surgical complications in pregnancy, labour and the puerperium. In Munro Kerr's Operative Obstetrics. 10th Edition Balliere Tindall, London 1982;203-11.
6. Kaymak O, Ustunyurt E, Okyay RE, Kalyoncu S, Mollamahmutough L. Myomectomy during Ceasarean Section. Int J Gynaecol Obstet 2005;89(2):90-3.
7. Roman AS, Tabah KMA. Myomectomy at time of Caesarean Delivery: Cohort Study; BMC Pregnancy and Childbirth 2004;4:14.
8. Joo JG, Inovay J, Silhavy M, Papp Z. Successful Enucleation of a Necrotizing fibroid causing Oligohydramnios and fetal postural deformity in the 25th week of Gestation. A Case Report. J Reprod Med 2001;46:923-5.