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Myomectomy during cesarean section in unavoidable circumstances - A case series

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Abstract

We commonly encounter fibroid in pregnancy. Because of the increased vascularity in pregnancy fibroids are generally left insitu but there are some unavoidable circumstances where myomectomy is necessary to deliver the baby. We present case series of 3 cases with large anterior lower segment fibroid in which baby was delivered after proceeding with myomectomy

Keywords: Cesarean section, myomectomy, fibroids, pregnancy

Introduction

Fibroids are benign tumor of uterus with an incidence of 1.6-4% in pregnancies and in recent times it is increasing [1]. They complicate pregnancy in 10-30% of cases thus in most of the cases they remain asymptomatic.[2] They are removed in the antenatal period only if they cause discomfort to the mother or the baby. In the rest they can be dealt during cesarean section. Removing fibroids during cesarean section is a highly debatable topic. According to some they should not be removed because of increased vascularity of uterus during pregnancy as removal may lead to torrential bleeding and may in turn lead to hysterectomy. While others believe that fibroids can be removed in the same setting to avoid second surgery. [3] There are times when the removal of fibrods becomes necessary during cesarean section. When fibroids are present in lower segment of anterior wall uterus they might come in way of lower segment cesarean section incision, in such cases the removal becomes necessary before delivering the baby. We are presenting three such cases of anterior lower segment large fibroid which were successfully removed while delivering the baby.

Case 1

A 29 years old graduate primigravida with married life of 1 year was 38 weeks pregnant and she was referred from community health center to casualty of our Medical College with complaints of 9 months amenorrhea with large uterine fibroid (on antenatal ultrasonography) with labour pains.

On examination her height was 156cms and weight was 68kgs. Her general condition was fair with no pallor, icterus, clubbing, cyanosis. She was having pedal edema on right side which was pitting in nature. Her pulse rate was 90/min, regular and good in volume, Blood pressure was 130/86 mm Hg on both arms, respiratory rate was 18/min with no use of accessory muscles of respiration. CVS examination was also within normal limits.

On per abdomen examination the uterus was 36 weeks, Sym physio fundal height was 37 cms and Abdominal girth was 36 inches. Fetus was in longitudinal lie with cephalic presentation. Fetal head was free floating (5/5th). Fetal back was on right side and fetal heart rate was 136/min. She was having mild uterine contractions with frequency of 2/10 min each lasting for 30-35 sec. A fixed, firm, non-tender mass was palpable in the lower uterine segment which was below the presenting part. In her per vaginal examination the cervix was 1.5 cm dilated with length of around 1cm. The presenting part was high up. Her cardiotocography was reactive. She was given a short trial of labour but the head did not descended so decision of cesarean section was taken.

After ensuring availability of blood in blood bank and proper consent explaining complications and even need for hysterectomy and ICU admission, cesarean section was started. Per op the fibroid was so large that it was not possible to give the lower segment incision before removing the fibroid. We quickly instilled diluted vasopressin (1ampule in 100ml NS) around the capsule till we noticed blanching. Then transverse incision was given over the fibroid and myoma screw was inserted and by giving traction over the myoma and counter traction over the capsule myoma was removed from upper half. After that transverse lower segment incision was given to deliver the baby. Baby was delivered by vertex and cried immediately after birth. Immediate cord clamping and cut was done as we were in hurry to remove the remaining fibroid and achieve haemostasis. Baby' s APGAR score was 8/10 in the first minute and 9/10 at 5 minutes. Placenta was removed and uterus was well retracted. We proceeded with the remaining myom ectomy and the bleeders were caught and haemostasis was achieved. Then the LSCS incision was closed after which some of the redundant capsule which was hanging loose was cut and the dead space was obliterated using interrupted polyglactin 910 suture No 1-0. The upper margin of the capsule was closed by Baseball sutures. Before closing the abdomen, intra peritoneal drain was inserted. Drain was removed after 48 hours after ensuring no collection in the drain. The recovery of the patient was uneventful. On day 5 after dressing of the stitch line and ensuring bladder and bowel movements patient was discharged.

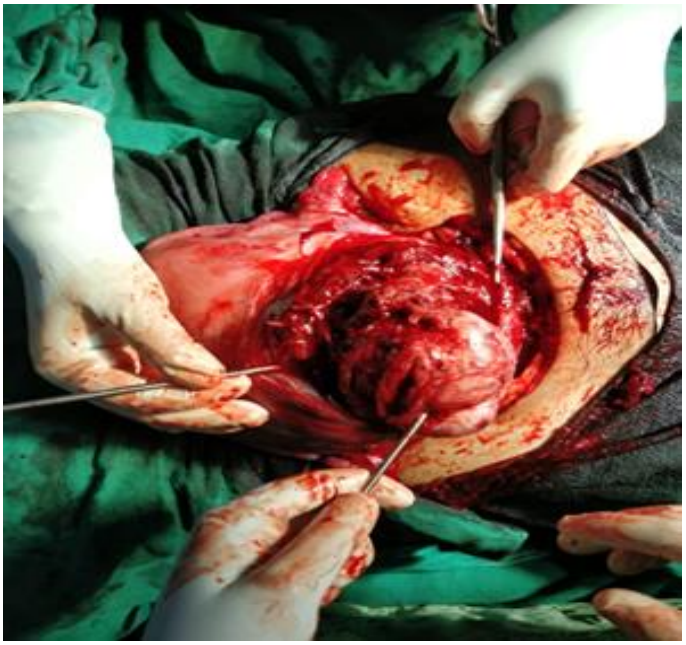

Figure 1:

Second patient with large anterior wall lower segment fibroid. Half of the myomectomy was done before delivering the baby and remaining being completed after delivery of the fetus

Case 3

A 38years old primigravida with 37 weeks pregnancy conceived spontaneously after 14 years of marriage educated till 4th class, unbooked to our institution came to the casualty with labour pains. She had only 1 ANC visit in some private hospital at 30weeks pregnancy where she got all basic investigations done and a single ultrasonography in which no findings other than growth scan was mentioned. Her tetanus prophylaxis was complete from anganwadi.

On examination her general condition was fair with no pallor, icterus, clubbing, cyanosis, edema. Her vitals were also stable. On per abdomen examination uterus was 34 weeks, longitudinal lie, cephalic presentation, head was fixed, FHS was 134/min, uterine contractions were mild with frequency of 2/10 min each lasting for 35-45 seconds. Her cardiotocography was reactive.

On per vaginal examination her cervix was 4cm dilated and fully effaced.

ARM was done to augment the labour in which liquor was adequate and clear. Par to gram was made and patient was left for trial of vaginal delivery. After 4 hours the findings were same but with good uterine contractions so decision of cesarean section was taken.

Per op she was diagnosed with lower anterior segment intramural fibroid which was not large (around 4 X 5cm) but was in the way of LSCS incision so in this case complete myomectomy was done and then baby was extracted by giving LSCS incision. On exteriorising the uterus there was one more fibroid in the posterior wall which was around 9 x 10 cms.

seemed to be highly vascular so was left undisturbed. Closure was done after achieving haemostasis. Recovery was totally uneventful.

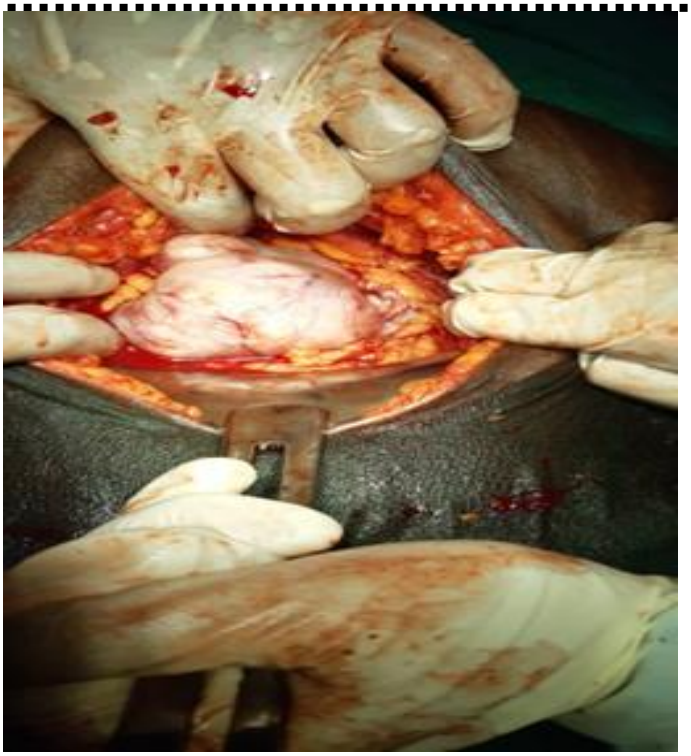

Figure 2

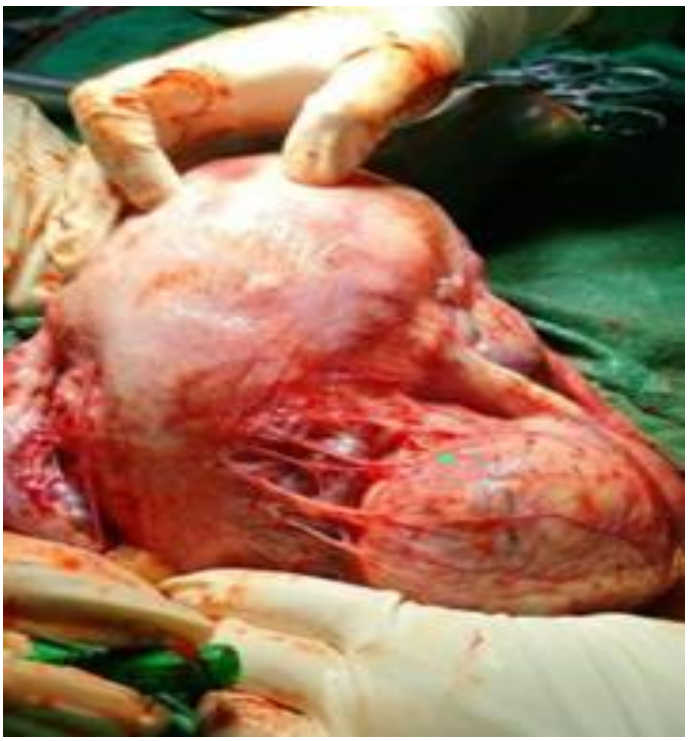

Figure 3:

Third case of anterior lower segment fibroid with pregnancy coming in line of uterine incision

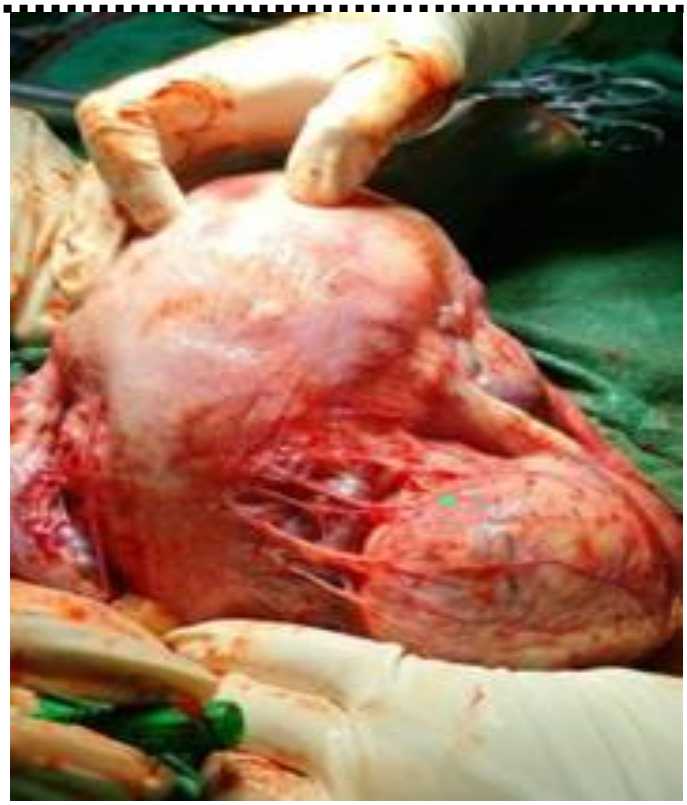

Figure 4

This figure shows the same uterus with posterior wall fibroid too but was left undisturbed because of high vascularity

Discussion

Fibroids in pregnancy are day by day increasing in frequency because of later age child bearing. [2] Fibroids can be single or multiple, small or large, intramural or sub serosal or even submucosal. Generally large, multiple or intramural or submucosal Fibroids cause com plications in pregnancy like abortions, mal present ations, preterm labour, intrauterine growth restriction, ante partum haemorrhage, placenta previa or accreta, urinary retention if fibroid is in anterior lower segment or cervix or constipation if it is posterior and large enough. [4] [5] They may remain constant or increase in size in antenatal period. Generally myoma of less than 5cm remain constant in size and larger once may become even more larger. [6] They may cause pain due to red degeneration or torsion if they are pedunculated sub serosal. During labour they may obstruct the passage of fetus. Even after delivery they may lead to atonic PPH or if placenta was implanted over submucosal fibroid it can retention of placenta and may lead to torrential haemorrhage. [5] Removal of fibroids during pregnancy is rarely required. They are removed only if they cause severe pain and discomfort or very large. During cesarean section their removal is highly debatable. Some prefer to leave because of increased vascularity of uterus during pregnancy while some are in favour of removal in the same sitting to prevent second surgery. [7] [8] [9] According to some removing larger fibroids and located in lower segment causes more bleeding and thus smaller fibroids and located in fundal region can be removed during cesarean section.[10] There are several studies going on whether to remove or leave the fibroid. Even if someone is in favour of leaving the fibroid during cesarean section, there are circumstances where myomectomy becomes unavoidable like in case of anterior lower segment fibroid which comes in way of LSCS incision line or if fibroid is large or pedunculated or submucosal.[11] In these circumstances with all precautions with proper consent, ensuring senior experienced obstetrician on floor and blood in hand one should proceed for myomectomy.

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