Unavoidable Caesarian Myomectomy In A Case Of Transverse Lie With Huge Fibroid At Incision

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ABSTRACT

Myomectomy during caesarean delivery may lead to hemorrhage and uterine atony ,hence it is not recommended. Myomectomy has been reported during cesarean section in recent studies. We presented a patient who was 30 yr old, primigravida with 40wks gestation with transverse lie in prelabour, taken for emergency lower segment caesarian section, and was accidentally found to have a huge myoma in the incision site. As uterine incision could not be closed because of the myoma, myomectomy was performed during caesarean section unavoidably. A single 760 g and 9 cmx 7 cm sized and another fibroid of 4cm x3cm myoma was removed. The physical examinations were unremarkable in the postoperative period.

If myomectomy during caesarean delivery becomes a widespread practice, it could potentially eliminate multiple surgeries for both indications. Many surgeons have been reluctant to adopt this policy without conclusive evidence demonstrating its safety. However, most of the authors suggested that the complications and morbidity following caesarean myomectomy do not significantly differ from those occurring during caesarean section alone, while fertility is apparently not compromised by this treatment.

Key words: Pregnancy; Caesarean Section; Myoma, myoma in pregnancy.

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Conflict of interest: No

Case report is Original: YES

Whether case report publishes any where? NO

INTRODUCTION

Uterine leiomyomas are the most common benign smooth muscle tumours of the uterus which predominantly develops in 20% to 40% of women during their reproductive age. Clinically they can present with different of symptoms depending upon their site and size[1].These tumours may be asymptomatic. In the pregnant women with coexisting fibroids, there are increased incidences of first trimester losses, pressure symptoms, pain from

red degeneration (necrobiosis), torsion of a pedunculated variant, malpresentations, preterm rupture of membranes and preterm labour [2, 3] during pregnancy, obstructed labour from a cervical or lower segment mass intrapartum and retained placenta, subinvolution of the uterus, postpartum endomyometritis, and postpartum haemorrhage in the immediate postpartum period [2, 3–5]. Management includes medical and surgical options, although the definitive and commonest treatment modality is still hysterectomy [6]. Thus, there exists the possibility of the same woman undergoing a myomectomy and, later a caesarean section or vice versa. If these two procedures can be safely performed at the same time, the risk of anaesthetic complications, multiple surgeries, adhesions and intra- or postoperative haemorrhage, exorbitant costs of operative procedures, and hospital stay could be reduced. Traditionally obstetricians are trained to avoid myomectomy during cesarean section due to severe hemorrhage often necessitating hysterectomy. The blood loss is usually severe as the size and blood supply of the myoma are increased in pregnancy. In most cases it is wise to defer myomectomy until the uterus has completely involuted, preferably for 6 months. Pedunculated fibroids, which maybe easily removed, are an exception .On the other hand uterus in the postpartum phase is better adapted physiologically to control hemorrhage. As contractions and retractions of muscle fibers occur, the blood vessels are closed. Also, the onset of vascular changes for clot formation in placental bed, helps in stopping the bleeding. Hence, myomectomy during cesarean will have the above advantages. But the policy of doing a myomectomy during cesarean to avoid second surgery may not always prove to be wise. Myomectomy as a separate operation during caesarean increases the hemorrhage by about 10% .(7)

CASE REPORT

30 yr old female, primigravida with 40 weeks gestation, registered under our antenatal clinic , unit 1 cama hospital .Patient is primigravida married since 5 years with 40.2 weeks gestation with transverse lie not in labour .Her vital parameter were stable and systemic examination revealed no abnormality.On abdominal examination uterus seems 34 weeks with fetus in transverse lie with head in right lumbar region,with no uterine activity and fetal heart sounds were 140 beats /minute and were regular .On vaginal examination cervix os was closed ,uneffaced and posterior.All routine investigations were done and were within normal limit. Patient complained of pain in abdomen on 17/2/16 morning. Patient went into spontaneous labour ,hence decision of emergency lower segment caesarian section was taken in view of transverse lie in labour .Intraoperatively, a 9 x 7 cm large fibroid on the left anterolateral surface of the uterus and another fibroid of 4x3 cm seen on lower segment . Incision was taken over the lower uterine segment away from the fibroid more towards the right side as the fibroid was present on the left anterior wall. After delivering the baby out by breech, a large 8 x 9 cm fibroid became evident. There was evidence both fibroids were present on the suture line, uterine closure was not possible. Hence decision for myomectomy was taken intraoperatively. Myoma was enucleated from the base and extracted and barb sutures were taken at the myoma bed by polygalactine 910 no. 1 and uterus was closed by continuous interlocking sutures, prophylactically bilateral uterine artery were ligated and hemostasis achieved . Average blood loss was 800 ml .Intraoperatively, two units of whole blood were given to the patient. Patient withstood procedure well. Patient was given broad spectrum

antibiotics,analgesics and hematinics were given post operatively. There were no maternal or fetal complications. Patient was discharged on 10th day post op after suture removal. Histopathalogy report suggestive of intramural leiomyoma with hyaline degenerative changes


DISCUSSION

Myomectomy is rarely performed during an ongoing pregnancy because of the risk of uncontrolled hemorrhage necessitating hysterectomy. In recent studies, Bhatla et al. (8) performed successful myomectomy in the second trimester for a large subserous fibroid, weighing 3900 g. Then the pregnancy continued uneventfully until term. Li H et al. (9) arised that mymectomy during cesarean section was a safe and effective procedure. Adesiyun et al. (10) investigated the fertility performance and pregnancy outcome in pregnants who had caesarean myomectomy at last delivery. They noticed no maternal or perinatal mortality factors. They suggested that the future fertility and or subsequent pregnancy outcome in patients were not affected by cesarean myomectomy. Hassiakos et al. (11) previously investigated the simultaneous surgical removal of myoma diagnosed during cesarean section and they recommended that this procedure may be applied during cesarean section. Kaymak et al. (12) compared myomectomy during caesarean section with myomas and underwent alone. They found no significant diferences in the incidence of postoperative fever, hemorrhage and frequency of blood transfusion between myomectomy and control groups. They concluded that myomectomy can be performed without significant complications by experienced obstetricians during the cesarean section. In our case, we performed unavoidable myomectomy in cesarean surgery without blood transfusion and maternal complication. Because the reclosure of the abdomen was impossible, we performed mymectomy without any complication. However, possible life threatening complications such as hemorrhage or disseminated intravascular coagulation might ocur. In conclusion, we do not always recommend but myomectomy during cesarean section may be performed in unavoidable conditions like in our present case.

CONCLUSION

In selected patients, myomectomy during Caesarean section is a safe and effective procedure at tertiary centres with experienced surgeons as in our case .The decision to proceed with elective myomectomy at the time of caesarean delivery should be approached with caution and should perhaps be limited only to patients with pedunculated fibroids or to instances in

which the lower segment incision (for extracting the baby) cannot be closed without removal of the fibroid(s). Centres in which caesarean myomectomy will occur routinely must of necessity have adequately staffed and equipped blood banks whose practices meet international standards. It is recommended that large multicentre randomized trials be conducted to evaluate the best practice for myomectomy at caesarean section. These will identify appropriate selection criteria, surgical techniques, and haemostatic options and improve the overall outcome of the procedure. Longitudinal studies to evaluate the long-term obstetric consequences and the risk of uterine rupture in subsequent pregnancies are also needed.

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