

## ANTEPARTUM MYOMECTIONY WITH A LIVE TERM DELIVERY- A CASE REPORT

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### ABSTRACT

We report a case of successful myomectomy in pregnancy. The patient, a 27 year old nulliparous, presented with 2 year history of progressive abdominal swelling and 13 weeks of amenorrhoea. Abdomino-pelvic ultrasonography revealed a viable intrauterine pregnancy at 18 weeks and 3 days; there was also a huge mass with cystic component, extending from the pelvis to the whole of the abdomen, with associated dilatation of the renal calyces bilaterally; sonographic diagnosis of ovarian mass in pregnancy was made. At exploratory laparotomy, a huge subserous leiomyoma coexisting with pregnancy was found; myomectomy was done. The rest of the pregnancy was uneventful, and the patient had spontaneous vertex delivery of a live infant at term.

**Keywords:** Uterine leiomyoma, Pregnancy, Myomectomy, Term delivery (Accepted 24 January 2007)

### INTRODUCTION

Uterine fibroids are the commonest benign tumour in women, occurring in approximately 20-30% of women of reproductive age. They are therefore common in pregnancy<sup>1</sup>. The prevalence of leiomyomas during pregnancy is reported as approximately 2%<sup>2-4</sup>. Although during pregnancy leiomyomas may remain asymptomatic, they may complicate its course. Fibroids affect pregnancy and delivery in several ways; these include increased frequency of spontaneous abortion, preterm labour, premature rupture of membranes, ante partum bleeding, placental abruption, malpresentation, and caesarean section<sup>5,6</sup>. The most common feature of fibroids in pregnancy is the syndrome of 'painful myoma,' this is due to red or carneous degeneration and occurs in approximately 5-8% of myomas in pregnancy<sup>6,7</sup>. The management of leiomyoma during pregnancy is medical, but in rare circumstances surgical intervention and myomectomy may be required<sup>8</sup>.

We report a case of successful myomectomy in pregnancy with delivery of a live infant at term in our unit.

### CASE REPORT

The patient presented in our unit having been referred from the state hospital on account of 2 year history of progressive abdominal swelling and 13 weeks of amenorrhoea. She had earlier presented at the referring hospital one year previously on account of the progressive abdominal swelling

but defaulted in the course of evaluation. The swelling started as a small mass at the left lower abdomen, and progressively increased in size. It was painless until about a week prior to presentation when she started having abdominal pain. There was progressive weight loss despite good appetite. There was no associated cough or difficulty with breathing. She was chronically ill-looking, and tachypnoeic (respiratory rate was 30 per minute). The pulse rate was 90 per minute and the blood pressure was 110/70mm Hg. The abdomen was grossly distended and there was a palpable abdominal mass which was compatible with a 36 weeks intrauterine pregnancy. Abdominal ultrasonography revealed an intrauterine viable fetus of 18 weeks and 2 days; there was also a large mass with cystic component, extending from the pelvis to the whole of the abdomen displacing the uterus to the right iliac region with associated minimal ascites; the renal calyces were dilated bilaterally. A sonographic diagnosis of ovarian tumour in pregnancy was made. The packed cell volume was 36%; the electrolytes and urea, and the urinalyses were within the normal limits. Two units of whole blood were grouped and cross matched. Because of the severity of the symptoms and the sonographic findings being suspicious of malignancy, surgery was proposed and discussed with the patient and her consent was obtained. Exploratory laparotomy was done under general anaesthesia with endotracheal intubation. The peritoneal cavity was entered through a midline, infraumbilical skin incision, which was extended 6cm above the umbilicus. Operative findings were minimal ascites, a huge subserous fibroid measuring 30 x 21 x 20cm

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**Figure1:** Pregnant uterus (uu) with hinge subserous myoma (ff)



The uterus was soft and compatible with a 20 weeks pregnancy (UU, fig 1); the ovaries and uterine tubes were grossly normal. The fibroid was removed and the myoma bed was closed with number '0' chromic catgut suture and haemostasis was easily achieved by interrupted figure of '8' stitches; the blood loss was very minimal. The post-operative period was uneventful. A repeat ultrasonography on 7<sup>th</sup> post-operative day revealed a viable intrauterine pregnancy. Histology report of the mass showed focal areas of myxoid hyaline changes. She was discharged home on 10<sup>th</sup> post-operative day. She was booked for antenatal care and had regular follow up. She went into spontaneous labour at 39 weeks gestation and had spontaneous vertex delivery of a live male infant, weighing 3.5kg with Apgar scores 7 and 10 at 1 and 5 minutes respectively. The puerperium was uneventful.

#### DISCUSSION

Our patient was 27 year old which is within the age range 24-40 years in which leiomyomata in pregnancy is said to be common<sup>8</sup>. Many cases of Caesarean myomectomy have been reported from the West African sub-region,<sup>9-11</sup> however, there had been two reported cases of successful myomectomy in pregnancy.<sup>12, 17</sup> Although it has been said that removal of fibroids is contraindicated in pregnancy except in the instance of pedunculated subserous ones with a thin stalk,<sup>7, 13, 14</sup> the case presented was associated with very short thick stalk that was excised from the uterus. Intramural leiomyomata can also be removed in carefully selected cases and by following the criteria outlined by Lolis et al<sup>15</sup> All patients that had ante partum myomectomy in a case series were delivered by Caesarean section,<sup>8</sup> however, our patient had spontaneous vertex delivery of a live infant at term, this might be possible because there was no deep surgical incision

into the myometrium. Although it had been reported that myomectomy in early pregnancy may predispose to foetal malformation,<sup>18</sup> no malformation was observed in the case presented.

This case also illustrate that cystic degeneration of a subserosa fibroid is a differential diagnosis of ovarian tumour in pregnancy.<sup>12,16</sup>

In conclusion, the case presented provide reassurance for pregnant women with leiomyoma, and surgical management of uterine leiomyoma during pregnancy may be performed successfully in carefully selected patients, and this seems to lead to an improvement in pregnancy outcome.

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