

## INEVITABLE MYOMECTIONY DURING CAESAREAN SECTION: A CASE REPORT

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### ABSTRACT

Myomectomy during Caesarean section is conventionally reserved for pedunculated myomas. When fibroids located in the lower uterine segment are encountered in pregnancy, due to fear of haemorrhage, obstetricians would prefer to perform a classical Caesarean section even with its high risk of subsequent uterine rupture and avoid the fibroids. We hereby present a case where removal of intra-mural fibroids in a 34-year old primigravida though inevitably performed, was successful.

**Key Words:** Primigravida, Lower Segment Fibroids, Caesarean Myomectomy. (*Accepted 24 February 2008*)

### INTRODUCTION

Uterine fibroids are benign tumours of uterine smooth muscle<sup>1,2</sup>. They are the most common tumours found in humans and are detectable clinically in about 20-45% of women over 30 years of age<sup>1</sup>. They are found more commonly in nulliparous women and tend to develop earlier, grow larger and are much more common in negroes<sup>3</sup>. Hence, they are not uncommonly encountered in our environment during pregnancy when their removal is strongly discouraged except when pedunculated and causing symptoms<sup>3-5</sup>. This is as a result of the associated haemorrhage that may follow due to the increased vascularity of the uterus during pregnancy<sup>3,5</sup>. Thus, when even fibroids located in the lower uterine segment are encountered in pregnancy, obstetricians would more readily perform a classical Caesarean section (CS) to deliver the baby in spite of its very high risk of subsequent uterine rupture and prefer to remove the fibroid later as an interval procedure<sup>5-7</sup>. Recent reports have however indicated that under certain circumstances, removal of even intra-mural fibroids may be safely performed during pregnancy<sup>4,6,8</sup>. Universally, this has not been accepted by most obstetricians. We hereby report the first case of an inevitable Caesarean myomectomy managed in our center.

### CASE REPORT

Mrs I.U.I, a 34 year old primigravida presented at the maternity unit of the University of Uyo Teaching Hospital (UUTH), Uyo at a gestational age of 41 weeks. She had booked at Saint Luke's hospital, Anua, Uyo where she had regular antenatal care. Her antenatal period was uneventful until 2 weeks prior

to presentation when an ultrasound scan (USS) report showed that the lower segment of her uterus contained fibroids and an elective CS was offered. However, following her sister's advice, she opted to present at UUTH.

On examination, she was afebrile, not pale and anicteric. Her blood pressure was 120/80 millimeters of mercury. Her fundal height was 39 centimeters. The fetal lie was longitudinal, presentation cephalic, and 5/5<sup>th</sup> of the fetal head was still palpable per abdomen. The fetal heart rate was 134/minute and regular. There was a firm irregular poorly defined palpable mass inferior to the fetal head. Vaginal examination revealed a poor Bishop's score and an irregular firm mass occupying the pelvis. A repeat USS showed a single active fetus in longitudinal lie with an anterior-fundal placenta. There were two round masses at the right fundal area. The larger of the two had a minimum diameter of 71 millimeters (mm). There was also a large fibroid in the lower uterine segment anterior to the fetal head with a maximum diameter of 75 mm (figure I). She was then counselled for an elective CS and 2 units of blood were cross matched. Her pre-operative haemoglobin was 13 grams/decilitre and urinalysis revealed no abnormality.

At surgery, a sub-umbilical midline incision was used to gain access into the peritoneal cavity. There were two large fundal sub-serous fibroids and a single large intramural fibroid occupying most of the lower uterine segment. A transverse lower segment incision below the inferior margin of the fibroid was made and a 2.6 kilogram female baby was extracted with Apgar scores of 7 and 8 at 1 and 5 minutes respectively. Due to difficulty in apposing the uterine wound, a decision was taken to remove the fibroid. High dose oxytocin infusion was commenced and the lower segment fibroid was then enucleated and its cavity repaired. The sub-serous fibroids were also enucleated and

their cavities closed in two layers. Two units of blood were transfused intra-operatively. The oxytocin infusion was continued for 24 hours postpartum and prophylactic antibiotics were prescribed. The estimated blood loss was 1200 milliliters. The postoperative period was uneventful and she was discharged on the 7<sup>th</sup> postoperative day.

## DISCUSSION

Traditional teaching has been that myomectomy in pregnancy should be reserved for the selective resection of pedunculated myomas<sup>9</sup>. However, our patient, a primigravida, had a fibroid in the lower segment obstructing the presenting part. In order to avoid performing a classical CS, the incision on the lower uterine segment to deliver the baby was made below the lower margin of the fibroid. However, the lower segment fibroid had to be inevitably removed, as it was extremely difficult to close the uterine wound after extracting the baby. The sub-serous fibroids were then removed as this can be easily and safely done in pregnancy<sup>3,6,9</sup>. During the procedure, high dose oxytocin infusion was used to ensure adequate contraction of the uterus and this was continued over 24 hours. This prevented any haemorrhage that would have followed as previously reported<sup>10</sup>. The alternative to this would have been to perform a classical CS and tackle the fibroid later as an interval procedure. However, our women prefer large family size and also have very strong aversion to operative delivery. Thus, those with CS scars often attempt vaginal delivery even at great risk to their lives<sup>11</sup>. Hence performing a classical CS whose scar is 4 times more likely to rupture even in pregnancy than the lower segment scar and following which a vaginal delivery is an absolute contraindication<sup>12</sup>, will not only prove disastrous in our patients and maim their reproductive career but will also lead to an increase in the already high maternal mortality rate. Removal of the fibroids which was safely carried out during the CS thus saved our patient the risk associated with a classical CS, the risk and cost of subsequent surgery, risk of fibroids complicating future pregnancies and provided psychological satisfaction. Thus, in our environment where CS rates in our hospitals are increasing<sup>13</sup> and where the incidence of uterine fibroid is high, when fibroids occupying the lower uterine segment are encountered in pregnancy particularly in women of low parity, we advocate their removal instead of the performance of a classical CS. There is therefore need for un-bias randomized control trials re-evaluating the safety of Caesarean myomectomy in our pregnant women.

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