Inevitable Caesarean Myomectomy: a Case Report

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Abstract

A 25-year-old woman having an elective caesarean delivery for breech presentation, after a previous caesarean section for fetal distress, developed severe intra-operative haemorrhage from a large fundal sub-serosal leiomyoma with a ruptured false capsule. After the delivery of the baby and repair of the uterine incision, myomectomy was done to prevent further blood loss.

Key Words: Myomectomy, Caesarean Section, Haemorrhage [Trop J Obstet Gynaecol, 2003, 20: 159-160]

Introduction

Removal of uterine fibroids during pregnancy or at caesarean section is contraindicated except where a life-threatening complication occurs [1, 2, 3]. This is due to the fact that myomectomy performed during pregnancy is often complicated by severe haemorrhage as a result of the increased vascularity of the uterus [3].

This case report illustrates one such rare occasion when it is safer to perform myomectomy during pregnancy. In this case caesarean myomectomy was performed to control haemorrhage following the rupture of the false capsule of a large sub-serosal uterine fibroid during an elective caesarean section.

Case Report

The patient is Mrs. AE, a 25-year old Gravida 2, Para 1^{+0} who was admitted at a gestational age of 38 weeks. She had undergone a caesarean section in her first pregnancy because of fetal distress in labour.

She booked for antenatal care at a gestational age of 28 weeks and attended clinic regularly. Ultrasound scan at 28 weeks confirmed a uterine fibroid coexisting with an intrauterine singleton pregnancy. The fibroid measured 15 x 18 cm. The antenatal period remained uneventful until the 35th week when the fetus was found to be presenting breech. The presentation persisted at 37 weeks and she was offered elective caesarean section at 38 weeks. Her haemoglobin concentration was 13.5 g/dl prior to surgery and 2 pints of blood, screened for HIV and for Hepatitis B & C, were grouped and cross-matched ready for her use.

At caesarean section, a male baby in frank breech presentation was delivered. The baby had Apgar scores of 8 in the first minute and 10 at the fifth. The uterine incision was repaired in two layers and reperitonised. A fundal, posterior subserosal fibroid measuring 20 x 18 cm, bleeding profusely from a ruptured capsule, was noted. Adherent to the capsule was the omentum and a segment of the intestine. Attempts at controlling bleeding by compression, infusion of high dose oxytocin and application of sutures failed. A decision was therefore made to remove the fibroid.

Two separate intravenous lines were secured. A Foley's catheter was applied circumferentially around the lower uterine segment, avoiding the Fallopian tubes and the ovaries. The tourniquet insertion time was noted. The tear on the capsule was extended bilaterally and the fibroid enucleated. The omentum and gut were dissected off the capsule and the latter was trimmed. The cavity was closed in 3 layers. The estimated blood loss was 1.2 litres. Oxytocin infusion was continued for 24 hours post partum. She was placed on prophylactic Ampicillin 500 mg six-hourly for five days. The post-operative period was uneventful and she was discharged home on the sixth post-operative day.

Discussion

Traditionally myomectomy during pregnancy or at caesarean section is contraindicated, except where a life threatening complication has occurred, because of the increased risk of haemorrhage and the need for blood transfusion [1, 2, 3, 4].

This case illustrates the fact that in life-threatening situations, caesarean myomectomy ought to be, and can be performed safely. The risk of haemorrhage must however be minimised [1, 3, 4, 5, 6]. In this patient, the use of a tourniquet, high dose oxytocin and meticulous closure, in three layers, of the cavity created by the removal of the leiomyoma ensured

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that haemorrhage was kept under control.

Though we are not advocating routine myomectomy during caesarean section, cases like this where circumstances make the procedure inevitable do occur, and the obstetrician should feel free to proceed, provided that it is performed with care and caution. Such an operation should only be carried out with optimal anaesthetic facilities, having sufficient cross-matched blood and with large doses of oxytocin available. A tourniquet is valuable to reduce uterine blood loss and an experienced surgeon, who has already had extensive experience in interval myomectomy, should carry out the procedure, as he may on occasion be confronted with considerable blood loss [3, 6].

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