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Case Report

Myomectomy at cesarean section: A safe option

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field of anesthesia, today many obstetricians are opting for myomectomy along with cesarean section (CS) to avoid a second surgery in the near future with its accompanying set of complications and cost factor. We present three cases of pregnancy with large fibroid uterus. Myomectomy was performed in only two of these three cases.

Case 1

A 34-year-old primigravida female patient was referred to the hospital with diagnosis of 36 weeks pregnancy. She was referred to the higher center as she had a large fibroid with malpresentation. She was married for six years and had conceived spontaneously. Her general and systemic examination was normal, including all antenatal investigations. Her ultrasound showed a 36-week fetus in oblique lie with a large anterior fibroid. In view of her oblique lie and fibroid uterus, she was taken up for elective CS. She was explained about the option of myomectomy at the time of CS to which she had consented. A male baby weighing 3 kg was delivered without difficulty. After delivery of baby and removal of placenta, the uterus was exteriorized. Anterior uterine wall was almost completely occupied by a fibroid of 14 cm size (Fig. 1). Myomectomy appeared feasible; hence, it was decided to perform myomectomy after liberal infiltration of diluted vasopressin; 20 units (in 1 ml) of vasopressin diluted in 50 ml of saline was used. There was transient increase in heart rate and blood pressure after infiltration, which subsided after some time. A fibroid (Fig. 2) was removed and the cavity was obliterated with delayed absorbable suture. Postoperatively, she made uneventful recovery.

Introduction

Fibroids are the most common benign tumors of the uterus. Nearly 20–50% of women are affected by them. The complications due to their presence however depend on their size, number, and location. When present in lower uterine segment, they may obstruct the passage of the fetus, and in such cases, cesarean delivery is indicated. Whether myomectomy should be combined with cesarean is still an unanswered question in modern obstetrics. Cesarean myomectomy till recently was a dreaded surgery. It was believed that because of increased vascularity in a pregnant uterus, myomectomy at the time of cesarean would lead to massive hemorrhage and increase in perioperative morbidity. However, with the advent of newer techniques of selective devascularization and advances in the

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Fig. 1 – A single large fibroid in the anterior wall of uterus.

Case 2

A 27-year-old second gravida female patient with one full-term normal delivery was a booked case; her antenatal period was uneventful except that she was detected to have a fibroid on left side of uterus (Fig. 3) in lower segment. General and systemic examination was normal, including all antenatal investigations. Obstetrical examination at 38 weeks of gestation revealed longitudinal lie with high floating head.

A mass was felt in lower segment on left side. Vaginal examination showed unfavorable cervix. In view of these findings, she underwent elective CS. She was explained about

Fig. 2 – Fibroid after removal.

option of myomectomy at the time of CS and she gave her consent for the same. After delivery of baby and placenta, the lower segment was closed. A big fibroid was seen on left side of broad ligament with large blood vessels running over the fibroid. In view of location and such high vascularity, it was decided not to perform myomectomy and abdomen was closed. Postoperative period was uneventful.

Case 3

A 23-year-old primigravida female patient was a booked case with normal antenatal period. At 37 weeks gestation, she was detected to have breech presentation. Ultrasound confirmed breech presentation and showed a 11 cm × 12 cm size fibroid on right side of uterus on its main body. She too was counseled about the possibility of myomectomy at the time of CS. She underwent elective CS for breech presentation. Myomectomy after vasopressin infiltration, as done in 'Case 1,' was performed for the subserosal fibroid situated on right side of

Fig. 3 – USG showing broad ligament fibroid.

uterus. There were no cardiovascular changes in this case. Postoperative period was uneventful.

Discussion

Pregnancy with fibroid/fibroids is a high-risk pregnancy; many complications may be encountered in these cases. During pregnancy, the management is usually conservative, but sometimes, surgical treatment too is required. Several authors have published their results on myomectomy during the course of pregnancy when conservative treatment fails to relieve the woman of her symptoms.^{1,2} Myomectomy should be performed rarely during pregnancy, and that too, in selected cases only.³ In recent studies, Bhatla et al.⁴ performed successful myomectomy in the second trimester for a large subserous fibroid, weighing 3900 g, and the pregnancy continued uneventfully until term. Many studies^{5–7} show that myomectomy at the time of CS is not that dangerous as has been traditionally thought and taught; enucleation is easier as the tissues become softer during pregnancy. The patient should be counseled and explained that myomectomy is feasible and the final decision is taken at the time of surgery depending on the location, size, and number of fibroids; intramural myomectomy should be performed with caution. Only those fibroids that would require surgery in future should be removed at the time of CS. The relationship of fibroid with placental attachment should be known; if placenta is attached below the fibroid base, then myomectomy should be avoided for the fear of uncontrolled hemorrhage. All efforts should be made to reduce the blood loss. Surgery may require more time and result in excessive blood loss.⁸ In their large study, Song et al.⁹ reported that there was drop in hemoglobin and longer time taken in cases who underwent myomectomy at CS as compared to control. But this drop and extra time taken was not significant. Similar results have been reported by Park and Kim.¹⁰ Myomectomy during CS is not always a hazardous procedure and can be performed without significant complications.¹¹ Myomectomy should be performed after CS unless delivery of baby is not possible without removal of fibroid; then the fibroid may have to be removed first. Fertility performance and pregnancy outcomes after CS myomectomy have been investigated by Adesiyun et al.¹² They suggested that the future fertility and or subsequent pregnancy outcome in patients were not affected by cesarean myomectomy. Myomectomy is not contraindicated at the time of CS, as was

traditionally believed. It should be assessed on case-to case basis, and can be performed if the procedure appears safe. At present, there are no standard and established guidelines for indications and contraindications of cesarean myomectomy. The patient should be counseled and decision of myomectomy be made on individual case depending primarily on safety.

Conflicts of interest

The authors have none to declare.

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