Case Report

Successful myomectomy during pregnancy

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SUMMARY

Leiomyoma is the most common benign tumor of the uterus and could complicate pregnancy. Here we present a case of leiomyoma in a nullipara women at the 24th week of gestation complained of abdominal pain and nausea which was not responding to conservative therapies. A laparotomy was done and a 30*20 cm mass was resected from the uterus. She had a normal term delivery after the operation.

KEY WORDS: Leiomyoma, Pregnancy, Abdominal pain.

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INTRODUCTION

Uterine fibromyoma or more correctly termed Leiomyomata is the commonest pelvic tumors in women but has other referred terms like: Myomas, Leiomofibromas and Fibroleiomyomas[1], the most common benign tumors of the uterus, and the most common female genital neoplasm.[2] It occurs in 20-25% of women in the reproductive age and is symptomless in most of the cases.[1] There is little data available about their etiology and epidemiology but researchers have suggested that risk is inversely associated with age at menarche, parity and age at first birth and have positive correlation with years since the last term birth, endogenic and exogenic hormonal factors, African-american ethnicity, nulliparity, diet, smoking and obesity.[2,3] Uterine fibroids can be completely asymptomatic but they also can cause menorrhagia, pelvic pain, infertility and reproductive dysfunction.[3]

Leiomyomas have been associated with an increased risk of spontaneous abortion, preterm labor, premature rupture of membranes, antepartum bleeding, placental abruption, malpresentation and caesarean section. The most common complication is "painful myoma" syndrome due to red or carneous degeneration and occurs in 5-8% of patients. It can cause nausea, vomiting and fever and usually occurs during the second trimester of pregnancy.[4]

There are various treatment options for leiomyoma performed based on the severity of the symptoms, size and location of the lesions, patient's age and their chronological proximity to menopause, and the patient's desire for future fertility. Relief of the symptoms is the main goal of therapy. Use of acupuncture and total hysterectomy are the two borders of treatment options.[5]

We describe a case of uterine Fibromyomas during pregnancy and the result of surgical management.

CASE PRESENTATION

A 30-years-old nulligravid woman with 24 weeks of gestation was referred to our hospital with abdominal pain since 5 days. The pain was first at the epigasteric area then it became generalized

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and did not relate to the patient's position. She also complained from nausea, vomiting, anorexia and diarrhea. She had a history of admission due to Hyperemesis gravidarum during the first month of pregnancy and no weight gain since then. She reported no special medical history and her menstrual cycle was regular.

Physical examination: Patient was pale and seemed ill. Her blood pressure was 85/60 mmHg and pulse rate was 90b/min. Abdominal examination revealed generalized tenderness especially in epigastric region. Fundal height was 34-36 weeks. Fetal heart rate was detected at 160b/min. An ultrasound report at 13rd week of gestation revealed: a 170*150*120 Fibroma with 1650 cc volume in right adenex with degenerated and echo-free regions.

Primary management: After admission, she received Metoclopramide, Promethasine and Pethedine. General condition did not change after this treatment and she reported dyspnea. Amp B-complex and Cap Omeprazole were prescribed and a semi-sitting position was suggested. The next morning she had a bile vomiting and metoclopramide was stopped. Surgery consultation ruled out pancreatitis. Internal consultation did not reveal a problem and the same treatment was continued.

Investigations: Ultrasound examination at 23rd week of gestation revealed a normal fetus with 500 gr weight. A heterogeneous mass with degenerative changes was seen in the right side dome of the uterus that was suggestive of Fibroma. At 24th week of gestation the same sized mass (230*170 mm) was seen and another mass (130*77mm) was detected at posterior superior area of the Fibroma (which was detected to be the result of cystic feature of the lesion not a real multiple fibroma). MRI reported a heterogeneous mass 228*141*130 mm in mid abdomen part centrally & bilaterally more to the left side appeared to be closely attached to uterus by a 60-70 mm pedicle and heterogenous cystic changes inside it attached to the fundus of uterus, the mass was bulged up into upper abdominal cavity with pressure on stomach. Mild free fluid was seen in abdomino-pelvic cavities, enlarged uterus was seen with a normal fetus & placenta. Kidneys were normal. Pressure on internal loops were seen causing dilatation & prominency at small intestine.

Lab tests: WBC:12800, Hb: 11.6 gr/dl, Hct: 35.7%, Plt: 484 * 10^9 /L , CRP:3+, ESR:49/1 hour, Urine Analysis: 1+ protein, LDH:394 units/L, Amylase: 70 units/L
Lipase: 61 units/L, Bilirubin total:0.95 mg/dl, Bilirubin direct: 0.6 mg/dl
AST: 18 units/L, ALT:13 units/L, Alkaline phospatase:875 units/L, Albumin:2.8 gr/dl, Calcium:7.8 mg/dl, P:3 mg/dl, Total protein:5.9 dr/dl
After discussing the case and in view of the pressure effect of the lesion and severe refractive abdominal pain without response to the medical treatment, we decided to do the Laparotomy which was performed under general anaesthesia using a midline incision. A 30*20 cm mass in dome of uterus had occupied right upper quadrant, left upper quadrant and epigaster. The mass had adhesion over the abdominal wall and omentum that were cut. Intenstine was fragile and swollen, 300 cc free fluid of intra-abdominal cavity was drained. Indomethacin suppository was prescribed for tocolysis and relieving the pain after the operation. She lost very few volume of blood during the surgery and no transfusion was necessary (Hb= 10.6 at the 3rd day post-operation).

After the surgery, she continued a normal pregnancy and delivered a normal term neonate at 37 weeks of gestation by elective caesarean section as desired by the mother.

DISCUSSION

The prevalence of leiomyoma during pregnancy is reported about 2% and remains asymptomatic, but could be complicated in its course. Spontaneous abortion, preterm labour, premature rupture of membranes and antepartum bleeding are the most frequent complications, but "painful myoma" is the most common one[4], which was seen in our case as well.

This case presented with abdominal pain and symptoms like an acute abdomen. Most symptomatic patients present with abdominal discomfort, abdominal mass, abnormal bleeding and pressure symptoms.[1]

Medical management is carried out during pregnancy and requirement for surgical intervention is rare and suggested to be done if symptoms persist after 72 hours of therapy.[4] However in this case we had to do laparatomy due to the large mass of leiomyoma with pressure effect, which was a risky operation but was done well without any complications.

In a similar case series reported by Lolis et al from Greece, among 622 pregnant patients with leiomyoma, 13 required surgical interventions due

to the symptoms not responding to conservative managements and in 92% of them successful myomectomy was done and the pregnancy progressed without any complication to the term time.[4] Another study from Nigeria showed that in 20.9% of cases postoperative complications did occur which included: pyrexia, blood loss warranting transfusion and postoperative anemia.[1] It has been shown that leiomyoma is more common in nulliparous and relatively infertile women[1] as our patient was nullipara.

CONCLUSIONS

There are different views regarding treatment of leiomyoma during pregnancy. However we have shown that surgery could be performed safely and with low or no adverse effects in these cases.

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