

UTERINE FIBROID IN LABOUR

by

PUSHPA KAWATHEKAR,* M.S.; S. R. ANSUYA,** M.D., D.G.O.

M. R. TANGA,*** M.S., F.A.C.S., F.I.C.S.

Fibroids with pregnancy are usually asymptomatic but occasionally they do produce some interesting problems in the diagnosis and management as illustrated by the following three cases treated by us at M. R. Medical College and Govt. General Hospital Gulbarga between January 1969 to December 1973.

Case 1

S. aged 30 years was admitted on 25th January 1972 with full term pregnancy and obstructed aftercoming head for 3 hours.

Obstetric history, para 2, gravida 2, first F.T.N.D. 2 years ago alive.

On examination patient was dehydrated; her pulse was 100/minutes and blood pressure was 130/90.

On abdominal examination uterus was of 36 weeks' size, its shape was abnormal and it was tense and tender on palpation. Foetal heart sounds were not heard.

On vaginal examination external genitalia were swollen and the foetus was hanging outside the vulva upto the shoulders. The anterior cervical lip was oedematous and thick. The foetal skull bones could not be reached per vaginam. The provisional diagnosis of hydro-

cephalous causing obstructed labour of the after coming head was made and lumbar puncture of the foetus tried without any avail. As the size of the uterus was almost 36 weeks the possibility of locked twins was thought of and the patient was taken to the operation theatre for examination under anaesthesia.

Even under general anaesthesia our attempts to reach the foetal skull to perform craniotomy failed. Abdominal encephalocentesis for drainage of hydrocephalous was tried and while passing the needle on the right side where we thought the head was situated, it met a hard fibromuscular resistance and no fluid could be withdrawn. Possibility of soft tissue tumour obstructing the labour was thought of at this stage and laparotomy was performed. On laparotomy the abnormal shape of the uterus was confirmed, the lower segment was thick and could be cut with considerable difficulty contrary to the usual thin, stretched, lower segment seen in obstructed labour cases. The foetal neck presented in the lower segment and was very much elongated, foetal head was pushed up on the left cornu of the uterus lifting up the whole uterus (Fig. 1). The head was delivered out by hooking the neck and baby was severed at neck and the breech was pulled out from below. The placenta was removed manually and uterus was brought out of the abdominal wound. A large fibroid was seen occupying the anterior wall of lower segment (Fig. 2). This was enucleated easily. The fibroid bed was closed properly ensuring complete hemostasis. The uterus and abdomen were closed in layers. Postoperatively patient was treated with injection crystalline penicilline 10,000,00 units every six hour and injection Streptomycin 1 gm per day. She had gross wound sepsis which responded well with local dressing and antibiotics.

Comments

This case illustrates the difficulty experienced in diagnosing fibroid as the cause of obstructed

Department of Obstetrics and Gynaecology and Surgery, M. R. Medical College and Government Hospital, Gulbarga (595105) (Karnataka).

**Associate Professor and Hon. Medical Officer, Obstetrics & Gynaecology.*

***Hon. Reader and Asst. Surgeon, Obstetrics & Gynaecology.*

****Hon. Associate Professor and Hon. Medical Officer, Surgery.*

M. R. Medical College and Government General Hospital, Gulbarga.

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labour in aftercoming head of a breech delivery and also the ease with which the fibroid could be enucleated without causing any adverse effects either during the operation or postoperatively. Retrospectively the abnormal shape of the uterus, the difficulty in reaching the foetal skull, inability to drain C.S.F. via the lumbar puncture and finally the hard fibromuscular resistance felt during attempted encephalocentesis were some of the clues to the diagnosis in this case. The interesting feature of this case was that even though the fibroid was situated in the anterior wall of the uterus, well above the sacral promontory, it produced serious dystocia. Considering a normal delivery by cephalic presentation two year earlier, it is quite likely that the breech presentation during this pregnancy has probably initiated or enhanced obstruction by slipping easily out of an incompletely dilated cervix. Myomectomy was easy and was not associated with excessive bleeding.

Case 2

G. aged 35 years was admitted at full term in labour on 6-7-1972 at 9.30 p.m.

Obstetric history, gravida 8, para 7, all full term normal deliveries, 3 alive, last delivery 3 years ago. B.P. 110/90; Pulse 100/minute.

On abdominal examination the uterus was of 36 weeks size, contracting and relaxing regularly and the position was right occipitoanterior, foetal heart sounds were regular 140/minute.

Vaginal examination revealed a fibroid filling up the vagina and was partly seen outside. (Fig. 3). This was arising from the anterior lip of the cervix which was 6 cms dilated. Presenting part was head and was at the brim. The ligation and cutting of the pedicle under anaesthesia was planned, as obstruction to the delivery of the head was anticipated. Patient refused for any operative interference and delivered spontaneously a male live baby weighing 3.2 Kg. at 12.55 a.m. Moreover, we tried to coax her for the removal of fibroid in the puerperium but she refused.

Comments

This case presented with a large cervical fibroid arising from the anterior wall of the cervix. Cervical fibroids even of very small size are known to produce obstruction to labour by lying in front of the presenting part. A spontaneous vaginal delivery in this case was a pleasant surprise for us probably due to the

softening of the fibroid, the strong uterine contractions and cephalic presentation, also played deciding roles in this situation.

Case 3

A primigravida, aged 30 years, was admitted with full term pregnancy and labour pains for 24 hours. Obstetric history, married 1 year, M.H. 5/30 days regular. Her general condition was good; B.P. 130/80; Pulse 88 minute; Past history revealed that at 12th week of gestation patient was admitted in the hospital for severe pain in the abdomen, fever and vomiting. She was treated conservatively, and 24 hours later appendectomy was performed by a general surgeon. The operative findings are not known and the histopathological report did not confirm the diagnosis of appendicitis. She had irregular, infrequent uterine contractions for 15 days prior to the admission.

On abdominal examination uterus was of 40 weeks' size, head floating, right occipitoposterior position of the foetus and foetal heart sounds 140/minute. On vaginal examination cervix was thick and 4 cms dilated, head at the brim, membranes absent and the pelvis was adequate. During the subsequent 24 hours, she developed hypertonic uterine inertia and foetal distress. Therefore, lower uterine segment caesarean section was performed, 24 hours after admission. Female child weighing 3.6 kg was delivered, who required resuscitation. A subserous fibroid of 2' X 1 1/2" was removed easily from the anterior wall of the uterus. Uterus and abdomen were closed in layers. Post-operative period was uneventful.

Comments

As the operative findings about the condition of appendix in this case are not available and histopathological findings do not confirm the diagnosis of acute appendicitis it is quite likely that red degeneration in the fibroid might have been the cause of her acute abdomen during her 12th week of pregnancy and the diagnosis was missed because this possibility was not thought of.

Discussion

Fibroid is the most common uterine tumour and yet its association with pregnancy is rare. As reported in the literature the incidence of pregnancy with

fibroid varies from 0.24 to 7.2% (Giri 1968). Individuals with fibroid uterus have a low fertility rate, a tendency to abort, or deliver prematurely. In addition the softening of the tumour during pregnancy evades the correct diagnosis. Because of these factors the reported low incidence appears to be more apparent than real. Uterine inertia, malpresentations and obstructed labour are some of the known complications of fibroid during labour. The obstruction to the labour depends upon the position of the fibroid. Fibroids in the posterior wall of the uterus situated below the sacral promontory and cervical fibroids of even very small size are considered to give rise to serious obstructive dystocia. Fibroids situated in the anterior wall of the uterus do not cause obstruction to the labour, (Moir, 1964; Douglas and Wilson, 1963; Mudaliar, 1968). Occasionally fibroids may not behave according to this generalisation and exactly opposite situations may have to be faced as can be seen from the first two cases presented in this paper. Myomectomy during pregnancy and at the time of caesarean section is usually not advocated (Giri, 1968; Moir, 1964; Mudaliar, 1968) because of the danger of haemorrhage during the operation, chances of post-operative infection and intestinal obstruction. All authorities

favour myomectomy at a later date; (Moir, 1964; Douglas and Wilson, 1963; Santpur, *et al*, 1968). We tend to agree with Willson Clyne and Mudliar that caesarean myomectomy requires judgement and can be undertaken safely if the fibroid is easily removable and if every precaution is taken to secure hemostasis in the tumour bed.

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See Figs. on Art Paper VI