

ABDOMINAL MYOMECTOMY FOR CERVICAL MYOMA DURING PREGNANCY

Report of a case

by

K. N. KULSHRESHTHA*, M.D., F.R.C.S. (Edin.)

Mrs. K. H. S., age 23 years, primigravida, with history of amenorrhoea of about $3\frac{1}{2}$ months, was seen on 15th June 1963. Her last menstrual period was on 24th February 1963. She had been seen by a senior gynaecologist outside Baroda and brought a note from the gynaecologist as follows:—

“Two lumps closely associated with the cervix — on the right side about $3\frac{1}{2}$ months' gestation — soft, left — smaller, hard; diagnosis — Pregnancy in the right cornu of a bicornuate uterus.”

My findings corresponded in general with these but on the left side one could not feel a smooth contour or alignment going upwards and outwards from the side of the portio vaginalis of the cervix as one expects in a case of a bicornuate uterus. The left mass felt hard and presented a convex contour downwards between which and the portio vaginalis of the cervix one felt a sensation of being able to insinuate the tip of a finger.

The patient gave a history of attacks of acute pain on the left side of the abdomen which began some time

before she missed her period. Between the acute attacks, pain completely disappeared. If the pain had been caused by the distension of the right cornu of a bicornuate uterus due to pregnancy then the pain should have been on the right side of the abdomen and should not have presented a clinical picture of acute attacks with complete intermissions. On these grounds a tentative diagnosis of twisted ovarian cyst was made even though the mass felt much harder than one expects a cyst to feel. Due to the history of acute attacks of pain an expectant line was not considered advisable in any case.

She was operated on 17th June 1963. On opening the abdomen uterus was found to be of the size corresponding to the duration of amenorrhoea. The whole uterus was pulled up out of the pelvis. On the left side of the cervix was felt a hard mass about the size and consistency of a cricket ball by feel. This mass had lifted up the cervix out of the pelvis. Only a thin layer of uterine muscular tissue was felt overlying the tumour. An incision was made obliquely in the peritoneum over this mass and then in the layer of uterine muscular tissue overlying the tumour. A line of cleavage was found and two

* Hon. Obstetrician & Gynaecologist,
Maharani Shantadevi Nursing Home,
Baroda.

Received for publication on 14-10-63.

myomata were enucleated with ease. Bleeding was controlled easily with interrupted No. 00 chromicised catgut sutures, which were used to obliterate the space left after the removal of the tumour. Then the peritoneal layer was sutured and the abdomen was closed.

She had an uneventful post-operative period. Her temperature rose only twice during the fortnight following the operation—to 100 degrees F. on the second day and to 99.4 degrees on the fifth day. She is registered for her delivery and her due date is 1st December 1963. Fig. 1 gives a diagrammatic picture of the condition.

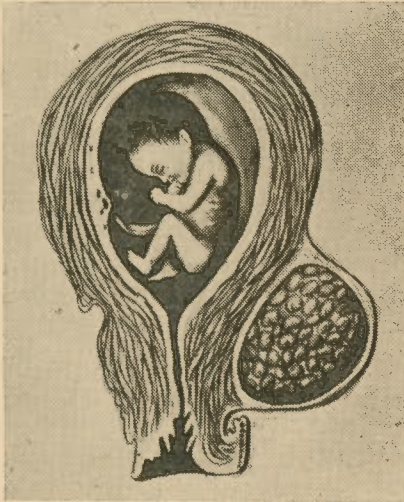


Fig. 1
Uterus with foetus in situ and myoma.

Special noteworthy features of this case are:—

1. The larger myoma measured 8.2 cm. x 5.6 cm. (about $3\frac{1}{4}$ " x $2\frac{1}{4}$ ") — Fig. 2, and the smaller myoma measured 2 cm. x 1.2 cm. (about $\frac{3}{4}$ " x $\frac{1}{2}$ "). The



Fig. 2
Myomata after excision.

larger myoma had lifted the cervix out of the pelvis and thus made the cervical myoma accessible for safe and easy removal by the abdominal route.

2. There was not any troublesome bleeding during the enucleation and the pregnancy has continued undisturbed.
3. Pain was in acute attacks with complete intermissions. One would have expected that a slowly and steadily growing tumour like a myoma would have given a continuous dull pain with only slight variations in intensity. There were no signs of any degenerative changes to the naked eye. May be there was periodical increase in congestion due to the displacement upwards.

Comment

A report by Child and Douglas, quoted in Stander's Text Book of Obstetrics, gives the frequency of myomata complicating pregnancy, needing operative interference, as 23 in 40,000 cases of pregnancy admitted

to the New York Lying-in-Hospital during an eleven year period, and of these, 9 were cases of myomectomy during the ante-natal period. Four of these aborted following the operation.

Beck expresses the opinion that when operative intervention becomes necessary hysterectomy is preferable to myomectomy. However, he admits that myomectomy can be done without great risk of interruption of pregnancy.

Greenhill says, "In the absence of unbearable pain, severe haemorrhage, extremely rapid growth, great distress from over-distention of the abdomen and signs of necrosis or torsion of the tumour it is justifiable to wait and watch. . . . A surgeon should not definitely promise a patient that only a myomectomy will be performed. He may find that it is far safer for the patient to have a hysterectomy. . . . Fibromyomas by themselves do not indicate that either hysterectomy or myomectomy is necessary. . . . Bleeding (in a myomectomy) is more profuse than in a simple hysterectomy. . . . Rupture of the uterus following myomectomy is unusual."

Wilson says that operative interference of any sort is unnecessary unless large tumours become impacted in the pelvis and produce severe pain or rectal obstruction, pedunculated tumours twist or become necrotic, or large subserous tumours undergo extensive necrosis. In such instances only does he consider myomectomy necessary but says that it can often be accomplished without interrupting the pregnancy.

Lull and Kimbrough think that

myomectomy during pregnancy carries a grave risk of abortion and advocate a conservative attitude.

Munro Kerr and Moir say that at the moment the most interesting question is the scope of myomectomy in the ante-natal period. They are of the opinion that it is obviously the ideal operation in the primigravida. According to them it may be stressing its importance unduly to employ it in women who already have several children. In such cases, they say, hysterectomy may be the better choice. They add that if it transpires that, by improvement in technique, abortion following the operation can be reduced below the present figure, then it naturally must follow that even the most conservative obstetric surgeon will feel justified in employing the operation more frequently and from employing it only as an emergency measure he will select it in order to prevent untoward recurrences. They say that the mortality rate is slightly higher for myomectomy in the gravid as compared to the non-gravid. According to Gemmell's investigations it was 2.95 per cent in the former and 2 per cent in the latter.

There is general agreement that rupture of the uterus during labour following myomectomy performed in the ante-natal period is unlikely. In fact Munro Kerr and Moir say that they have not come across a case or heard or even read of a case of such an occurrence.

Gemmell, of Liverpool, quoted by Munro Kerr and Moir, gives collected statistics showing that the lowest incidence of termination of pregnancy following myomectomy is when the

operation is done during the fifth month of gestation (6.6 per cent), but that the incidence goes up as the period of gestation at the time of operation is more or less than the fifth month, reaching over 40 per cent at the second and the seventh months.

Conclusion

Thus we see that, though there is a great deal of controversy regarding the indications and the safety to the parturient and the foetus from the operation of myomectomy during the ante-natal period, it may be said that the general consensus of opinion is increasingly in favour of such an intervention when the tumour is causing symptoms like pain or haemorrhage. When it is necessary to operate before or after the fifth month of gestation a more liberal use of a potent progesterone preparation will considerably reduce the risk of a premature termination of pregnancy. Such treatment should precede as well as follow the operation.

Fig. 3 shows the histological section of the larger tumour removed in this case. Fig. 4 is a recent x-ray photo

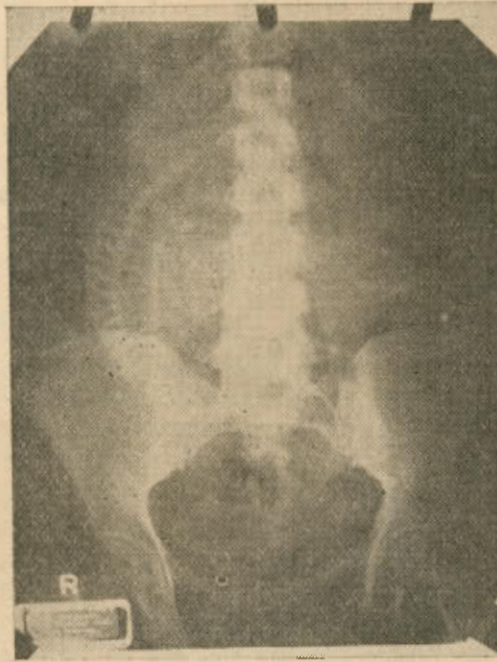


Fig. 3.
Recent Xray showing foetus presenting by vertex.

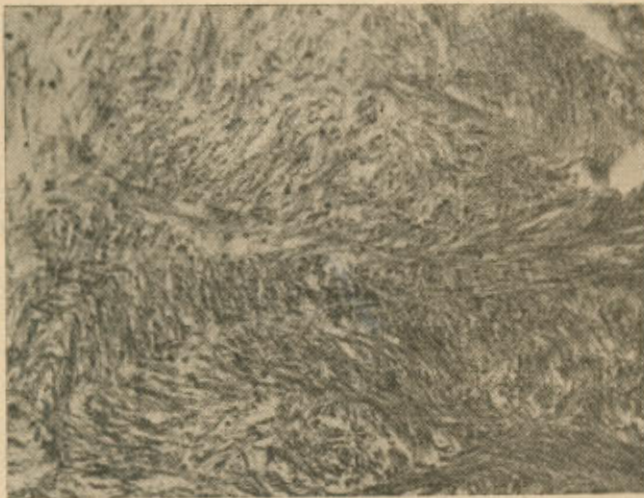


Fig. 4.
Histological Section of the larger myoma.

showing the foetus presenting by the vertex.

Mrs. K. H. S. was admitted with labour pains at 11.50 p.m. on 23rd December 1963 and delivered normally at 8.28 a.m. on 24th December 1963. Male baby; weight — 5 lbs.; length 18½". Mrs. K. H. S. had an uneventful and afebrile puerperium and was discharged on 2nd January 1964 and at that time the baby weighed 6 lbs.

References

1. Beck, A. C.: *Obstetrical Practice*, ed. 4, Baltimore, 1947, Williams & Wilkins Company, p. 612.
2. Greenhill, J. P.: *Obstetrics*, ed. 11, Philadelphia and London, 1955, p. 563.
3. Lull, C. B. and Kimbrough, R. A.: *Clinical Obstetrics*, ed. 1, Philadelphia, 1953, J. B. Lippincott Company, Section-Surgical Complications of Pregnancy — Clarence C. Brown, p. 346.
4. Munroe Kerr, J. M. and Moir, J. C.: *Operative Obstetrics*, ed. 5, Bailliere, Tindall and Cox, p. 380.
5. Stander, H. J.: *Text Book of Obstetrics*, ed. 9, New York, 1945, D. Appleton Century Crafts. Inc. p. 884.
6. Willson, R. J.: *Management of Obstetric Difficulties*, ed. 6, St. Louis, 1961, C. V. Mosby Company, p. 117.