MYOMECTOMY IN PREGNANCY

(Report on 3 Cases)

by

B. K. Goswami,* D.G.O., M.S. (Cal.)

and

K. Mukherjee,** D.G.O., M.O. (Cal.), M.R.C.O.G., Ph.D. (Lond.)

Introduction

Association of fibromyoma with pregnancy is not very uncommon in obstetric practice. The reported incidence varies from 0.24 to 7.2 per cent (Giri, 1968). Usually the pregnancy and delivery are uneventful but some cases develop complications such as acute pain in the abdomen due either to torsion of pedunculated fibroid or red degeneration. Other complications, although rare, are malpresentation, obstruction and also it has been alleged to produce accidental haemorrhage. The treatment of such complications except torsion is conservative because myomectomy is considered dangerous during pregnancy for the risk of haemorrhage, infection and subsequent abortion. The general teaching was to leave the fibroid as such during the pregnancy and even during caesarean section with advice of operation afterwards (Douglas and Wilson, 1963; Giri, 1968).

Now time has come to reconsider the opinion against extreme conservatism. The risk of haemorrhage from myomectomy during caesarean section is perhaps minimum as the uterus is better adapted physiologically in the immediate postpartum period than at any other stage of a woman's life. It is because of contraction and retraction of the uterus with rapid vascular changes in the placental bed with fibrin deposition and clot formation (Howkins and Stallworthy, 1974). Here we are presenting three cases of myomectomy—one during caesarean section and two during pregnancy.

Case 1: Mrs. M. B., 26 years, PO + O, attended Eden antenatal clinic on 15.6.77 with the complaint of 9 months' amenorrhoea and pain in the right iliac fossa. The pain was constant and dull aching in nature.

Menstrual History: Menarche—12 yrs. Cycles —regular, duration 5-6 days, LMP-3rd October 1976. Past History—She suffered from similar pain when the pregnancy was of 6 months duration. She was then hospitalised and treated conservatively for 14 days.

General Examination: G. C.—fair, anaemia—nil, B.P. 130/90 mm of Hg., Oedema—slight.

Abdominal Examination: Uterus—36 wks. size, floating head. FHS +, Multiple fibromyoma were palpable and the fibroid situated near the right iliac fossa was tender.

Investigation: Urine-NAD, Hb-11 gm%, Blood Group—B +ve. She was treated conservatively but on 30.6.77, foetal distress (FHS—160—180/min.) suddenly developed with B.P. 140/90 mm of Hg. Emergency L.S.C.S. was done. Seven subserous fibroids (none pedunculated) were present of which the largest one (3″ x 3″) was situated near the right iliac fossa with omentum adherent on it. Of the other 6 fibroids, 3 were on the anterior and 3 on the posterior

* *Resident Surgeon.*

** *Lecturer, Post Partum Unit, Department of Obstetrics & Gynaecology, Medical College, Calcutta.*

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surface. All were removed without undue bleeding. She developed P.P.H. 2 hours after operation for which 2 bottles of blood transfusion was given. The rest of the postoperative period was uneventful. H.P. exam. report showed Fibromyoma with hyaline and red degeneration (largest one).

Case 2: Mrs. S. S., 28 yrs., P1 + O, attended O.P.D. on 31.8.77, with amenorrhoea for 3 months and acute pain in abdomen.

Menstrual History: Menarche—13 yrs., Cycles regular, duration 4-6 days, LMP—14.5.77.

Obstetric History: Caesarean section at Eden Hospital in 1972, girl, living. indication-unknown

General Examination: G.C. fair, Uterus—16 wks., deviated to the right. A firm, tender mobile mass 4″ x 4″ in size with smooth surface and rounded margins was palpable in the right iliac fossa.

Provisional Diagnosis: Pregnancy with twisted ovarian cyst. Investigations: All within normal limits.

On laparotomy, the uterus was 16 wks., bicornuate with subserous fibroid 4″ x 4″ in size, arising from the medial border of small non-pregnant left horn. Myomectomy was performed and the scar area peritonised with omental graft. Bleeding was within normal limits. The patient was treated with Duvadilan. Her postoperative period was uneventful and was discharged after 14 days. She attended antenatal clinic regularly. On 28.1.78, she came with dribbling per vagina. On examination, there was cord presentation and dribbling. Emergency. L.S.C.S. was done, girl, alive.

H.P. exam. report—Fibromyoma with red degeneration.

Case 3: Miss R. S., 22 yrs. was admitted on 18-11-77, with swelling of the lower abdomen for one year. The mass was gradually increasing with irregular and excessive periods for the same duration. There was no history of amenorrhoea.

Menstrual History: Menarche—14 yrs., cycle—irregular, excessive flow, duration—8 days, LMP 16.10.77.

General Examination: G. C. poor, Anaemia + P/A—A midline globular firm swelling of 22 wks. size, mobile, lower margin could not be reached.

Vaginal Examination: Uterus—22 wks. firm, Cervix—soft, Provisional diagnosis—Fibromyoma of uterus.

Investigation: Hb. 6.5 gm%. All others within normal limits St. X-ray abdomen—a soft tissue shadow seen. Chest X-ray-NAD.

Treatment: She was given two bottles of B + ve blood before operation. On laparotomy a big interstitial fibroid was seen on the posterior surface and two small ones on the anterior. Posterior one was removed by Bonney's Hood incision, the anterior 2 removed by local incision. The softness and size of uterus after myomectomy aroused suspicion of associated pregnancy. Hysterotomy was done and a 8 wks., gestation sac removed. The amount of bleeding was average. 1 bottle of blood was given to correct anaemia. Her postoperative period was uneventful.

Discussion

The conventional obstetric practice is to avoid myomectomy during pregnancy except when a pedunculated myoma undergoes torsion. Differences of opinion regarding treatment arise when symptoms are not acute. Conservative treatment often pays. If it does not, it may lead to constant suffering till her delivery.

The chances of abortion or premature labour as sequela to myomectomy are not many. One would think that the chances are proportional to the difficulty and extent of operation but this is not always the case (Moir, 1956). The irritability of the uterus varies widely from one person to the other. It has been observed that, if myomectomy is performed in the 4th or 5th month, the chances of miscarriage are less. From 24th week onwards, one should try to defer the operation until 38th week. Others emphasise that the chance of abortion is less when the tumors are symptomless than if it is performed following the conditions stated earlier as an rmergency measure. While Mussey *et al* (1945) observed 50% abortion, Gemmell (1936) in his review on 349 cases of myomectomy in pregnancy recorded 282 (80%) living children

(quoted by Moir, 1956). Many of such cases did not require section at term.

As fibromyomas are usually multiple, one is to decide how many he should remove. It would be a sound practice to remove the offending one and avoid courting further unknown dangers. As regards caesarean myomectomy, traditional teaching has been to defer it for 3-6 months after delivery. But some authors like Willson (1961) and Mudaliar and Menon (1972) advocate it provided the fibroid is easily removable and one is careful to secure proper haemostasis. Cases should be very carefully selected and done by experienced surgeons. Stallworthy has for over 30 years performed myomectomy in selected cases with good result (Moir, 1956).

Our first case responded to conservative treatment to some extent but a mild pain persisted till her delivery. During caesarean section, all the 7 subserous fibroids could be easily removed as the capsule was well identified. There was no undue haemorrhage during myomectomy and she was saved from a second laparotomy. Myomectomy was done in Case 2 at 16 weeks of pregnancy, operative blood loss was minimum and the pregnancy continued uneventful. She had L.U.C.S. for reasons stated earlier. We were happy to note that the amount of bleeding was not much in spite of the presence of pregnancy in the third case.

Conclusion

We like to say that myomectomy during pregnancy and caesarean section can be done safely and effectively in selected cases without much haemorrhage, subsequent infection and interruption of pregnancy, thereby we can save her from the suffering until delivery or another laparotomy after Caesarean section.

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