Coexisting Large Fibroid and Pregnancy

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INTRODUCTION

Giant uterine leiomyoma concomitant with pregnancy is a rare clinical entity, a diagnostic dilemma and a great surgical challenge. There is a common belief that uterine growths increase in size during pregnancy. Uterine leiomyoma are usually asymptomatic but may be occasionally complicated by red degeneration and an increased frequency of spontaneous abortion, preterm labor, premature rupture of fetal membranes, antepartum hemorrhage, malpresentations, obstructed labour, cesarean section and postpartum hemorrhage. The two factors most important in determining morbidity in pregnancy are myoma size and location. Resection of myomas during pregnancy is generally contraindicated. Resection of intramural myomas during pregnancy or at the time of delivery usually stimulates profuse bleeding. An interesting case of giant fibroid uterus with severe pregnancy induced hypertension with previous cesarean in full term pregnancy in woman of advanced age is discussed.

CASE REPORT

Patient was referred to our hospital as a case of G2 P1 L1 with 7 months amenorrhoea with severe pregnancy induced hypertension (PIH) and previous cesarean section. She was 35 years old with one female child of 4 years delivered by cesarean section due to PIH. She had her first antenatal visit at 2 months amenorrhoea in private hospital when large fibroid was diagnosed along with pregnancy. Patient was explained all risks of obstetric complications for large fibroid with pregnancy. She decided to continue the pregnancy. At 7 months amenorrhoea as she developed hypertension she was referred to our hospital. Her pulse was 88/min, BP was 170/110 mm of Hg. There was mild pedal edema and proteinuria was trace. On per abdominal examination abdomen was grossly distended and appeared to be 38 weeks size. Fetus with cephalic presentation was on left side of the uterus and on right side huge firm mass was felt. Patient was admitted and put on oral antihypertensives nifedipine retard 1 bd and alpha methyl dopa 1 tds. Her Liver function tests, Renal function tests and platelets were normal. Sonography showed normal fetus with 30-32 weeks gestational age, posteriorly situated placenta with normal liquor and huge fibroid of about 16x11 cm size in anterior wall of uterus on right side. She was counselled regarding further course of management. Steroids were administered and she was discharged after 10 days as her BP was well controlled with drugs. She was advised twice a week followup in OPD and readmission at 36 weeks for planned cesarean after 37 weeks.

Patient complained of abdominal pain at 35 weeks of pregnancy & was admitted. At the time of admission her vitals were normal with pulse rate 80/mins and blood pressure of 140/90 mm Hg. On per abdomen examination uterus was unduly large but relaxed and no scar tenderness. Fetus was with cephalic presentation and...
FHS were normal. There was mild tenderness at the site of fibroid. Per vaginal findings confirmed that she was not in true labour. Sonography confirmed 35 + weeks pregnancy and large fibroid. Patient complained of abdominal pain constantly for next three days. Decision for elective cesarean section was made. Risk of hemorrhage was explained and consent for hysterectomy if needed was taken.

Elective cesarean section was carried out under spinal anaesthesia. Abdomen was opened in right paramedian incision. Intra operative findings was suggestive of dextrorotation of uterus with fibroid of approximately 16x11 cm on anterior wall of uterus on right side (fig.1). from fundus to lower segment. Space was identified on left side in lower segment and ‘J’ shaped incision was kept on uterus on left side in upward direction. Live male baby was delivered with good Apgar score. Capsule of fibroid got opened during uterine incision. Haemostasis was difficult to achieve. As patient had completed her family decision was made for obstetric hysterectomy. Total obstetric hysterectomy was performed. Intraoperative two units of PCV transfusion was given. Specimen weighed 3.5 kg and was sent for histopathological examination. Her postoperative period was uneventful.

Histopathology report was suggestive of on gross examination total specimen was of 25x15x8cm with 3.5 cm long cervix. Gross examination was suggestive of marked decidual changes with congestion and extravasation at placental site. There was firm nodular capsulated intramural mass in right anterior segment of body of uterus. On microscopic examination there was focal mononuclear cell infiltration, section plumped spindle cells with whorled pattern and no mitosis. Histopathological diagnosis was benign intramural leiomyoma.

**DISCUSSION**

Uterine leiomyomata are the most common benign solid pelvic tumors encountered during pregnancy. Their reported incidence ranges from 0.3- and practice of routine sonography\(^2\). However the true frequency is probably underreported as majority of leiomyomas are asymptomatic in pregnancy and not all pregnant patients get a prior antenatal scan done. Leiomyomas in pregnancy can cause premature labor, abruptio placentae, malpresentation, labor dystocia, intrauterine growth retardation and pelvic pain.\(^3\) Adequate blood and optimal hydration status should be ensured preoperatively. Surgeon must be prepared to deal with the extent of tumour which involves not only hysterectomy and sometimes oophorectomy but also management of bowel or ureteric involvement or injury rarely. The interesting features of the case are the normal, full-term development of the fetus in a large fibroid uterus, excellent recovery of mother following Caesarean and hysterectomy and absence of fibroid related complications during whole pregnancy. Myomectomy at cesarean section is currently advocated for small and medium size fibroids. For big fibroids large raw area with increased vascularity due to pregnancy poses a problem. Leaving behind the fibroid at cesarean section and treatment at later stage is also an option. In our case as the capsule got opened during uterine incision, it led to increased bleeding and decision for hysterectomy was taken.

Paucity of literature regarding colossal sized fibroids with pregnancy reflect the rarity of our case. Although rare, emergency encounters with such masses continue to be the surgeon’s nightmare. Fibroids during pregnancy lead to increase in rate of Caesarean Section due to high
incidence of dysfunctional labour and malpresentation. They are also associated with increased risk of postpartum haemorrhage, thus the obstetrician dealing with such patients should be experienced to deal with any untoward events during management.

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