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Caesarean Myomectomy - Intracavitary Enucleation through Lower Segment Incision

Dr. Indrani Roy[1*], Dr. Punam Jain[2]

[1]MD, FIAOG, FICOG, Senior consultant and H.O.D, Department of Obstetrics and Gynecology, Nazareth Hospital, Shillong, Meghalaya, India
[2]DNB (T), Department of Obstetrics and Gynecology, Nazareth hospital, Shillong, Meghalaya, India

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***Corresponding author:** Dr Indrani Roy

Abstract **Case Report**

Routine caesarean myomectomy is not a standard procedure and has been condemned in the past due to fear of uncontrolled haemorrhage and peripartum hysterectomy. However, it may be considered a safe option in carefully selected cases in the hands of an experienced obstetrician. In this case, we describe a 35-year-old primigravida posted for elective caesarean section in view of breech presentation. Intraoperatively a 6 *7 cm anterior intramural fibroid was noted which was removed by intracavitary approach through lower segment uterine incision, thus reducing uterine scar and future adhesions. Increasing evidence suggests that myomectomy can be performed concurrently with caesarean section without an increased risk of blood transfusion or hysterectomy.

Keywords: Myomectomy, Caesarean, Pregnancy, Fibroid.

INTRODUCTION

Fibroids are common benign smooth muscle tumours occurring in 20-40% of women with an incidence of approximately 0.1% to 12.5% of all pregnancies [1]. The incidence is rising due to delayed childbearing and a rapid increase in the number of caesarean sections over the last few years. Myomectomy during caesarean section is avoided due to increased vascularity of the gravid uterus leading to massive haemorrhage, unnecessary obstetric hysterectomy, and increased perioperative morbidity and mortality. Caesarean myomectomies are now routinely performed in patients known to have fibroid in pregnancy or even in those coincidentally found intraoperatively, after several studies showed the procedure to be safe.

CASE DESCRIPTION

A 35-year-old primigravida was posted for Elective LSCS in view of breech presentation at term. Her antenatal period was uneventful. Her previous sonography record was normal and the patient did not have any c/o pain, bleeding per vaginum etc. On examination her vitals were stable and uterus was term size. She was posted for elective caesarean section in view of breech presentation. Abdomen was opened through Pfannenstiel incision and intra-operatively, an anterior fundal intramural fibroid of size 6 x 7 cm was noted. After delivering the baby and placenta, Caesarean myomectomy was performed, through the intracavitary route with no additional uterine incisions. The dead space was then obliterated with layered suturing using delayed absorbable sutures. Post-operatively, no significant decrease in blood levels were noted, hence the patient did not require any blood transfusion postoperatively. Patient had an uneventful post-operative stay and was discharged after routine suture removal.

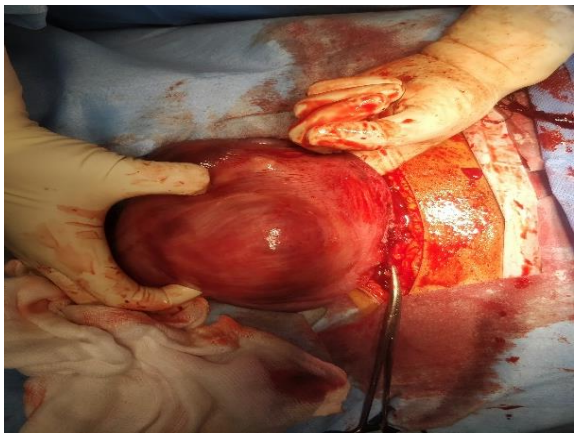

Fig A: Anterior fundal intramural fibroid of approximately 6*7 cm seen

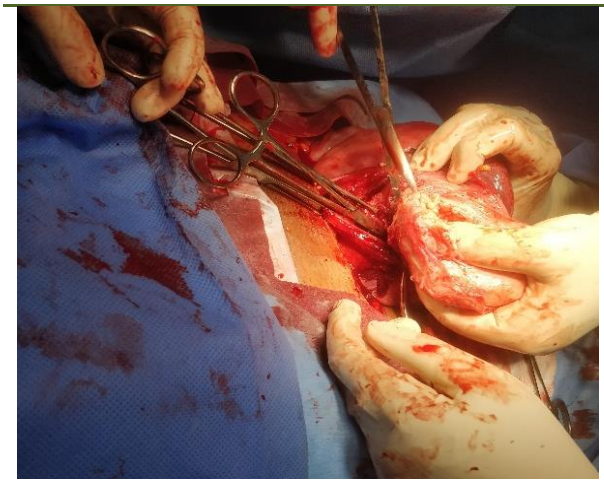

Fig B: Fibroid being removed through lower segment uterine incision

Fig C: Enucleated intramural fibroid

DISCUSSION

During pregnancy fibroids usually remain asymptomatic, but they may be associated with increased frequency of spontaneous abortion, preterm labour, premature rupture of membranes, antepartum bleeding, abruptio placenta, malpresentation and high incidence of caesarean delivery. Sometimes it may also undergo red degeneration during second trimester of pregnancy. A pedunculated fibroid may undergo torsion. The impact of uterine myoma on pregnancy 3.

depends on size, number and localization of myoma. If it is located in lower uterine segment or cervix, it can lead to obstructed labour or cervical dystocia. It can also lead to retained placenta, subinvolution of uterus, postpartum endomyometritis and Postpartum Haemorrhage in immediate postpartum period [2].

Intraoperative assessment of fibroids is important in decision making for caesarean myomectomy. The main aim of intracavitary enucleation through lower segment incision, as in this case, is to minimalize the uterine scarring and eventual adhesion formation. In an attempt to reduce post-operative adhesions, this is a technique of retrieving the fibroid(s) without additional incisions on the uterus. The fibroid(s) are accessed through the lower segment incision, then delivered through the same, thus maintaining an intact uterine surface.

CONCLUSION

The avoidance of multiple uterine scars and the ease of removal of fibroids via a single incision and the insignificant amount of blood loss makes intracavitary approach for caesarean myomectomy a better method. It is a very quick technique in handling amount of intraoperative haemorrhage thus decreasing the risk of peripartum hysterectomy and also preventing post-operative adhesions. The idea of performing myomectomy at the time of caesarean section appears to be effective in a low-resource country like India, which if performed safely, it can avoid the additional morbidity of a future surgery, thus justifying the cost-effectiveness of the procedure.

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