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CASE REPORT

Prolapsed Fibroid in Pregnancy

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ABSTRACT

Uterine fibroids are commonly encountered in clinical practice. Majority of the fibroids are usually asymptomatic during pregnancy; however, they may lead to complications in pregnancy and even in post natal period, causing a management dilemma**.** Vaginal prolapse of uterine fibroids is an uncommon presentation during pregnancy, delivery or postpartum period. While most of the fibroids are managed conservatively, a few require surgical intervention. Despite multiple publications in the medical literature on the gynecological aspects of fibroids, scanty data is available on management during pregnancy and labor, posing a therapeutic dilemma. We present a case of a G4P3, presenting at 30weeks gestation with large degenerated prolapsed uterine fibroid which was successfully managed by vaginal myomectomy concurrently with cesarean section.

Key Words: Fibroid, Myomectomy, Pregnancy, Prolapse.

Authors' Contribution:
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Introduction

Fibroids are benign smooth muscle tumors of the uterus. The incidence of Leiomyoma in reproductive age group is approximately 26.41%.[1] Depending upon the size , the incidence of uterine fibroids in pregnancy varies between 1.6 and 10.7%, while cervical fibroids are less than 1%.[2] The morbidity of pregnancy with fibroid is related to their number, location and size. In majority cases, fibroids do not cause symptoms during pregnancy, however, in 10-30% of the pregnancies, they may lead to complications in pregnancy and even in post-natal period, causing a management dilemma**.**[3] Vaginal prolapse of submucosal uterine fibroids is not a common occurrence during pregnancy, delivery, or puerperium.[4] While most of the fibroids are managed conservatively, a few require surgical intervention. Here we report a case of pregnancy with a large prolapsed uterine fibroid managed successfully by vaginal myomectomy concurrently with the cesarean section.

Case Report

A 38-year-old, gravida 4 Para 3, with previous 2 normal deliveries followed by one cesarean section was booked in our unit at 13 weeks gestation. The ultrasound at the time of booking showed an intrauterine gestational sac with CRL of 9+6weeks and a uterine fibroid arising from the posterior wall of uterus measuring 7.7x7.0cm. The patient then had one episode of per vaginal bleeding, for which

she presented in emergency at 17weeks gestation, and was advised progesterone support. She did not get any antenatal care following this visit. The patient then presented at a private clinic at 30+3weeks gestation with history of urinary incontinence and something coming out of vagina for three days. She was referred to our department with the suspicion of prolapsed cervical/uterine fibroid. On physical examination, she was a thin lean woman, lying in uncomfortably in dorsal lithotomy position, with urinary catheter in situ. Her vitals were stable. Abdominal palpation showed a symphysio-fundal height of 30cm with a positive fetal cardiac activity. Vaginal examination revealed a 16x16cm degenerated infected, foul-smelling fibroid, coming out of the vagina (fig I).

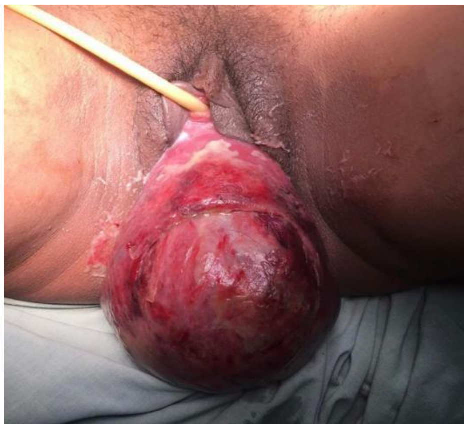

Figure 1: Prolapsed Fibroid in Pregnant Female

On investigations, she had hemoglobin 9.2g/dl with rest of baseline investigations being normal. Her ultrasound showed a single alive intrauterine fetus with biometry of 29+0weeks, breech presentation, anterior placenta, absent liquor and normal Doppler indices. There was a hypo echoic mass along the posterior wall of cervix measuring 11x12cm with flow on color Doppler. The patient underwent elective cesarean section and delivered a 1.1kg alive, healthy female baby. EUA showed 16x14cm, prolapsed degenerating fibroid, arising from the posterior uterine wall for which vaginal myomectomy was done and the pedicle was clamped and ligated. One unit RCC was transfused per operatively. The patient remained well in the post-operative period with minimal vaginal bleeding.

Discussion

Uterine fibroids are commonly seen in obstetric clinical practice. The management of uterine fibroids during pregnancy is a therapeutic challenge. About 20% of fibroids increase in size, the greatest increase occurring before 10weeks gestation.[5] While most fibroids are usually asymptomatic, 10-30% can lead to complications, increasing the risk of miscarriage, preterm delivery, placental abruption, pain, obstructed labor and post-partum hemorrhage.[6] Rarely complications may include prolapse of uterine fibroid, resulting in retention of urine. Patients may present with vaginal bleeding, pain and discharge in case of prolapse of a leiomyoma through the cervix however it may be asymptomatic, and noted incidentally on pelvic examination. Prolapsed uterine fibroid is most likely to be infected and necrotic. This can be a challenge for doctors to manage, especially in case of preterm pregnancy, where vaginal delivery is not possible as fibroid had occupied almost the entire pelvis.

Traditionally, pregnancy with fibroids was treated conservatively. Myomectomy conducting simultaneously at the time of caesarean section is known to cause uncontrollable hemorrhage, about 35.5%, requiring reoperation, hysterectomy, uterine artery ligation or embolization, so majority of obstetricians discourage myomectomy at the time of caesarean section, unless pedunculated myoma is encountered.[7] However, studies done have shown that myomectomy done with caesarean section can potentially eliminate the need for multiple surgeries, reduce the risk of anesthetic complications and intraoperative hemorrhage and ultimately reducing overall cost and duration of hospital stay.[8]

A report of 13 cesarean myomectomies and a review of 47 incidental myomectomies done during caesarean section showed that although the duration of procedure was increased by 11 minutes and additional blood loss was 112 ml, there were no wound infections or serious morbidity.[9] Cesarean myomectomy shows better scar integrity on serial ultrasound in subsequent pregnancies and increases the chance of vaginal delivery especially when fibroid is removed from lower segment. Cesarean myomectomy, can therefore, only be recommended in selected cases, by very experienced surgeons, approaching each individual case with caution. Timely anticipation regarding issues and proper counselling of patients to seek early help is necessary. Such high-risk pregnancies should be managed in a tertiary care centers. While the literature on Cesarean myomectomy is limited and current data provides a lot of conflicting results, the indications and contraindications still need to be defined.

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