Complications during cesarean delivery in a patient with two previous myomectomies

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INTRODUCTION

Uterine myomas are observed more frequently in pregnancy because many women are delaying childbearing to their late thirties, the time of greatest risk for myoma growth. The true prevalence of uterine myomas in pregnancy is unknown. However, they are associated with numerous pregnancy-related maternal and fetal complications, including high rate of cesarean deliveries. Literature suggest high rate of cesarean delivery in women with myomas up to 58,3%.

CASE OUTLINE

A 41-year-old gravida 2, para 0 woman who was known to have multiple myomas was admitted for delivery. Her prenatal course was uncomplicated. Her medical history revealed two previous myomectomies, two and five years before. Gynecological examination revealed the uterine cervix 2 cm in length with its orifice closed. Ultrasonography showed 9 cm myoma involving most of the posterior uterine wall and lower uterine segment and two others on the anterior uterine wall and in fundal region 6 to 7 cm in diameter. The presenting part (vertex) was visualised high above the internal os with this leiomyoma interving in between. Fetal biometry and the amniotic pocket were normal.

At 38 gestational weeks, elective cesarean section was performed under general anesthesia. The abdomen was opened through the previous Pfannenstiel incision. During the cesarean section, the anatomy was found to be grossly distorted. The bladder was attached very high on the anterior wall of the uterus. Omental adhesions with the surface of the uterus were released. After dissecting the bladder off the lower uterine segment, the uterus was opened with a low transverse incision, liquor was seen, but the baby could not be delivered, due to the posterior wall myoma. For this reason, the abdominal incision was thus extended with midline incision and uterine incision was thus extended up with a 5 cm corporeal vertical incision. A live male baby weighing 3100g was delivered, head first, with Apgar score of 6 at 1 min, 20 minutes after the skin incision. The placenta was removed without difficulty. A standard technique for myomectomy was used with no complications, and posterior wall myoma was enucleated. The uterus was closed in two layers with a continuous stitch, and the corporeal incision was closed in two layers with single stitches. Oxytocin 20 IJ was injected and the uterus was properly contracted. The operation lasted for 70 minutes. At the time of surgery, patient’s hemoglobin reading was 101g/l. Two units of packed red blood cells were transfused intraoperatively, and the hemoglobin reading was 93 g/l on the first postoperative day. The patient received antibiotics for 7 days after the surgery. The mother recovered uneventfully, and was discharged with the baby on the the seventh postoperative day.
DISCUSSION

It is well known that myomas cause numerous problems during pregnancy and delivery\(^1,2,3,4\). The risk of developing complications may be associated not only with myoma quantity and size, but also with its localization and postoperative adhesions forming after previous pelvic surgery as was the case in our patient. There has been a report of the surgeon inadvertently opening the vagina in a case of large anterior myoma, thus necessitating cesarean hysterectomy\(^5\). Previous abdominal surgery is also well known risk factor for intraoperative complications during cesarean delivery\(^6\).

If the location of the myoma is in the lower segment of the uterus, it presents a difficulty not only for a vaginal delivery, but also during cesarean section. In our case, extraction of the fetus was not possible through transverse incision due to the position and size of the posterior wall fibroid. This was the indication for inverted T-incision on the uterus, which facilitated delivery of the fetus. This kind of uterine incision is used in 0,8% of cesarean sections, and is sometimes inevitable in patients with myomas\(^1,6,7\). Delivery of the fetus in woman with myomas can be complicated with fetal injuries, such as bone fractures\(^8\). Clinicians should be prepared to manage those difficulties with inverted T-incision in order to prevent fetal injuries during cesarean delivery as was the case in our patient.

Since cesarean myomectomy may lead to massive hemmorhage, it is not recommended, unless the myomas are pedunculated or subserosal and or affecting the lower uterine segment\(^1\). Of the nine cases of cesarean myomectomy reported by Exacoustos and Rosati, three were complicated by severe hemorrhage necessitating hysterectomy\(^9\). The indication for cesarean myomectomy in our case was the possibility of obstruction of the lochia passage in puerperium by huge posterior lower segment myoma. The case of uterine myoma obstructing the cervical os and preventing the passage of lochia resulting in hematometra, uterine atony and subsequent serious uterine hemmorhage indicating postpartum hysterectomy was published in the literature\(^10\).

This case illustrates the difficulties that may arise during cesarean section as a result of the distorted anatomy that may occur in the presence of uterine myomas in patients with previous myomectomies. In some instances, myomectomy during cesarean section is inevitable\(^3,11\). This kind of surgery should be performed by experienced hands in order to prevent maternal and fetal complications.

SUMMARY

KOMPLIKACIJE TOKOM CARSKOG REZA KOD PACIJENKINJE SA DVE PRETHODNE MIOMEKTOMIJE

Uvod: Miomi su udržena sa brojnim fetalnim i mater- nalnim komplikacijama u trudnoći, što podrazumeva i vi- soku učestalost carskih rezoa.


Zaključak: Ovaj slučaj pokazuje teškoće koje se mogu pojaviti tokom carskog reza pri postojanju mioma uterusa kod žena koje su prethodno imale miomektomiju. Kliničari moraju biti spremni da ove teškoće prevazidiju izvodnjem obrnutog T reza kako bi se sprečile povrede ploda. Ovakve operacije bi trebalo da rade iskusni akušeri.

Ključne reči: miom, carski rez, komplikacija

REFERENCES