



## FIBROID COMPLICATING PREGNANCY- MULTIFACETED APPROACH

## Obstetrics &amp; Gynaecology

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## ABSTRACT

Uterine fibroids are most common finding in women during reproductive age group. In most cases these fibroids account for about 10 to 15% cases of infertility. The symptoms of fibroids depend upon their size, number, location and type of fibroid. Fibroids become more common during pregnancy due to delayed age during conception, infertility and advances in diagnostic modalities. We bring to your notice two cases with different types of fibroids with different antenatal difficulties and two modes of delivery.

## KEYWORDS

Fibroid, Pregnancy, Preterm, Labour Natural, Ceasarean. Myomectomy

## INTRODUCTION

Fibroids (leiomyomas) are benign smooth muscle cell tumors of the uterus. Although they are extremely common, with an overall incidence of 40% to 60% by age 35 and 70% to 80% by age 50, the precise etiology of uterine fibroids remains unclear.[1] During pregnancy only 42% of myomas were diagnosed by physical examination. However, when the myoma was 3 cm to 5 cm in diameter, the rate of detection on physical examination was only 12.5%. [2]. The ability of ultrasound to detect fibroids in pregnancy is even more limited (1.4%–2.7%) primarily due to the difficulty of differentiating fibroids from physiologic thickening of the myometrium.

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## CASE 1

24 old primi, married since 1 year has come with 60 days amenorrhea. Her periods were regular. On ultrasound she was diagnosed with a large fundal fibroid of size 12 cm x 8 cm. The fetal growth corresponds to her dates with 8 weeks CRL and cardiac activity was good.

She was started on progesterone, iron, folic acid and calcium supplements. She was followed up regularly. Around 32 weeks she developed mild pain at the site of fibroid. She was diagnosed to have red degeneration fibroid in ultrasound. She was treated conservatively and advised bed rest. On reaching term she came with mild labour pains at around 39 weeks of gestation. Labour acceleration was done and she delivered an alive term female baby of weight 3.2 kg. Her postnatal period was uneventful and she was discharged on her 2<sup>nd</sup> postnatal day.

## CASE 2

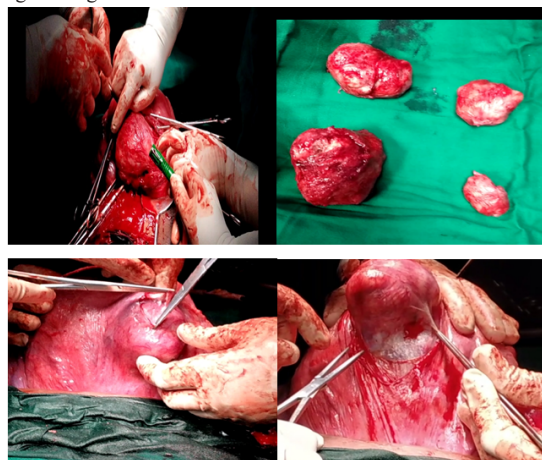
35 yrs old Primi, married since 14 yrs, visited our antenatal OPD around 20 weeks of gestation with multiple fibroids at different sites. The sites of fibroids according to early scans as follows

- i. Right upper sub serous measuring 7.8 x 5.4 x 5.2 cm
  - ii. Left upper posterior 2 x 2 cm
  - iii. Intramural upper posterior 1.8 x 2.1
  - iv. Sub serous posterior upper 4.1 x 3.4 cm
  - v. Left fundal sub serous 3 x 3 cm
  - vi. Left lateral lower sub serous 4.5 x 4.9 cm
  - vii. Left cervical fibroid 8.1 x 7.5 x 6.6 cm
- And  
Viii, ix – small 2 intramural fibroids measuring about 2 x 2 cm.

She was followed up regularly. She was diagnosed as gestational diabetes mellitus at around 32 weeks of gestation and was started on inj. Insulin. On reaching 36 weeks patient complained of reduced fetal movements and on account of abnormal CTG patient was taken up for

emergency LSCS.

During the procedure, she delivered an alive healthy female baby of weight 2.6 kg.



Intra op, due to the presence of fibroid at the incision site the fibroid number i, was removed along with ii, vi, and vii fibroids. There was not much intra operative bleeding. The procedure went well. The patient was discharged on 4 th postoperative day uneventfully.

## DISCUSSION

Most of the fibroids during pregnancy remains asymptomatic. However the complications may arise depending on the size, and position and the risk to fetus during pregnancy. Prospective studies using ultrasound to follow the size of uterine fibroids throughout pregnancy have shown that the majority of fibroids (60%–78%) do not demonstrate any significant change in volume during pregnancy.[3] The major complication during first trimester due to fibroids per se are spontaneous miscarriage, preterm labour, placental abruption, malpresentations and caesarean section. Pain is the most common complication of fibroids in pregnancy, and is seen most often in women with large fibroids (> 5 cm) during the second and third trimesters of pregnancy.[4] However, severe localized abdominal pain can occur if a fibroid undergoes so-called “red degeneration”, or impaction.

Pregnant women with fibroids are significantly more likely to develop preterm labour and to deliver preterm than women without fibroids. Multiple fibroids and fibroids contacting the placenta appear to be independent risk factors for preterm labour.[5] Sub mucosal fibroids, retroplacental fibroids, and fibroid volumes > 200 cm<sup>3</sup> are independent risk factors for placental abruption.[6]

## LABOUR AND DELIVERY

The risk of fetal malpresentation increases in women with fibroids compared with control subjects. Large fibroids, multiple fibroids, and fibroids in the lower uterine segment have all been reported as independent risk factors for malpresentation[7]. In a systematic review, women with fibroids were at a 3.7-fold increased risk of caesarean delivery (48.8% vs 13.3%, respectively). This is due in part to an increase in labour dystocia, which is increased 2-fold in pregnant women with fibroids.[reference table 1][8]

| COMPLICATIONS           | WITH FIBROIDS | NO FIBROIDS |
|-------------------------|---------------|-------------|
| Caesarean Section       | 48.8%         | 13.3%       |
| Malpresentation         | 13.0%         | 4.5%        |
| Labour dystocia         | 7.5%          | 3.1%        |
| Preterm labour          | 16.1%         | 8.7%        |
| Abruption               | 3.0%          | 0.9%        |
| Peripartum hysterectomy | 3.3%          | 0.2%        |
| Postpartum haemorrhage  | 2.5%          | 1.4%        |

## MYOMECTOMY AND CAESAREAN SECTION

With large myomas in lower segment of the uterus, myomectomy may be inevitable and there appears to be no absolute contra-indication to myomectomy. With an adequate experience in myomectomy during caesarean section and use of high dose oxytocin infusion, severe haemorrhage which is the most serious complication can be controlled.[9]

Some women with a previous myomectomy may need to be delivered by elective caesarean delivery prior to the onset of labour, particularly if the uterine cavity was entered. Women with a previous myomectomy should probably be delivered by caesarean prior to the onset of labour, particularly if the uterine cavity was entered.[10]

## CONCLUSION

In the above 2 cases we reported the first case is a large fundal fibroid with nil other complications. The patient went in for spontaneous labour and delivered without any postpartum or intrapartum complications. The second case was having both obstetrical complications and cervical fibroid which may obstruct normal labour progress, so she was taken up for caesarean section. The mode of delivery depends upon both fibroid position and added up obstetrical complications. It seems to be safe to perform myomectomy during caesarean section if surgeon is experienced and the size and location of myoma is considered.

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