DOI: 10.14260/jemds/2015/1781

ORIGINAL ARTICLE

LOWER UTERINE SEGMENT FIBROID UNCOMLICATING DURING CESAREAN SECTION

Vijayalakshmi B[1], Kaveri Shavi[2]

HOW TO CITE THIS ARTICLE:
Vijayalakshmi B, Kaveri Shavi. "Lower Uterine Segment Fibroid Uncomlicating during Cesarean Section". Journal of Evolution of Medical and Dental Sciences 2015; Vol. 4, Issue 71, September 03; Page: 12336-12339, DOI: 10.14260/jemds/2015/1781

ABSTRACT: Uterine fibroids (Leiomyomas) are benign smooth muscle tumors of the uterus. These tumors are of clinical concern since they are common in reproductive age. The potential effects of fibroids on pregnancy and the effects of pregnancy on fibroids are conflicting because majority of fibroids do not have any complication during pregnancy, although one third may grow during pregnancy and may cause slight increased risk of obstetrical complications such as miscarriage, premature labour, abnormal fetal position, abruption, mal-presentations, labour dystocia, caesarian delivery and post partal hemorrhage (PPH).

KEYWORDS: Fibroids, Preterm Labour, Pregnancy Outcome, Term pregnancy, Cesarean Section.

INTRODUCTION Fibroids may be as small as a pea or as large as a football. Having uterine fibroids does not increase your risk of cancer. They are almost always benign, no matter how large they may be. Fibroids have different names depending on where they grow: The most common type of fibroids develop within the muscle wall of uterus. These are called intramural fibroids. They make uterus appear bigger, and cause menstrual disturbances and fertility problems. Fibroids that grow just under the inner lining of uterus (Endometrium) are called sub mucosal fibroids. They alter the lining of uterus and reduce fertility. Sub mucosal fibroids cause heavy and prolonged bleeding. Fibroids that grow on the outside of uterus are called subserosal fibroids. They may bulge and cause pressure on bladder or bowel. Cervical fibroids develop in the cervix, manifest symptoms by causing pressure on bladder and bowel. Sub mucosal and subserosal fibroids may grow from a stalk (Pedunculated). They may stick out into uterus or into pelvic area. If a fibroid or cluster of fibroid is particularly large or is growing on the outside of the uterine wall, it pushes the uterus aside or force it to grow abnormally.

MATERIALS AND METHODS: It is a rare presentation studied in the Dept. of OBG VIMS Ballari. A 25 Years old G2P1L1 with 38 weeks of gestation with sub serous fibroid in lower segment of uterus with term gestation presented in latent phase of labour. On 21/01/2015. On examination her PR=88/min, BP=120/80mmHg, CVS and RS clinically normal. P/A uterus full term, acting, longitudinal lie, cephalic in the lower pole, mobile. A well-defined non-tender mass of about 10x8x8cms felt at lower pole of uterus with fetal head above this mass. FHR-146/min, regular. P/V revealed-os with 3cm dilated, 60%-70% effaced, vx-high up, pelvis adequate. Investigations were within normal limits. Patient was posted for emergency LSCS. Under spinal anesthesia, a vertical mid line sub umbilical incision was taken, abdomen opened in layers. A sub serous fibroid of 10x8x8cms size found in the upper part of lower uterine segment in the anterior wall of the uterus. After separating bladder, a transverse incision was taken in the lower uterine segment below the fibroid and extracted a live term female baby by vertex weighing 3.5Kgs. placenta and membranes were removed in Toto which was present in the fundo-posterior region. There was no PPH or angle extension or tear. Uterus was closed in two layers and abdomen closed in layers after mop and instrument count and perfect haemostasis. Post-

DOI: 10.14260/jemds/2015/1781

operative period was uneventful. Sutures were removed on 8th post-operative day and patient was discharged and fallowed up post operatively.

Figure 1: Term Pregnancy with Fibroid (Visible Per abdomen)

Figure 2: Fibroid in the Lower Uterine Segment

Figure 3: Fibroid in the upper part of lower segment of Gravid Uterus (Hidering uterine Incision during cesearian Delivery)

Figure 4: Fibroid in the lower segment after extraction of Fetus

Figure 5: Patients in post partal period

DOI: 10.14260/jemds/2015/1781

DISCUSSION: Fibroids are benign smooth muscle cell tumours of the uterus, although they are extremely common with an overall incidence of 40-60% by age 35years, 70-80% by 50 years. The precise etiology of uterine fibroids remains unclear. The diagnosis of fibroids in pregnancy is neither simple nor straight forward. Only 42%of large fibroids (>7cm) and 12.5% small fibroids (3-5cm) can be diagnosed by physical examination. The ability of sonography to detect fibroids in pregnancy is even more limited (1.4%-2.7%), primarlly due to the difficulty in differentiating, fibroids from physiological thickening of the myometrium.[2] The prevalence of uterine fibroids during pregnancy more likely under estimated. Reflecting the growing trend of delayed child bearing, incidence of fibroids in older woman undergoing treatment for infertility is around 12-25%.[3] Despite these growing prevalence, relationship between uterine fibroids and adverse pregnancy outcome is not clearly understood the prevalence of uterine fibroids in pregnancy varies between 1.6-1.7%, and approximately 10-30% of women with fibroids develop complications depending upon the size and trimester of pregnancy.[4,5]

Pain is the most common complication fibroid in pregnancy and in seen most often in women with fibroid >5cm during 2nd and 3rd trimester of pregnancy. If pain is severe enough it may be due to fibroid undergoing so called “red degeneration”, torsion, or impaction. But in our case it was fibroid of 10X8x8cms, which was asymptomatic till delivery. Effects of fibroids on pregnancy outcome have been reported incompletely due to selection bias, small and differing population, varying inclusion criteria, low occurrence of 3 adverse outcomes, and inadequate confounding variables. As a result, these studies have reported inconsistent relationships between fibroids and adverse obstetric outcomes. But there may be decreased uterine dispensability or mechanical obstruction may explain some of these adverse outcomes, the precise mechanism by which uterine fibroids induce obstetric complications is not clear. In our case it was a fibroid of about size 10X8x8cm, which was situated in the upper part of lower uterine segment, the incision was taken below the fibroid by avoiding it and all complications of fibroid that were expected during Cesaerian, were avoided.

Early pregnancy	Late pregnancy	During labour and delivery
Miscarriage	Pre-term labour	Labour dystocia
Bleeding per vaginum	PROM	Cesaerian delivery
Impaction of scar	Red degeneration	Uterine rupture
	Torsion	

Table 1: Complication of uterine fibroids during pregnancy

CONCLUSION: Uterine fibroids are a very common in women of reproductive age. The majority of fibroids are asymptomatic, but one-third may grow in pregnancy and cause pain which is managed conservatively, however severe localized abdominal pain can occur if a fibroid undergoes red degeneration, torsion or impaction. About 10 to 30% of women with fibroids develop complications during pregnancy but available data are conflicting due to inadequate evidence on literature. The uterine fibroids are associated with an increased rate of spontaneous miscarriage, preterm labor, placenta abruption, mal-presentation, labor dystocia, cesarean delivery, and postpartum hemorrhage. Prior to pregnancy, myomectomy may be considered in women with unexplained infertility or recurrent pregnancy loss, although whether this intervention improves fertility rates and perinatal

outcome remains unclear. Uterine artery embolization is an alternative procedure to operative intervention for the treatment of symptomatic fibroids, but is absolutely contraindicated in pregnancy and in women desiring future fertility.

REFERENCES:

1. Rice JP, Kay HH, Mohony BS. The clinical significance of uterine leomyomas in pregnancy, Am J obstet Gynecol. 1989; 160: 1212 -1216. [Pub Med]
2. Burton CA, Grimes DA, March CM. Surgical management of leiomyomata during pregnancy. Obstet Gynecol. 1989; 74: 707–709. [PubMed]
3. Klatsky PC, Tran ND, Caughey AB, Fujimoto VY. Fibroids and reproductive outcomes: a systematic literature review from conception to delivery. Am J Obstet Gynecol. 2008; 198: 357–366. [PubMed]
4. Day Baird D, Dunson DB, Hill MC, et al. High cumulative incidence of uterine leiomyoma in black and white women: ultrasound evidence. Am J Obstet Gynecol. 2003; 188: 100–107. [PubMed]
5. Rice JP, Kay HH, Mahony BS. The clinical significance of uterine leiomyomas in pregnancy. Am J Obstet Gynecol. 1989; 160: 1212–1216. [PubMed]

AUTHORS:

1. Vijayalakshmi B.
2. Kaveri Shavi

PARTICULARS OF CONTRIBUTORS:

1. Associate Professor, Department of Obstetrics & Gynaecology, VIMS, Bellary.
2. Junior Resident, Department of Obstetrics & Gynaecology, VIMS, Bellary.

FINANCIAL OR OTHER COMPETING INTERESTS: None

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Vijayalakshmi B.
Associate Professor,
Department of Obstetrics & Gynaecology,
VIMS, Bellary.
E-mail: vijaya.b.yadav72@gmail.com

Date of Submission: 18/08/2015.
Date of Peer Review: 19/08/2015.
Date of Acceptance: 31/08/2015.
Date of Publishing: 01/09/2015.