Introduction

Uterine lieomyomata or fibroids are the commonest tumours of the female genital tract. It is 3-9 times commoner among the Negroid race, compared to the Caucasians. Traditionally obstetricians and gynaecologist had avoided performing myomectomy either during pregnancy or at cesarean section because of fear that bleeding may be intractable as a result of the increased vascularity of the pregnant uterus. The presence of fibroid in the lower uterine segment may be an indication for classical caesarean section. Recent reports indicate that myomectomy, at the time of cesarean section operation; can be safely undertaken by skilled practitioners and with the application of tourniquet at the base of the broad ligament or infusion of high dose oxytocin to control haemorrhage. A case is presented of an unavoidable myomectomy performed during caesarean section for persistent transverse lie at term due to a huge uterine fibroid filling the whole of the lower uterine segment.

Case

Mrs M.O. is a 35 years old primigravida who booked for antenatal care at the Wesley Guild Hospital Unit of Obafemi Awolowo University Teaching Hospitals Complex (AUTHC), Ilesa at gestational age of 17 weeks. The uterine fundal height at booking was larger than the gestational age by date. An ultrasound scan performed revealed a singleton foetus in longitudinal lie with breech presentation with adequate amniotic fluid. There was a fibroid mass measuring 16 x 12 x 8 cm anteriorly placed in the lower uterine segment (Fig 1). The antenatal period remained uneventful until 35 weeks gestation when the fetal lie was found to be transverse. The transverse lie persisted at 37 weeks and she was offered elective caesarean section at 38 weeks of gestation when she was 37 years old. The uterine fibroid was a huge mass filling the whole of the lower uterine segment.

Abstract

Establishment of the feasibility and need to perform myomectomy during caesarean section when fibroid obstruct wound closure with associated hemorrhage has been presented.

A case of a primigravida with a huge uterine fibroid located in the lower segment lifting up the uterine cavity leading to persistent transverse lie of the fetus at term is presented. An elective classical caesarean section was performed with difficulty in uterine wound closure and haemorrhage necessitating myomectomy. Haemorrhage was controlled with the use of Foley catheter tourniquet and high dose oxytocin infusion. Literature review was carried out. The mother and baby had satisfactory outcome.

To conclude, life threatening situations of myomectomy with caesarean section ought to be, and can be safely performed using tourniquet and high dose oxytocin to reduce haemorrhage. The uterus in the immediate post partum period is better adapted physiologically to control haemorrhage than any other stage of a woman’s life.

Key Words: Classical caesarean Section, Myomectomy, caesarean-myomectomy, Haemorrhage.

Unavoidable caesarean myomectomy

A case report

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weeks. Pre-operative haemoglobin concentration was 11.5 g/dl. Two units of blood screened for HIV and Hepatitis B & C, were grouped and crosshatched for her use.

The fibroid occupied the lower uterine segment completely lifting up the uterine cavity above it with the baby in transverse lie necessitating the use of classical caesarean section to deliver the baby (Fig 1). A life female baby weighing 3.5 Kg and Apgar score 8 at one minute and 10 at ten minutes was delivered. The anteriorly located intramural uterine fibroid mass measuring 16 x 13 x 9 cm made wound closure impossible with associated profuse bleeding from the wound site (Figure 1). High dose intravenous oxytocin infusion (60 i.u. in 500mls of 5% dextrose in water) was set up to ensure adequate uterine contraction. A tourniquet was applied to the lower part of the broad ligament to compress both uterine arteries and the vessels in the infundibulo-pelvic ligament so as to achieve a bloodless operating field. The fallopian tubes were lifted and excluded from the tourniquet. The tourniquet insertion time was noted. The fibroid was dissected and enucleated and the cavity was closed in three layers. The classical uterine incision closure was then completed effectively. The estimated blood loss was 1.3 liters. Oxytocin infusion was continued for 24 hours post-operatively. Prophylactic antibiotics and analgesics were given.

Post operatively the patient remain stable however on the 3rd postoperative day her haemoglobin concentration was 8 g/dl while the packed cell volume was 24%. She was transfused with two pints of blood to correct the anemia. Subsequent post-operative period remained uneventful she was discharged home on the 8th post-operative day with hemoglobin concentration of 10.5 g/dl and a packed cell volume of 30%.

**Comment**

Management of fibroids during caesarean delivery remained controversial. Although the standard practice is to avoid myomectomy during caesarean delivery, under certain conditions cesarean myomectomy becomes unavoidable. This case illustrates the need for caesarean myomectomy because of the threat to the life of the patient from haemorrhage arising from the difficulty with wound closure due to the huge lower uterine intramural fibroid. The alternative of caesarean
The uterus in the immediate post partum period is better adapted physiologically to control haemorrhage than any other stage of a woman’s life.

References


