

## Successful Myomectomy During Second Trimester of Pregnancy: A Case Report

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### Dear Editor

We present a successful case of open myomectomy at 25 weeks gestation for a subserous fibroid, causing severe pain and sub-acute intestinal obstruction. Myomectomy during pregnancy may be considered in carefully selected cases, when benefit outweighs risk.

A 31-year-old Afro-Caribbean primigravid woman presented to hospital at 22 weeks gestation with acute abdominal pain, distension, vomiting and constipation. On admission she was afebrile, tachycardic and tachypnoeic. Bloods revealed anaemia, raised inflammatory markers and elevated platelets. She was treated for sepsis and possible bowel obstruction with analgesia and antibiotics.

Ultrasound showed an appropriately grown fetus and a 17 x 10 cm subserous fundal leiomyoma, with 1000 mls of intra-abdominal free fluid. MRI confirmed a 20 cm subserosal fibroid with large areas of cystic degeneration and necrosis. The fibroid had grown significantly and recently degenerated, compared to previous imaging.

A second 9 cm subserosal fibroid had similarly enlarged and degenerated. MRI also showed 1000 mls of intra-abdominal free fluid and there was concern that the fibroid might have ruptured into the abdomen. An ultrasound-guided ascitic tap showed a sterile exudate. Blood cultures showed no bacterial growth, but urine culture confirmed *E. coli* infection, which was subsequently treated.

By day 11, she was clinically stable on intravenous antibiotics and she was transferred to a tertiary centre. Despite conservative management with analgesia and antibiotics, she remained systemically unwell with sepsis and severe abdominal pain and therefore open myomectomy was considered. She was thoroughly counselled about the risks of uterine surgery, including pregnancy loss. Following this, she underwent an open myomectomy, with interventional radiology cover with internal iliac catheters. She had a midline laparotomy and removal of two large fibroids.

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She had a stormy post-operative course, including septicaemia (with blood cultures positive for *Serratia*), anaemia necessitating blood transfusion, severe pain and poor mobility. However, six weeks after her first admission, she was discharged from hospital fit and well and with an appropriately developed fetus. She went on to deliver by uncomplicated Caesarean section at term.

The role of myomectomy during pregnancy is controversial. The prevalence of uterine fibroids in pregnancy is approximately 2%, and 10% of these women suffer serious complications during pregnancy or delivery [1]. Many are managed conservatively, but 2% of patients will require surgical intervention during pregnancy. Although the literature reports an increase in myomectomy at Caesarean section in the past decade, myomectomy during pregnancy remains rare.

Literature review suggests that myomectomy during pregnancy may be considered safe in certain cases. Common indications include severe intractable abdominal pain due to degeneration or torsion of myomas, or rapid increase in myoma size, resulting in compression and displacement of surrounding organs [2,3]

Certain studies show that myomectomy during the second trimester may be safe, if the myoma does not enter the uterine cavity. Indeed, women who undergo myomectomy may have better outcomes than those managed conservatively [2,3]. There are fewer reports of myomectomy during the first trimester, and it is uncertain whether safety data can be extrapolated to earlier gestations.

The majority of myomectomies described were excisions of subserous myomas, performed laparoscopically at 15-19 weeks gestation [2-5]. In our case, laparotomy was obligatory because of the size and position of the fibroids. The predominant concerns are spontaneous miscarriage and haemorrhage, possibly necessitating hysterectomy [1].

Myomectomy during pregnancy is now better understood. Detailed evaluation on ultrasound and MRI allows preoperative mapping, planning and risk assessment. Management of refractory symptomatic myomas should be individualized after taking into account symptoms, gestation, size and location of the myomas. Thorough patient counselling should take place, but in experienced hands the procedure may be safe.

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