ECRONICON OPEN ACCESS

GYNAECOLOGY
Editorial

Caesarean Myomectomy: To Do Or Not To Do?

Naiknaware Sachin Vijay*

Department of Gynaecology, Kasturba General Hospital Mumbai, India

***Corresponding Author:** Naiknaware Sachin Vijay, Department of Gynaecology, Kasturba General Hospital, Boriwali, Mumbai, India.

Received: June 26, 2015; **Published:** July 17, 2015

Fibroids are benign tumors of uterine smooth muscles generally affecting women in childbearing age with incidence of approximately 2% in pregnancy women [1]. These myomas/fibroids may be asymptomatic but if associated with pregnancy, there is increased incidence of first trimester losses, increased pain, pressure symptoms with bid fibroids, malpresentations, premature rupture of membranes and preterm labour during pregnancy. Sometimes lower segment myoma or cervical fibroid may cause obstructed labour and postpartum complications, may include subinvolution of uterus, postpartum haemorrhage and retained placenta [2,3].

Many a time we encounter with a fibroid during caesarean section, but due to previous beliefs and dictum, we try not to do myomectomy during caesarean and only go ahead with caesarean. This is done because of fear of excessive bleeding after myomectomy in pregnant patient because of increased vascularity.

Due to lack of Multicenter Randomized trials, appropriate selection criteria, surgical technique and national and Gynecological society guidelines, it is left to individual experience to go ahead and do myomectomy or not.

Now-a-days uterine myomas associated or co-existant with pregnancy are going to be observed more often than before because of practice of late marriages and improved diagnostic technologies. This editorial is an effort to put forward a balanced view considering various individual studies in which myomectomy have been done along with caesarean section.

The management of myomas encountered at caesarean still remain a therapeutic dilemma as myomectomy during caesarean has traditionally been discouraged due to the risk of intractable bleeding, but recent studies has described techniques to control blood loss at caesarean myomectomy including uterine artery tourniquet, bilateral uterine artery ligation and electrocautery.

Roman AS., *et al*. [4] compared the outcomes of 111 patients who had myomectomy at caesarean with 257 patients who had undergone caesarean alone. In this study no significant difference was found in the intraoperative or postoperative complications between two groups.

In a large retrospective case control study by Li Hui., *et al*. [5] assessed the effectiveness, safety, outcome and complications of myomectomy during caesarean section in Chinese women with fibroids present since antenatal periods. Study group comprises of 1242 pregnant women with fibroids who underwent myomectomy during caesarean section was compared with three control groups. Group A comprising of 200 pregnant women without fibroid. Group B consists of 145 women with fibroids who underwent caesarean alone. Group C consisting of 51 patients who underwent caesarean hysterectomy. No significant differences were noted between the groups in the mean haemoglobin change, the frequency of haemorrhage, postopertive fever or length of hospital stay. These findings supports the fact that myomectomy during caesarean section is safe, effective procedure not associated with significant complications.

Similarly Kaymak., *et al*. [6] compared 40 patients who underwent myomectomy at caesarean section with 80 patients with myomas who underwent caesarean alone, In this study, there was no significant difference in the incidence of haemorrhages, postoperative fever or frequency of blood transfusion between the two groups and concluded that myomectomy during caesarean section is not always a hazardous procedure and can be performed by experienced obstetrician without any complications.

Considering the above few case studies amongst many, it can be said that myomectomy during caesarean section is safe and not always a hazardous procedure in carefully selected patients performed by skilled obstetrician. As preservation of an organ without loss of its function is always a greater surgical achievement than its destruction, myomectomy is usually preferred to hysterectomy.

Pioneer of myomectomy, Bonny wrote," It is tempting for adventurous and sympathetic surgeon to condense the operation of caesarean section and myomectomy in one undertaking and save his patient the ordeal of second admission to hospital. This kindly but misguided policy we heartily deprecate. "But Bonny's students, Hawkins and Stall worthy [7] deviated from Bonny's idea and advocated caesarean myomectomy in selected cases particularly when myoma is located anteriorly and in lower segments at the site of proposed incision for lower segment caesarean section.

From the above discussion, some points can be considered while reaching at a decision of whether to do a caesarean myomectomy or not.

a. In carefully selected patients and resourceful setting, myomectomy during caesarean section is safe and effective procedure at tertiary centers in experienced hands.
b. Myomectomy during caesarean is not always a hazardous procedure and can be performed safely without significant complications [8].
c. Fibroids obstructing lower uterine segments or accessible subserosal or pedunculated fibroids in symptomatic patients can be safely removed.
d. Rather than doing classical caesarean section, in case of lower segment obstructing myoma, caesarean myomectomy can be considered as safe and effective alternative.
e. Various haemostatic measures to decrease the blood loss such as bilateral uterine artery ligation, placement of uterine artery baloon catheters, uterine tourniquets, stepwise devascularisation, and post caesarean uterine artery embolisation would optimize the outcome and may decrease the chance of hysterectomy.
f. Myomectomy during caesarean section done in conventional way with making an incision over the myoma and enucleating it. Enucleation of fibroids is easier in gravid uterus owing to greater looseness of capsule. The dead space obliterated with 1-0 vicryl interrupted sutures.

Considering this, it can be concluded that myomectomy during caesarean section, in carefully selected patients is safe and effective procedure.

As these are individual studies with small sample sizes, multicenter randomized trials needs to be conducted to evaluate the best practices at caesarean myomectomy identifying appropriate selection criteria, surgical techniques and hemostatic options and improve the overall outcome of the procedure and studies to evaluate the long term obstetric consequences and risk of uterine rupture in subsequent pregnancies is also a need of time.

Bibliography

1. Katz VL., *et al*. "Complications Of uterine leomyoma during pregnancy". *Obstetrics & Gynecology* 73.4 (1989): 593-596.
2. AO Omigbodun and AO Fawole. "Myomectomy during pregnancy and delivery Is it safe?" *Tropical journal of obstetric and gynaecology* 22.1 (2005): 2005.
3. UI Nwagha., *et al*. "Emergency myomectomy during pregnancy a case report". *Tropical journal of obstetric and gynaecology* 22.1 (2005): 79-80.
4. Roman AS and Tabsh KMA. "Myomectomy at the time of cesarean delivery; retrospective cohort study". *BMC Pregnancy and Childbirth* 4.1 (2004): 14.
5. Li H., *et al*. "Myomectomy during cesarean section". *Acta Obstetricia et Gynecologica Scandinavica* 88.2 (2009): 183-186.
6. Kaymak O., *et al*. "Myomectomy during cesarean section". *International Journal of Gynecology & Obstetrics* 89.2 (2005): 90-93.
7. Hawkins J., *et al*. "Bonneys gynaecological surgery". 8th edn London: *Bailliere Tindall Publication* (1974): 421.

8. Ortac F., *et al*. "Myomectomy during cesarean section". *International Journal of Gynecology & Obstetrics* 67.3 (1999): 189-190.

Volume 2 Issue 1 July 2015