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Case Report

Previa Uterine Myoma in Full-Term Pregnancy: A Case Report and Literature Review

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Received: June 01, 2024; **Published:** June 21, 2024

Abstract

Uterine myomas are benign tumors that can cause different types of complications during pregnancy in women of childbearing age: fibroids can hinder conception and implantation. The myoma can be an obstacle for the evolution of pregnancy, childbirth and postpartum depending on its size, its location and the gravid state can facilitate the progression of fibromyomas towards complications. Before any conception plan in women who have a Myomatous uterus, they must be warned of the risk of complications on fertility and future pregnancies. We report the case of a patient admitted to our teaching hospital at full term of her pregnancy for method of delivery and whose ultrasound showed a praevia obstacle related to a myoma. From this case with a review of the literature, we focus on the complications of myomas in pregnancy and childbirth, as well as their management during labor and discuss the implications for the health of the mother and fetus.

***Keywords**: Myoma; Previa; Pregnancy; Hemostasis Hysterectomy; Myomectomy; Necrobiosis*

Introduction

Uterine myomatous pathology is quite common, affecting 20% of women during periods of genital activity. Its frequency with pregnancy is between 3 to 4% and 10% of myomas become complicated during pregnancy [1]. Indeed, fibroids can interfere with the development of pregnancy, labor, delivery and postpartum. This situation can be aggravated in the presence of a uterine praevia myoma. It itself may undergo some physiological modification due to hormones and anatomical changes due to pregnancy. We present a primigravida patient admitted to our training of 39 weeks + 5 days for delivery modality with the incidental discovery of myomeprevia during labor.

Patient History

A 37-year-old patient, primigravida, was consulting at a private facility for le last 5 years for infertility according to the patient's statement (undocumented), rhesus grouping A+, admitted to the gynecological-obstetric emergency service for method of delivery in a pregnancy of 39 weeks + 5 days not in labor, with fortuitous discovery on obstetric ultrasound of a previa myoma. then was programmed 48 hours later for cesarean section.

Clinical findings

The clinical examination found a conscious patient stable on the hemodynamic and respiratory level, BP at 13/07, normal cardiac rate, afebrile with on obstetrical examination: uterus spread longitudinally, uterine height at 36cm, in a patient not in labor.

Diagnostic approach

An obstetric ultrasound revealed a progressive single-fetal pregnancy, satisfactory biometry corresponding to the gestational age; anterofundal placenta; amniotic fluid in normal quantity; estimation of the fetal weight at 3700g, presence of a posterior isthmic previa myoma measuring 7*6 cm with a wide implantation base suggesting a FIGO type 7 myoma filling the posterior cul de sac, associated with other localized myomas anterior, corporeal and interstitial, cervical length estimated at 2cm; a preoperative assessment was carried out and returned without particularity, namely: HB 12, Platelets 170,000, PT 100% Rhesus Grouping A+.

Therapeutic intervention and follow-up

The patient benefited from an upper approach with intraoperative discovery of a polymyomatous uterus with a posterior myoma previa type 7 with a wide implantation base, with an incision made 3cm above laterally while respecting the implantation base. of myoma, head extraction of a female newborn, APGAR at the 1st and 5th 10/10 with a birth weight of 3600g with clear amniotic fluid, we carried out the closure plan by plan while respecting the myoma; at the end of the procedure, the patient was conscious, hemodynamically and respiratory stable, BP: 12/7, diuresis estimated at 300cc, bleeding estimated at 100cc, placed on antibiotics, analgesics and preventive anticoagulation, We did not note immediate postpartum hemorrhage. The rest was simple for mother and child. And was scheduled for myomectomy +/- hysterectomy 1 year postpartum.

Discussion

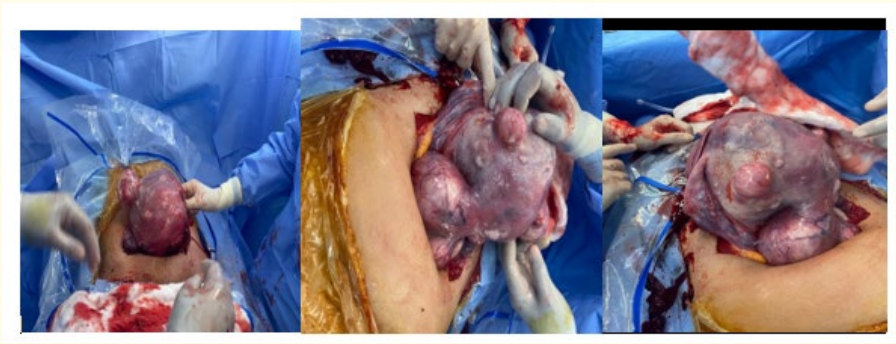
Praevia myomas can be responsible for pregnancy complications by several mechanisms, as shown in the various publications. According to several studies and literature review, it was estimated that one in 500 pregnancies had a complication secondary to a polymyomatous uterus and that 10% of women with praevia myomas had an obstetric complication [1]. In order to link the complications of myomectomy on a subsequent pregnancy and on the fertility of the woman, according to Shokeir., *et al*. [2] Reports the results of miscarriage rate before and after hysteroscopic myomectomy in 29 patients with a desire to conceive, according to some authors, there was a reduction from 61.6 to 26.3% in the miscarriage rate after hysteroscopy [3,4].

Fibroids can compress the ovular cavity, ascend the bladder, cause myometrial distension and be responsible for fetal compression and uterine deformation syndrome [6]. They can disrupt the regulation of the quantity of amniotic fluid provided mainly by fetal diuresis. But there may be detection bias; In fact, these women undergo far more ultrasound exams than the general population. Pain is often subjective in some of the patients with myomas during pregnancy [1,5] which is mainly due to the volume of the myoma which can complicate aseptic necrobiosis. The percentage of threatened premature birth varies from 17% to 24.6% [7,10] with premature birth from 8.5% to 17% of cases [4,12]. Cervical or isthmic fibroids may impede lower segment expansion and accommodation of the presentation: breech or transverse presentations are more common.

Regarding the complications of fibroids during pregnancy, there is no evidence of the adverse effect of pregnancy on the occurrence of necrobiosis. No preventive treatment has been validated. The diagnosis is made on clinical panels combining: localized pain, hyperthermia below 38.5°C and good treatment effectiveness. Pain management is based on symptomatic treatment combining analgesics and rest [8].

Uterine myomas during pregnancy may be complicated by placentation disorders with a significant increase in the risk of placenta previa and retroplacental hematoma, as has been reported in several studies [6-9]. In the literature, the birth weights of children born to women with myomas are similar to those of patients without myomas [11]. As with the risk of premature birth, there is an increased

risk in women with fibroids during pregnancy that are greater than 3 cm in diameter. The presence of myomas at the time of delivery is statistically linked to a higher rate of cesarean section (48.8 versus 13.3%) linked to obstructed presentations [1]. The most common complication during childbirth in patients with myomas is delivery hemorrhage due to uterine atony which can be life-threatening for the patient (2.5 versus 1.4%) [1]. Delivery hemorrhages 7.3% and 1.8% for polymyomatous uteri [10]. They are explained by the difficulties of uterine retraction and involution linked to fibroids. Patients should always be informed of the risks of hemostasis hysterectomy. The main indications for myomectomies during pregnancy are severe pelvic pain due to torsion of a pedunculated basement myoma or necrobiosis. During cesarean section, only myomas previa or on the uterine scar should be treated [11]. Studies have demonstrated that performing a myomectomy following a cesarean section is no more morbid in terms of blood loss than a cesarean section without myomectomy [12].



Figure

Conclusion

A pre-pregnancy myoma is a high-risk pregnancy warranting close, close monitoring to detect complications that may occur such as (aseptic necrobiosis, premature miscarriage, intrauterine growth retardation, birth defects, postpartum hemorrhage).

Monitoring will be based on clinical examination and ultrasound, namely:

- Raise awareness among women for early prenatal consultation for accurate diagnosis of myoma mapping before conception.
- Know how to detect pregnancies associated with fibroids very early, including their location, size, type and assess good fetal development.
- Encourage vaginal delivery if possible.
- Prevent complications during childbirth.
- Myomectomy during cesarean section is characterized by the high hemorrhagic risk, it is reserved for myoma located on the lower and pedunculated segment. Surgical treatment of myoma after pregnancy or during cesarean section should be discussed on a case-by-case basis according to the indication. The patient should always be informed of the risk of hysterectomy.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

All authors participated in the care of the patient, and in the writing and correction of the manuscript. They all also declare having read and approved the final version of the manuscript.

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Volume 13 Issue 7 July 2024