

Successful Outcome of Pregnancy of a Sub-fertile Woman with Multiple Fibroids and Placenta Praevia and Accreta

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Summary:

Fibroids, the commonest benign pelvic tumor, have a common association with subfertility and increasing maternal age. Placenta praevia and fibroid (if submucous) has an association with placenta accreta. Here we report the case of an elderly primigravida with history of prolong subfertility, admitted with 37 weeks pregnancy with multiple

fibroids and central placenta praevia with focal increta. Even with all these complicating factors, with the advent of better uterotonic drugs, conservative management could be considered successfully now-a-days.

Key words: *Caesarean myomectomy, Fibroid, Placenta praevia/accreta, Postpartum haemorrhage.*

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Introduction:

Fibroids are the commonest of all pelvic tumours, being present in 20 percent of women in reproductive age group. They are frequently multiple and more common in nulliparous and relatively infertile women^{1,2}. Most fibroids are asymptomatic during pregnancy and are diagnosed on routine ultrasound examination². Approximately 10% of pregnant patients with fibroids have complications related to or caused by the fibroids. These can be: first trimester loss, compression effect from myomas on the mother as well as on the fetus, pain (red degeneration), premature labour, premature rupture of the membranes, malpresentation, placenta praevia, retained placenta, postpartum hemorrhage and puerperal sepsis^{3,4}.

On the other hand, placenta accreta is a condition in which all or part of the placenta is abnormally adherent to the uterine wall^{5,6,7}. Incidence varies from 1 in 2000 to 1 in 7000 deliveries⁸. Because of partial or total absence of the decidua basalis and imperfect development of fibrinoid layer, placental villi are

attached to the myometrium in placenta accreta (75-80% of cases). With placenta increta, villi invade into the myometrium (15-17% of cases). With placenta percreta, villi penetrate the full thickness of the myometrium (5-7% of cases)^{5,6,7,8,9}. This variant can lead to the placenta attaching to other organs such as the urinary bladder and rectum⁹. Here we report a case of term pregnancy with multiple fibroid with central placenta praevia, in which case focal placenta increta diagnosed peroperatively. During management of such a case, all preparation including sufficient blood should be in hand. Proper counseling should include consent for hysterectomy. Obstetric and anaesthetic expertise is the most important part for management.

Case Report:

A 37 years old, primigravid lady, hailing from Chowdhury Bary, Narayanganj, housewife of a lower socio-economic class, got herself admitted in 200 Bedded Hospital, Narayanganj on 21st April, 2012 with 37 weeks pregnancy with multiple fibroids and central placenta praevia. The patient is the 2nd wife in her 2nd married life and her present husband has 2 children from his previous wife. She had history of prolong subfertility of about 20 years (including both 1st and 2nd marriage).

For the first time, she came to the Gynae OPD, 200 Bedded Hospital, Narayanganj five months back on 28 November, 2011 with lower abdominal pain for three days which was severe for one day and slight per vaginal bleeding for two days. An urgent USG was done which shows about 16 weeks pregnancy with central placenta praevia with multiple fibroids within the body of uterus (largest one measuring 8.5cm X 7.4cm). Her pregnancy was first diagnosed at that time by USG and her EDD

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was on 9th May 2012. She gave history of repeated per vaginal bleeding in early pregnancy which she confused with irregular menstruation. She was admitted on that day, treated conservatively and discharged with treatment after 7 days. Thereafter, her pregnancy period was uneventful and she was on regular antenatal check-up in Gynae OPD of 200 Bedded Hospital, Narayanganj. At 37 weeks, she developed mild lower abdominal pain and slight per vaginal bleeding for several hours. Once again she got herself admitted urgently. After proper counseling and keeping two units of fresh blood and two donors ready, caesarean section was done on the same day. A healthy male baby weighing 3 kg was delivered. Placenta was found in the lower segment, completely covering the internal os from the posterior uterine surface. It could not be separated by controlled cord traction. It was unusually adherent in the upper part, from where complete manual removal was possible but focal adherence of the placenta into the myometrium was found in the posterior part of the lower segment, from where it was removed incompletely by piece meal. A small submucous fibroid measuring about 1.5cm X 1.5cm was found there which was removed by finger dissection. Mattress suture was given in that part and uterine incision was closed. Four other myomas

(intramural) of different sizes were found in the anterior wall and fundus of uterus, largest one measuring about 8cm X 7cm. They were removed by two planned incisions and incisions were closed by haemostatic sutures. Keeping a drain in situ abdomen was closed in layers. Two units of fresh blood were transfused peroperatively. Within two hours, the patient developed PPH and was managed by oxytocin, ergometrin and misoprostol. Intrauterine balloon tamponade was administered at that time and again two units of fresh blood were transfused. Rest of the post partum period was uneventful. Patient was discharged on 10th post partum day. Both the mother and the baby were healthy during discharge.

Discussion:

Uterine fibroids are seen in 1.6-4% of pregnancies. With increasing age of obstetric patients, more cases are being encountered during pregnancy^{2,4}. Ultrasonography is helpful not only in diagnosing the presence of fibroid with pregnancy, but also in finding out size, number and site of fibroids and their relation to the placenta¹⁰. Uterine fibroid during pregnancy is usually managed expectantly and surgically removal is generally delayed until after pregnancy¹⁰. Pedunculated fibroids can easily be removed and hemostasis secured at the time of cesarean delivery without endangering life of the mother. Yet, myomectomy at the time of cesarean section was practically absent from the obstetric literature until the last two decades¹¹.

Myomectomy at the time of cesarean delivery has traditionally been discouraged because of high risk of intra- and post-operative complications, such as uterine atony, uncontrollable hemorrhage and postpartum sepsis^{12,13,14,15,16}. The medical literature has reported an increase in myomectomy during cesarean section in the past two decades¹⁷. This procedure is not always hazardous and it can be performed without significant complications by experienced obstetricians¹². Rather, at delivery and puerperium a high incidence of hysterectomy for postpartum hemorrhage and postpartum sepsis was observed in some literature in which myoma was not removed¹³. There are some reports of huge, symptomatic leiomyomas successfully managed by myomectomy in second trimester^{17,18}. This seemed to lead to an improvement in pregnancy outcome in carefully selected patients¹⁸. However, myomectomy performed during pregnancy remains a rarity¹⁷. In our

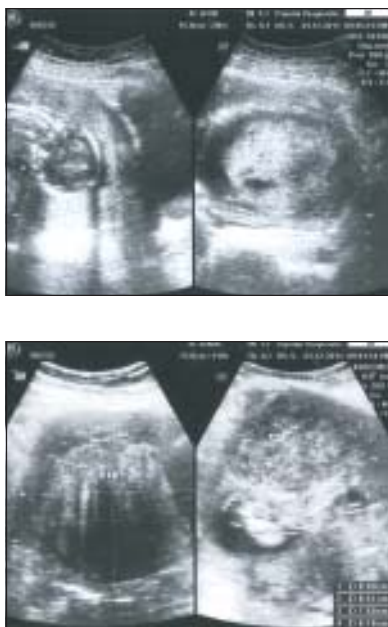


Fig. 1 & 2: Ultrasonography showing multiple fibroid with 16 weeks of pregnancy in this patient.

case, although myomas were symptomatic at 16 weeks of pregnancy, the patient got relieved with conservative management.

Placenta accreta occurs when there is a defect in the decidua basalis, allowing the anchoring villi to adhere to the myometrium. The frequency of abnormal placentation has increased 10-fold over the last 20 years and is now observed in 9.3% of women with placenta praevia or in 1 per 533 deliveries¹⁹. It is a life-threatening problem that is rising in incidence throughout the world. The increased risk of this problem in women with placenta praevia and one or more prior cesarean deliveries is well established. Other risk factors include previous uterine curettage, submucous uterine myomas, previous myomectomy, Asherman syndrome, maternal age older than 35 years, smoking and elevated α -fetoprotein levels^{5,9,19}. Problems associated with delivery of placenta vary appreciably, depending on the site of implantation, depth of myometrial penetration and number of lobules involved⁵. Focal or partial involvement may be manifested as difficulty in establishing a cleavage plane during manual removal of placenta. Removal of a totally adherent placenta is difficult. Persistent efforts to remove a totally adherent placenta manually results in an even more blood loss and nearly always ends with caesarean hysterectomy^{5,8}. There are a few case reports of patients with placenta accreta where caesarean hysterectomy was done due to intraoperative bleeding. In a recent study of 315 patients who required hysterectomy for antepartum or intrapartum bleeding, 38% had placenta praevia, and 68% of them also had placenta accreta, increta, or percreta¹⁹. Fortunately, our case has focal placenta increta where there was an option for conservative management. Placenta was removed manually incompletely by piecemeal from the adherent part. We found a submucous fibroid which was removed by finger dissection. To achieve haemostasis, mattress suture was given in that part. With the use of high dose of oxytocin and misoprostol peroperatively, myomectomy was not very hazardous in this case.

Conclusion:

With the increasing incidence of both placenta accreta with praevia and fibroid in pregnancy, obstetrician should carefully select the cases where conservative management could be tried. Per-operative haemorrhage

is the prime indicator for abandoning the desire for conservation of uterus. Post-partum haemorrhage and puerperal sepsis again may end in hysterectomy in such a patient. In spite of that, myomectomy during cesarean section can be a safe and effective procedure in carefully selected patients in experienced hands. Successful management is a team work which requires co-operation among obstetricians, anaesthetists, physicians and haematologists.

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