WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 8.084
Volume 12, Issue 22, 57-61. Review Article ISSN 2277–7105

PREVIA UTERINE MYOMA DURING PREGNANCY: ABOUT A CASE AND LITERATURE REVIEW IN THE OBSTETRIC GYNECOLGY DEPARTMENT OF THE MOHAMMED V MILITARY TRAINING HOSPITAL IN RABAT

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Article Received on
27 October 2023,

Revised on 16 Nov. 2023,
Accepted on 06 Dec. 2023

DOI: 10.20959/wjpr202322-29458

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ABSTRACT

Uterine myomas are the most common benign tumors in women of childbearing age. The interference of fibroids in all stages of conception, the course of pregnancy and childbirth depends on their size, number and location. Before any treatment of myomas, patients must be informed about the risk of complications on fertility and subsequent pregnancies. We report the case of a patient followed in our training whose ultrasound objectified a myoma previa. Based on our case with review of the literature, we highlight the impact of myomas on pregnancy and childbirth, as well as their management.

KEYWORDS: Fibroid, myoma, isthmic, previa, pregnancy, myomectomy, hemostasis hysterectomy.

I- INTRODUCTION

The prevalence of fibroids varies according to the ethnic group and the age of the patients. The frequency of the association between myoma and pregnancy is between 3 and 13%.[1] All stages of pregnancy as well as childbirth and postpartum can be complicated by the presence of fibroids. Knowing about these complications during pregnancy is essential to prevent them and for better management.

II- Clinical Case: This is a 26-year-old patient, primigravida, with no notable pathological history, O rhesus positive blood group, followed in our training from 12 SA in whom the ultrasound of the 1st Trimester objectified an anterior isthmic myoma type 5 measuring 10*8

cm, having benefited from 04 CPN and 03 ultrasounds with a complete prenatal check-up which objectified gestational diabetes on hgpo75 put under balanced lifestyle and dietary measures without fetal repercussions summoned at 38 SA and 3 days to take care of her delivery.

The clinical examination finds a stable parturient on the hemodynamic level, afebrile, and on the obstetrical examination, a uterus spread out longitudinally, a uterine height of 36 cm, the fetal heart sounds perceived above the umbilical, vulvo-perineal inspection without particularities, at the cervix speculum difficult to visualize, on vaginal touch, the cervix is long and posteriorly closed, difficult to access.

The obstetric ultrasound objectified an evolving mono-fetal pregnancy, in breech presentation, estimated fetal weight at 3400g, placenta of homogeneous fundal location, amniotic fluid in normal quantity, moreover it showed an image of a myoma previa of 11 X 9 cm just behind the bladder (figure 1). The delivery was made by Caesarean section, with skin incision of the pfannestiel type, and corporeal hysterotomy above the myoma previa which occupies the entire lower segment and is 10 cm in diameter, the podalic extraction of a male baby, Apgar 10/10, birth weight 3480g. The postoperative follow-up was unremarkable, in particular no postpartum hemorrhage and the patient maintained good hemodynamic status in the early postpartum period.

In addition, no therapeutic gesture on the myoma was made during the caesarean section.
An ultrasound is planned in 3 months after delivery to check the isthmic myoma and possible scheduling of myomectomy.

III- DISCUSSION

The impact of myomas on fertility is confirmed by the Pritts meta-analysis which includes 23 series and which finds a significant decrease in the pregnancy rate, the implantation rate and a higher rate of spontaneous miscarriage in the presence of myomas (all locations and sizes combined).[2] As part of proving the impact of myomectomy on fertility, a prospective work by Shokeir et al.[3] reports the results of the comparison of the miscarriage rate before and after hysteroscopic myomectomy in 29 patients with a desire to conceive, the authors report a reduction of 61.6 to 26.3% in the miscarriage rate. Campo[4] confirms these results by reporting a significant reduction in the miscarriage rate after myomectomy (57.1 versus 13.8%) for patients with subserous and intramural myomas. Pain is described in about 15% of

patients with myomas during pregnancy[1, 5] which is mainly due to the increase in the size of the myoma which can be complicated by aseptic necrobiosis our patient was asymptomatic during her pregnancy. Pain management is based on symptomatic treatment combining analgesics and rest.[2,3] Uterine myomas during pregnancy can 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.[6,7,8,9] In the literature, the birth weights of children born to women with myomas are similar to those of patients without myomas.[1,7,8,9,10] As for the risk of premature delivery; Rice et al.[8] observe an increased risk in women with fibroids during pregnancy, whose diameter is greater than 3 cm. The presence of myomas at the time of delivery is statistically linked to a higher rate of caesarean section (48.8 versus 13.3%) mainly due to dystocic presentations.[1] The most common complication during childbirth in patients with myomas is postpartum hemorrhage due to uterine atony (2.5 versus 1.4%).[1] The main indications for myomectomies during pregnancy are severe pelvic pain due either to torsion of a pedunculated subserous myoma or to necrobiosis. During caesarean section, only myomas previa or on the uterine scar should be treated.[11] Studies have shown that performing a myomectomy after cesarean section is no more morbid in terms of blood loss than cesarean section without myomectomy.[8,10,11] Our patient did not benefit from myomectomy during the caesarean section.

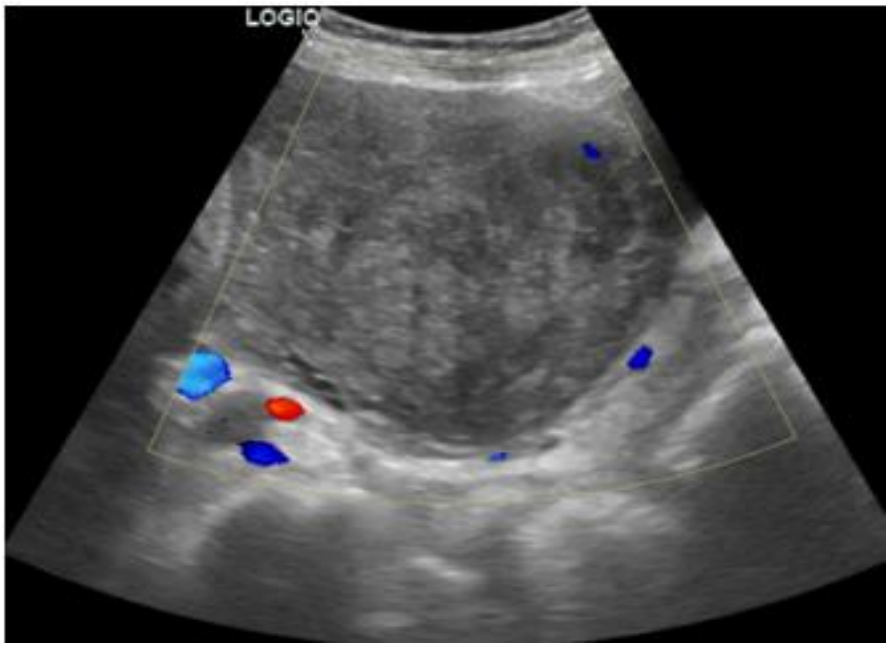

Figure 1: Anterior myoma of the lower segment of the uterus making (11 X 9 cm).

IV- CONCLUSION

Pregnancy on a myomatous uterus is a high-risk pregnancy justifying close monitoring to detect the complications that may result (aseptic necrobiosis, intrauterine growth retardation, placentation disorder, dystocic presentation, postpartum hemorrhage, etc.). Surgical treatment of myoma during pregnancy or during caesarean section should be discussed on a case-by-case basis depending on the indication. The patient should always be informed of the risk of hysterectomy.

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