

Deliveries of Four Healthy Neonates after Multiple Myomectomy

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Article information	Abstract
Article history: Received: 20 July 2012 Accepted: 12 Oct 2012 Available online: 12 Mar 2013 ZJRMS 2013; 15 (9): 93-94	Two main risk factors of uterine rupture during pregnancy or labor are prior uterine myomectomy and cesarean section. The risk of uterine scar rupture increases with increase of the size and numbers of incision. Severe complications may occur following uterine scar rupture. We report a case with prior large and multiple myomectomies, repeat cesarean sections, deliveries of 4 normal large, alive fetuses without any complication or uterine scars rupture.
Keywords: Myomectomy Cesarean section Uterine rupture	Copyright © 2013 Zahedan University of Medical Sciences. All rights reserved.

Introduction

Uterine scars rupture is one of the dangerous obstetric complications and is associated with increased risk of maternal and perinatal mortality and morbidity [1]. Prior cesarean section and myomectomy are the main risk factors and prior cesarean is the most common cause of uterine rupture [2]. Other causes are thermal injury, previous unknown uterine rupture and failure of labor progress. Uterine rupture occurs previous or during labor, at pre term or term delivery, with or without changes in fetal heart rate [3]. Absolutely, presence of multiple uterine scar following myomectomies and prior cesarean sections are associated with the increased risk of uterine rupture but in this report, no uterine rupture occurred in a case with prior multiple myomectomies and 3 times cesarean sections.

Case Presentation

A 41-year-old woman with multiple myomectomies about 11 years ago was admitted for third times of cesarean section. The patient was referred with chief complaint of progressive abdominal enlargement, abdominal pain, irregular menstruation and menorrhagia, a huge ovarian mass was diagnosed by ultrasonography. The patient was underwent a midline laparotomy. During surgery there was a large intramural myomas 150×120×150 mm in diameters in fundus of uterus and 2 others intramural myomas one 62×60×50 mm in diameters in posterior and the other 50×48×40 mm in diameters in anterior wall of the uterus. So, the three mentioned myomas were excised.

The patient was married when she was 36, she was underwent cesarean section for the first time at 37 years old and a term, normal, male fetus 3800 g in weight was delivered. Her second cesarean section was performed in 39 years old (39 weeks of gestation) and a term, normal fetus 4100 g in weight was delivered. Her third pregnancy occurs in 41 years old and two normal, male fetuses with breech-transverse presentations (37 weeks of gestations) 2880 and 2705 g in weights were delivered. During third

cesarean section there was adhesion of omentum to the anterior and adhesion of colon to the posterior wall of the uterus and adhesionolysis was performed. The uterus was containing myomas and there were several myomas in incision line that was excised (Fig. 1, 2).

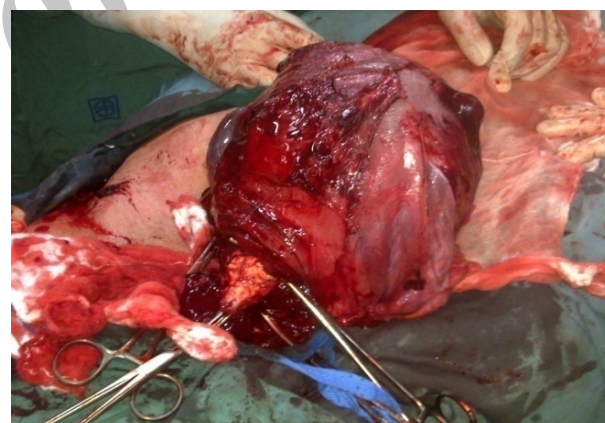


Figure 1. The uterus during third cesarean with adhesion of omentum in anterior wall of uterus and presence of myomas in incision line



Figure 2. Adhesion of the colon to the posterior wall of the uterus during third cesarean section

However, multiple myomectomies, macrosomia of fetus, twin pregnancies and repeat cesarean sections are the risk factors of uterine scar rupture but no rupture or dehiscence of uterine scars was occurred in our case.

Discussion

The most common causes of uterine rupture are cesarean section and myomectomies and in Cultura et al. study among 37 cases of uterine rupture after 59660 deliveries 33 cases of had prior cesarean section or myomectomy [2].

Prior myomectomy is one of the main risk factor of uterine rupture and in William et al study uterine rupture was happened during labor in a woman (34 weeks of gestations) that was underwent prior laparoscopic monopolar cauterization of pedunculated leiomyomas but fortunately the mother and the fetus were saved by emergency cesarean section [4]. However, our patient was undergone multiple and larger myomectomies, 3 times cesarean section and delivery of macrosomia fetuses, uterine rupture did not happened.

In Park et al. study a 35-year-old woman with prior myomectomy who gets pregnant after IVF, transvaginal ultrasonography showed that gestational sac was present in subserosal area of posterior wall of uterus and histopathology confirmed it, it means that there was no complete repair in myomectomy area and there was some defect in that area [5]. Despite in our case with several pregnancies and three times cesarean sections, all of the pregnancies were terminated at term and were normal.

Uterine rupture may occur in no scar uterus, spontaneous uterine rupture occurred in a woman with

twin pregnancy in 29 weeks of gestation who gets pregnant after IVF procedure [6]. So, uterine rupture may occur even there is no risk factor.

Laparoscopic myomectomy is associated with more probability of uterine rupture in compare to others techniques [7]. In our case the technique of surgery was laparotomy and the repair was performed in 2 layers. So, the laparotomy approach may be a preventive technique for uterine rupture.

laparoscopic myomectomies was performed on 69 cases of Kucera et al. study and there were no complications, it approved that if the surgery were done by experienced surgeon the complications rates could be very low but the rates of cesarean sections are high [8].

Therefore, the risk of uterine rupture in our case was so high but the patient had no complications and this case has a message to my colleague that even there are several risk factors uterine rupture may not occurs.

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Conflict of Interest

The authors declare no conflict of interest.

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