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Atony and Postpartum Hemorrhage because of a Large sub mucous myoma

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KEYWORDS

Atony, Myoma,
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A B S T R A C T

Patient was a 35 Years old woman G6P5-5 Vaginal delivery-admitted to the hospital with labor pain. Dilatation was 5-6 cm. Labor progressed appropriately and the live baby was born with a good apgar score. Placenta separated completely. But the uterus was atonic and there was a heavy bleeding. We started uterine massage – oxytocin infusion and Methergine injection. They were ineffective so we examined uterine cavity-cervix and vaginal walls to find the probable laceration. There was a large mass of 10-10 cm in the uterine cavity and it was like a myoma extending from the fundus to the cervix. We planned for a myomectomy. Patient went to the operating room. We made a midline laparotomy. Then with a classic incision we entered uterine cavity. There was a large pedunculated myoma originated from the fundus in the right. We made myomectomy and the bleeding of the pedicle controlled with sutures. The uterus contracted completely and the bleeding stopped. Patient transfused two units of packed cells.

Introduction

Uterine Myomas are the most common benign uterine tumors stemming from uterine smooth muscle (1). Prevalence of these kinds of tumors is almost 70% in white women (1). There are only 4% of visible myomas in pregnant women in the uterine Ultrasound (1).

Leiomyomas are the most common benign uterine tumors. Although 20-40% of all women in reproductive age may have uterine leiomyomas, they are not very common in pregnancy.

Only 0.3-2.6% of all pregnant women are diagnosed with leiomyomas. The leiomyomas are symptomatic in 20-50% of all cases (2). Fibroid in pregnancy is common in clinical obstetric practice (3). During the pregnancy they can grow, stay the same size or as well decrease (2). The incidence of uterine myomas in pregnancy is estimated from 0.1 to 3.9 % (4).

Fibroids enlarge during pregnancy regardless of their initial size or local factors, and maternal age, pre pregnancy

BMI and parity are apparently correlated with these changes(5).

Uterine leiomyomas are the most common gynecological tumor and represent 30% of all benign gynecological tumors. The vast majority of leiomyomas are asymptomatic and do not need to be treated. Pelvic pain and abnormal uterine bleeding should be considered as the most important reasons for surgical treatment of uterine fibroids (6).

Uterine fibroids are associated with an elevated risk of spontaneous pregnancy loss. The loss rate is higher in patients with multiple fibroids than with a single fibroid. The cesarean-section rate is also higher in patients with fibroids than in patients with a normal uterus (7).

Experimental

Patient was a 35Years old woman G6P5-5 Vaginal delivery-admitted to the hospital with labor pain. Dilatation was 5-6 cm.

Ultrasound in 12th week of pregnancy had showed a 45 at 52 mm myoma located in the upper anterior portion of the uterus.

Another ultrasound at 35 weeks showed a 47 at 90 mm myoma inside the right lateral wall of the uterus.

Labor progressed appropriately and the live baby was born with a good apgar score. Placenta separated completely. But the uterus was atonic and there was a heavy bleeding. We started uterine massage – oxytocin infusion and Methergine injection. They were ineffective so we examined uterine cavity-cervix and vaginal walls to find the probable laceration. There was a large mass of 10-10 cm in the uterine cavity and it was like a myoma extending from the fundus to the cervix. We planned for a

myomectomy. Patient went to the operating room. We made a midline laparotomy. Then with a classic incision we entered uterine cavity. There was a large pedunculated myoma originated from the fundus in the right. We made myomectomy and the bleeding of the pedicle controlled with sutures. (Figure I).

The uterus contracted completely and the bleeding stopped. Patient transfused two units of packed cells.

The initial hemoglobin was 12.5 and was 8.7 when discharged from the hospital, so iron supplements were prescribed. The patient had no trouble during the 2 months after delivery.

It is worth mentioning the patient noticed myoma accidentally during pregnancy and uterus sonography and had not problems such as pain and menorrhagia before pregnancy.

Result and Discussion

Cesarean Delivery risk, the mal presentation, premature delivery, Placental abruption, Placenta Previa and severe bleeding arising from postpartum was significantly higher in women suffering from uterine myomas than those with normal uterine (8).

Effects of myoma before, during and after childbirth are controversial.

According to some researchers, myomas rarely affect gestational outcomes and mothers often pass pregnancy and childbirth without important complications (9-14).

To many, the incidence of complications such as spontaneous abortion, non cephalic presentation,

Placental abruption, mal position, PROM, preterm delivery, Placenta Previa and severe bleeding after vaginal delivery and cesarean section increase with the presence of the myoma (15-17).

But in a retrospective study by Qidwai et al the differences of the amount of Placental abruption and the PROM in the two groups of myoma and control were not statistically significant (8); While, study of Baloniak et al showed increased placental abruption in the myoma group (10).

In a study of Qidwai et al the higher ages of mothers was relevant to the myoma (10). Bleeding in the first three months of pregnancy and spontaneous abortion in the myoma group had twofold increase compared to control group (18).

In a study performed by Vergani et al, size of myoma larger than 5 cm and existence of myoma in lower segment resulted in incensement of Cesarean delivery compared to cases in them myoma was smaller than 5 cm and it was located in the Fundus; however, there was no significant differences in terms of Cesarean in two groups with multiple myomas and single myoma (19).

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