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Case Report

A huge polypoid uterine myoma causing severe primary postpartum haemorrhage. A report of one case

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Abstract

Complications from uterine myomas in pregnancy could occur antenally, intrapartum or in the puerperium. One of such was diagnosed in a 36-year old para 2+0 who had successful gestation to term delivery in co-existence with a huge fibroid polyp and had spontaneous vaginal delivery of a life baby. She however developed severe primary postpartum haemorrhage prompting emergency postpartum digital vaginal myomectomy which was very helpful.

Introduction

Myomas are detected in about 2% of pregnancies and one of ten pregnant women with myomas may manifest with complications referable to myomas during pregnancy, delivery and the puerperium. Such complications include necrobiosis with pains, abortions, preterm premature rupture of the membranes, preterm deliveries, abnormal lies and presentations, increased caesarean delivery rates, postpartum haemorrhage and endomyometritis[1].In order to prevent these complications some have performed antenatal myomectomies in selected cases[2]. Huge uterine myomas are not frequent encounters in Post Partum Haemorrhage. For huge myomas, operative removal may be associated with increased morbidity and so is not a choice procedure
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Case Report

A 36 year old para 2+0 presented to the delivery suite with labor pains of 5 hours duration at a gestational age of 38 weeks and 6 days. This pregnancy was booked and was uneventful. Her two previous pregnancies and deliveries were supervised and were all normal. When assessed on admission, contractions were adequate and her cervix was 6 centimeters dilated. She progressed and had a spontaneous vaginal delivery of a live male infant weighing 3800grams with good Apgar scores 4 hours later. The third stage of labor was actively managed and her immediate postpartum blood loss was 300mililiters.
About 30 minutes postpartum, the patient started bleeding profusely per vaginum and collapsed. The uterus was tender and consistent with 24 weeks gestational size. On vaginal assessment there were no tears and blood clots were evacuated from the utero-vaginal cavity measuring about 1,800 milliliters. Post evacuation the uterus felt flabby and atonic.

She had a pulse rate of 110 beats per minute and her blood pressure was 80/50mmHg. Her urine output adequate. The uterus was stimulated to contract with manual massage, administration of 0.5 milligrams of ergometrine followed by infusion of 40 IU of syntocinon per liter of 5% dextrose saline running at 30 drops per minute. The bleeding persisted despite these measures. A pelvic examination revealed normal vulvovaginal skin and an intact cervix 8 centimeters dilated. A prolapsing pedunculated fibroid measuring 10 x 6 centimeters with a narrow pedicle attached to the posterior wall of the lower uterine segment was felt. The uterine wall felt normal.
A clinical diagnosis of huge fibroid polyp with massive primary post partum hemorrhage was made. The fibroid was removed by gentle manipulation and finger fracture of the pedicle

From the myometrium. Further manual exploration of the uterine cavity revealed an essentially normal uterine cavity with improved tone. The bleeding stopped and she was transfused whole blood to correct anemia and shock.

Her packed cell volume appreciated to 32%. She was also managed with antibiotics and analgesics and was discharged home. She was healthy on follow up at six weeks postpartum. The histology of the removed uterine mass was consistent with leiomyomata.

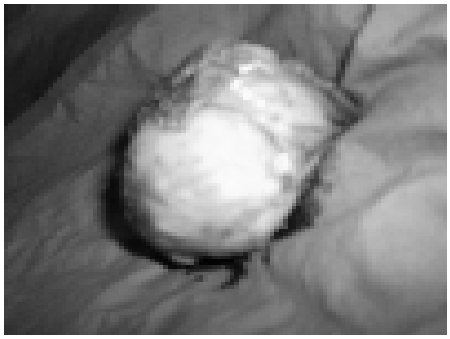

Fig1: Protruding submucous fibroid polyp from the vagina

Discussion

Myomas may be the cause of significant post partum morbidity from many complications and life may be threatened by severe Post Partpartum Haemorrhage. In this patient, it is of interest to note that despite the location and size of the myoma, it did not cause any fetal postural fetal deformity. The myoma may have changed its position or softened its consistency to accommodate the fetus. Several authors have reported this successful co-existence with intramural and pedunculated myomas in literature[3].The uncommon association with a huge myoma is of interest especially where it does not interfere with normal gestation and delivery. Severe post partum hemorrhage encountered in association with myomas has been previously reported[4] it can be made worse by a fibroid of this magnitude.

Prompt surgical intervention is commonly advised in this situation. Trans-vaginal enucleation of the myoma was the approach chosen for this patient. This procedure has been described in the emergency management of myoma induced post partum Haemmorrhage.It is short, simple and also definitive with minimal morbidity[5]. It proved beneficial in this patient. The alternatives to this would be the transabdominal myomectomy or hysterectomy both of which carry higher morbidity to the patient[5].

As the age of marriage and childbearing increases in developing countries, the prevalence of fibroid pregnancies and its complications could rise. Vigilance is necessary to detect and manage myomas (especially the submucous and intramural variants) before or during pregnancy as this has been shown to reduce morbidities[6] .

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