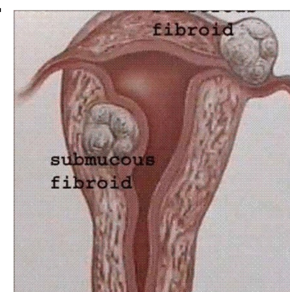
CASE REPORT PROF-874



SUB MUCOUS FIBROIDS
(EFFECTIVE SURGICAL APPROACH)

PROF. MAHNAAZ ROOHI
MBBS, MRCOG, FRCOG (ENG)
Head and Professor
Department of Gynaecology & Obstetrics
Punjab Medical College
Faisalabad

DR. TAZEEN
MBBS, MCPS, FCPS
Assistant Professor
Gynaecology & Obstetrics
Independent Medical College, Faisalabad
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ABSTRACT: editor@fsd.paknet.com.pk One case of removal of 34 submucous fibroids is presented because of its rarity.

Key Words: Submucous fibroids, Myomectomy

INTRODUCTION

Uterine fibroids are the most common tumours seen in women. These benign tumours arise from uterine myometrium or less commonly from the cervix. They are composed not only of smooth muscle but of various amounts of elastin, collagen, & extracellular matrix protein. They are classified as leiomyoma or myoma. Microscopically fibroids are round, or oval, firm in consistency, may be single or multiple of varying size, present at multiple sites, even tiny seedlings are present with bigger fibroids. They have white whorled appearance on cross section. Fibroids are present in three different layers of the uterus with different symptoms and complications. Subserosal fibroids project outward from uterine surface, covered with the peritoneum, may be pedunculated or sessile can under go torsion and sometimes may become parasitic. Intramural fibroids lie within the wall of the uterus, having pseudocapsules. They have small nutrient arteries penetrating the capsule, usually have a single large artery.

Submucous fibroids are less common comprising around 5% of all leiomyomata. These tumours are covered by endometrium and project into the uterine cavity. No uterine enlargement is usually seen unless other fibroids are also present. 50% of the tumours may project into the uterine cavity and if have a long stalk may prolapse through cervix and becomes pedunculated. These fibroids cause severe inter-menstrual bleeding, can become ulcerated or infected[1].

Submucous fibroids have been discovered at the time of an infertility work up or when recurrent spontaneous miscarriage is being evaluated. So these fibroids should be removed before the patient attempts a pregnancy again.

CASE REPORT

A 25 year old, unmarried girl was admitted with the

complaints of bleeding per vaginum for the last 8 months. Her age of menarche was 13 years. Previously her cycle was regular. She used to bleed 5 days every month with mild flow. Then she developed menorrhagia slowly. She started bleeding heavily and continued for 10 days every month. After that her cycle became irregular during these 4 months and for the last 40 days she was bleeding heavily and continuously. She was taking treatment from a local doctor off and on. In the hospital she was admitted twice, was given mefanamic acid, tranexaminic acid and progesterones with no relief of symptoms.

On examination she was extremely pale. Her abdominal examination revealed no abnormality, or mass was palpable. Ultrasound examination revealed uterus to be irregularly enlarged about 10 weeks size of pregnancy by multiple small fibroids. The biggest one measuring 5x5cms and many others ranging from 2cm to 4 cm. Ovaries were normal. No other abnormality was detected. Ultrasound impression was that there are submucus fibroids.

Haemoglobin on admission was 4.5gm per dl. 4 units of blood were transfused preoperatively to correct her anemia and she was operated after the haemoglobin level was 10.3 gm per dl.

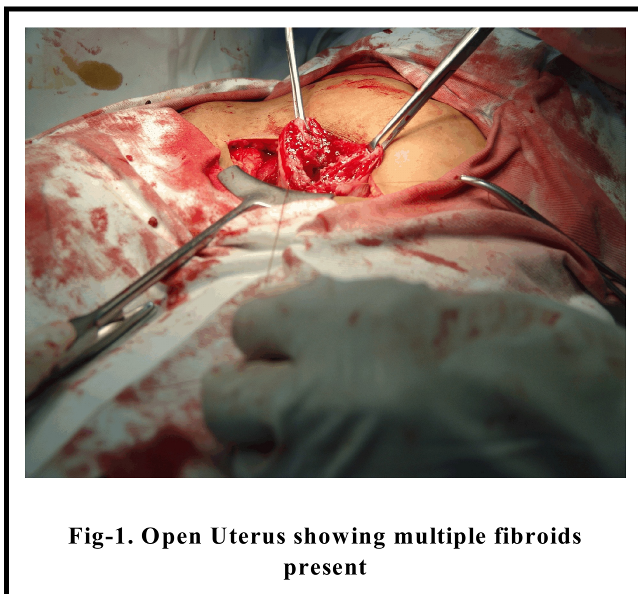

Fig-1. Open Uterus showing multiple fibroids present

OPERATIVE PROCEDURE

Patient was put in supine position, and catheterized. Under general anaesthesia abdomen was opened by Pfannestiel incision. Uterus was 8 weeks size with no fibroids in myometrium or serosa. Cavity was opened by vertical incision. A necrosed, ulcerated and hemorrhagic fibroid was occupying almost the whole uterine cavity with size about 5x5cm. It was removed easily. Multiple fibroids were present in the whole cavity.

They were removed with help of artery forceps gently and very carefully avoiding undue incisions and hemorrhage. The whole uterine cavity was cleared off from small seedlings and a total number of 34 submucous fibroids were removed. No fibroid was found in the cervical canal. Uterus was closed into layers with chromic catgut No.1 and 0.

Abdominal cavity was closed in reverse order securing good hemostasis. One unit of blood was transfused postoperatively. Patient was discharged on 7th postoperative day.

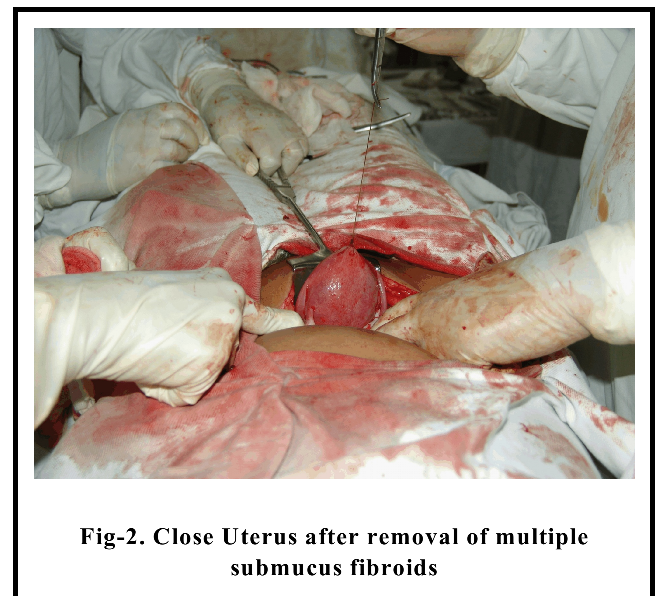

Fig-2. Close Uterus after removal of multiple submucus fibroids

She was advised to have an injection of Zoladex (GnRH analogue) every month subcutaneously for three months.

On follow up visit four months later the patients had no

residual fibroids on ultrasonography.

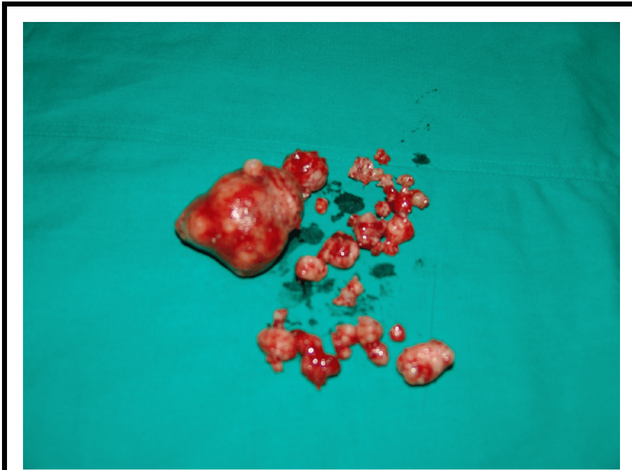

Fig-3. Multiple submucus fibroids after excision.

DISCUSSION

30 years ago, the indications for surgery on fibroids were far more liberal then they are today. The accepted treatment then was also far more extreme i.e. HYSTERECTOMY which was done almost automatically in the face of fibroids, once child bearing was no longer an issue. Over the years studies have shown that fibroids are in many cases a much less threatening condition then once believed.

A variety of medical and surgical techniques have been proposed in the management of fibroids with identifiable benefits and risks including GnRH analouges, minimal invasive surgery and uterine artery embolization (UAE) but conventional myomectomy is still very popular and needs expertise. GnRH analouges are expensive and cause artificial menopause. The most commonly used drug to treat fibroids is luprolin[2]. The effect of this injection is to supress the ovaries, drop the patient's estrogen putting her into a temporary menopause, which then shrinks the fibroids as much as 50%. It is not useful as a permanent solution. The reason is that it has two problems.

1- The shrinkage is not permanent. Once the monthly injections are stopped, in 85% or more of cases, the fibroids return to pretreatment sizes in 06 months.

2- The medication is not advised for use over 06 months as a menopausal induced bone loss occurs.

UAE needs interventional radiologist and a specialized centre. Minimal invasive surgery like laparoscopy / hysteroscopy is not available in every centre. Although submucous fibroids are regarded as suitable for hysteroscopic resection but so many fibroids could not be removed possibly by hysterosope[3]. Medical treatment had already failed. So myomectomy remained best possible surgical approach in this patient.

Myomectomy simply means removal of a fibroid with a uterus remaining in place. Because over 60 to 80% of fibroids are multiple, "Multiple Myomectomies" is what usually takes place.

Removal of individual fibroids was first reported in middle of 19th century, and current surgical techniques are attributed to Victor Bonny to described a personal series of 304 cases. A classic case reported by (Dr. V Bonney in 1931) of removal of over 225 fibroids[4].

ALL THE DIFFERENT TECHNIQUES COME DOWN TO FOUR METHODS:

1- Excise the fibroid by making the incision.
2- Pare a submucous fibroid down and remove it a piece at a time.
3- Vaporize the fibroid and suction it away.
4- Interrupt its blood supply so that it breaks down and is suctioned away by the body itself.

MYOMECTOMY

For submucous fibroids if done abdominally always requires entry into the endometrial cavity and hence later C-section in pregnancy. Myomectomy is very useful as an alternative to hysterectomy and conserving the uterus. The operation is simple and safe for the residents to learn. Enucleation of fibroids from their capsule can be a rapid and simple procedure but its major hazards are

hemorrhage and post operative adhesions. Heavy blood loss can be severe and can cause greater post operative morbidity and mortality than the hysterectomy. It is therefore an operation, which should be restricted to a woman who has completed her family. Hemorrhage associated with myomectomy can be reduced by various techniques like use of Bonneys myomectomy clamp & pretreatment with GnRH agonist to reduce the vascularity and size of the fibroids. The second major hazard is post operative adhesions formation reducing the chance of successful conception & rendering the future surgery more difficult. Therefore the decision to perform a myomectomy should be carefully considered. To minimize adhesion formation as many fibroids as possible should be removed through a single incision. Minimal tissue handling and meticulous haemostasis should be tried. So in expert hands both these complications can be reduced.

With a newer understanding of modern surgical techniques, gynaecologist can-in good conscience that they are still doing the best for their patients - offer options more tailored to their patients needs. In an unmarried, nulliparous woman, myomectomy followed by GnRH analogs for 03 months seems the best surgical approach for multiple submucous fibroids.

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You have to be hungry to appreciate hunger

Shuja Thair