Indian Journal of Obstetrics and Gynecology Research 2019;6(4):545–547

Content available at: iponlinejournal.com

Indian Journal of Obstetrics and Gynecology Research

Journal homepage: www.innovativepublication.com

Case Report

Cervical fibroid in pregnancy - Case report and review of literature

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ARTICLE INFO

Article history:
Received 02-08-2019
Accepted 24-09-2019
Available online 06-12-2019

Keywords:
Cervical fibroid
Conservative management
Caesarean section

ABSTRACT

Introduction: Fibroids are common during pregnancy with incidence ranges from 0.1 to 10.7% of all pregnancies. However, cervical fibroid is rare among pregnant woman. Despite, most of fibroids show no change in size during pregnancy, few may increase in volume due to elevated vascular supply to uterus and increased level of steroid hormone. Depending on the size and type of fibroid antenatal and postnatal hazards can occur.

Case History: We report a case of term pregnancy with cervical fibroid of 225 centimetre square size. In this case caesarean section was performed and for fibroid conservative management was done to prevent surgical complication and to retain future child bearing.

Conclusion: Pregnancy with cervical fibroid is very rare. Approximately 10% to 30% of women wit h fibroid develop complication. This case demonstrated that in large cervical fibroid with pregnancy conservative management over surgery can be the right choice.

Key message: Term pregnancy with big cervical fibroid should be managed by conservative approach because myomectomy at the time of caesarean section can lead to inevitable complications.

1. Introduction

Most common tumors of the uterus are fibroids but cervical fibroid is rare during pregnancy with different management difficulties. Majority of fibroids (60-78%) showed no considerable change in size during pregnancy, some may increase in size due to increased vascularity and elevated level of steroid hormone. During pregnancy about one-third of fibroids increase in size[1] and are associated with numerous complications which include early pregnancy bleeding, miscarriages, degeneration in fibroid, preterm labour, abruption placentae, foetal growth restriction, and foetal anomalies can occur. There can be malpresentations, dysfunctional labour, caesarean section, postpartum haemorrhage, retained placenta or post myomectomy uterine rupture during labour and delivery.[2]

Although the data are conflicting, as such there are no clear guidelines on the management of pregnancy with cervical fibroid. An attempted myomectomy either abdominally or vaginally can be complicated by need for a hysterectomy in case of torrential bleeding so some prefer conservative management.[3] However, myomectomy can be safe in carefully selected patients.[4] We report a case of large cervical fibroid in pregnancy for which caesarean section was performed and conservative management was done for fibroid.

2. Case Report

We presented here a case of large cervical fibroid in term pregnancy who had previous one full term normal vaginal delivery three year s back. A 28-year-old female non-booked patient which was referred for 37 weeks pregnancy with non - progression of labour to the department of obstetrics and gynaecology of a Medical College and

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https://doi.org/10.18231/j.ijogr.2019.117

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On examination, her vital signs were stable, mild pallor present. On per abdominal examination uterus size was consistent with term pregnancy. A moderate degree of contraction was present ed and foetal heart sound was audible. On per vaginal examination, there was a leaking present. Her cervix was 3-4 cm dilated. Foetal head was not engaged and a mass of 15×15 cm size felt in anterior lip of cervix suggesting cervical fibroid.

Her all blood investigations were done all were with in the normal range. Her ultrasonography was done and it was showing 37 weeks of live foetus with approximately 15×15 cm size cervical fibroid. The preliminary diagnosis non-progression of labour with giant cervical fibroid was made and the patient was taken for emergency caesarean section. Prior to caesarean section counselling of patient and her family was done regarding the condition and management options. Considering the age of patient and future fertility required decided conservative management, as torrential bleeding may occur during myomectomy. She gave informed consent for the procedure.

On caesarean section a healthy baby girl of three thousand grams was delivered and there was a large cervical fibroid of about 15×15 cm size (Figure 1). Proper haemostasis was ensured and uterotonics were used to prevent PPH. The patient was under regular follow up for 3 months when she was counselled for use of GnRH agonist after breastfeeding. Rest intraoperative and postoperative period was uneventful. Patient and baby were healthy at the time of discharge.

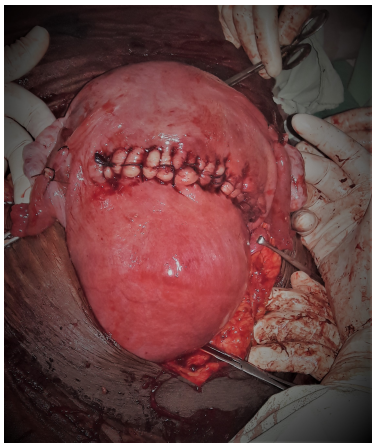

Fig. 1:

3. Discussion

The most common pelvic tumor in women were leiomyomas with one percent incidence in pregnancy. During pregnancy about 20% of fibroids decrease in size and similar percentage increases according to a sonographic study. Before 10thweek of gestation, the greatest increase in the size of fibroid occur.[5]

The supra- vaginal or vaginal portion of the cervix is affected by a cervical fibroid. The lower segment is high up because the size of fibroid might increase significantly during pregnancy so midline abdominal incision should be used in such type of cases.[6]

The most common complication of fibroids during pregnancy is a pain. In rare instances, it may require definitive surgical resection but in most cases, the symptom can usually be controlled by conservative management (bed rest, hydration, analgesics).[2]

A cervical fibroid may cause malpresentation of foetus, obstructed labour, infection, pain, urinary or bowel symptoms and bleed. One of the major problem s with fibroid in pregnancy is obstructed labour.[7]

The most accurate imaging technique for the detection and localization of leiomyoma is MRI. Conservative management during caesarean section should be used because myomectomy at the time of caesarean section is known to be hazardous due to uncontrollable haemorrhage.[8]

However, depending on patient's symptoms, fertility desire, site of mass and associated uterine fibroids uterine artery embolization and myomectomy can be performed.

This case report revealed the fact that in pregnancy complicated with large cervical fibroid conservative approach should be used. If we opt for a conservative approach rather than myomectomy during caesarean section there is a decreased need for blood transfusion, decreased operative time and less chances of complications like an embolism. The patient also has early post-operative recovery and thus less hospitalization time and cost.

4. Conclusion

Cervical fibroid in pregnancy is rare, so it is necessary to raise the patient's awareness towards the possible outcomes by obstetricians.

Obstetricians need to be more vigilant about the consequences and the challenges faced with cervical fibroid in pregnancy.

Preference should be given to conservative management over surgical approach. Furthermore this type of cases should be managed at tertiary care hospital were blood transfusion, emergency caesarean section and peripartum hysterectomy like services easily accessible.

5. Source of funding

None.

6. Conflict of interest

None.

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Cite this article: Saini SR, Nama A, Khajotia S, Kochar S. Cervical fibroid in pregnancy - Case report and review of literature. *Indian J Obstet Gynecol Res* 2019;6(4):545-547.