

Necrobiosis of a Uterine Fibroid in the Course of a Pregnancy

Eida Moya Hernández¹, René Vázquez Estévez¹, Andrés Pérez Morales², Yanet Flores Mirabal², Hanuary L. Sosa Estebanés³, Leydy Rodríguez del Toro⁴, Arianna Rodríguez Mesa⁴

¹I Degree Specialist in Surgery, Assistant Professor, Provincial General University Hospital “Mártires del 9 de Abril”, Sagua la Grande, Villa Clara, Cuba.

²I Degree Specialist in Surgery, Instructor Professor, Provincial General University Hospital “Mártires del 9 de Abril”, Sagua la Grande, Villa Clara, Cuba.

³I Degree Specialist in Surgery, Provincial General University Hospital “Mártires del 9 de Abril”, Sagua la Grande, Villa Clara, Cuba.

⁴3rd year resident in Surgery, Provincial General University Hospital “Mártires del 9 de Abril”, Sagua la Grande, Villa Clara, Cuba.

***Corresponding Author:** Eida Moya Hernández, I Degree Specialist in Surgery, Assistant Professor, Provincial General University Hospital “Mártires del 9 de Abril”, Sagua la Grande, Villa Clara, Cuba.

Received Date: 13 November, 2021 | Accepted Date: 03 January 2022 | Published Date: 21 January, 2022

Citation: Eida M Hernández, René V Estévez, Andrés P Morales, Yanet F Mirabal, Hanuary L. S Estebanés. (2022). Necrobiosis of a Uterine Fibroid in the Course of a Pregnancy. *Biomedical Research and Clinical Reviews*. 6(2); DOI: [10.31579/2692-9406/096](https://doi.org/10.31579/2692-9406/096)

Copyright: © 2022 Eida Moya Hernández, This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Uterine myoma is a very common benign neoplasm. A 32-year-old patient with 8 weeks of gestation was presented, who came to the emergency room presenting abdominal pain of two days of evolution, vomiting and low-grade fever in the course of an already known and desired pregnancy, with a diagnosis of necrobiosis of a uterine fibroid. The fibroid was resected and the gravid uterus is preserved. The patient is progressing satisfactorily, she being discharged seven days later, she is followed by outpatient consultation and 20 weeks later she maintains a normal pregnancy. Key words: necrobiosis, uterine fibroma, pregnancy.

Keywords: uterine myoma; leiomyoma; liomyoma; fibromyoma

Introduction

Uterine myoma is a benign neoplasm of the uterus that is popularly known by the name of fibroma and from the anatomopathological point of view as leiomyoma, liomyoma and fibromyoma, according to the predominance of smooth muscle fibers or the amount of fibrous tissues [1].

Its frequency makes it one of the most common diagnoses in patients undergoing surgery in gynecology and general surgery services. Predominantly in women aged 30-50 years, although nowadays they are diagnosed earlier, before they produce the symptoms, due to the widespread use of ultrasound [2].

On the other hand, it can be single or multiple and be located anywhere in the uterus; A higher frequency is also reported in black, mestizo and multiparous women. Some authors [3] consider that the cause is unknown, others value the sustained or increased estrogenic stimulus, which activates the genitoblasts (immature muscular elements), mesodermal and embryonic cells that respond to this stimulus.

Many women with uterine fibroids have no symptoms and never require treatment; however, one in four women of reproductive age suffers from

significant symptoms, which can vary depending on the location, size, and number of fibroids.

Presentation of the case

LMN patient, female, black race, housewife, 32 years old with 8 weeks of gestation, who went to the emergency room of the General Hospital “Dr. Loery Comba” in Malabo, in the Republic of Equatorial Guinea, with abdominal pain of two days of evolution, vomiting and low-grade fever. She has a history of three previous full-term pregnancies and eutocic deliveries, no Family History of Chronic Hereditary Diseases is collected. Current desired pregnancy.

Physical exploration

The physical examination revealed a general condition, temperature of 37.6 ° C, blood pressure of 100/60 mmHg, heart rate of 100x min. Flat abdomen that follows respiratory movements, normal abdominal air-fluid sounds, on soft and depressible palpation, diffusely painful with peritoneal reaction towards the hypogastrium, especially the right iliac fossa, no tumor is palpated, normal percussion, negative digital rectal examination. Vaginal examination with an enlarged uterus that impresses more than 10cm, the glove comes out stained with blood.

Diagnostic evaluation

After the meticulous physical examination, laboratory tests were performed: HIV negative, Hepatitis B negative, Hepatitis C negative, Hct in 0.32, urine not useful, Eneb test positive, abdominal ultrasound (Fig. 1) that shows complex image in the body of the uterus Hypogenic predominance, with a single and living fetus inside, normal adnexa, a discrete amount of fluid in the Douglas sac. A diagnosis of necrobiosis of a uterine fibroid was raised during a pregnancy, the possibility of Acute Appendicitis was also assessed. Since it was a desired pregnancy, the patient and family members were explained the possibility of losing it and

that action would be taken according to the intraoperative findings. In the operating room, after spinal anesthesia, an infraumbilical median laparotomy is performed and necrobiosis of a pedunculated fibroma of the fundus of the uterus is verified, we proceed to resection between forceps and continuous helical chrome-plated suture 0 in 2 planes, the hemostasis and it was verified that the pregnancy of the uterus did not present other manifestations and the abdomen is closed by planes. The patient recovers satisfactorily and is transferred to the conventional room with treatment: Rocephin (1g) 1bbo intravenous every 12 hours, hydration and Diclofenac Sodium (75mg) 1 amp intramuscular every 12 hours and also includes the proper care of the surgery.



Figure 1: Gynecological ultrasound. Gravid uterus with live fetus

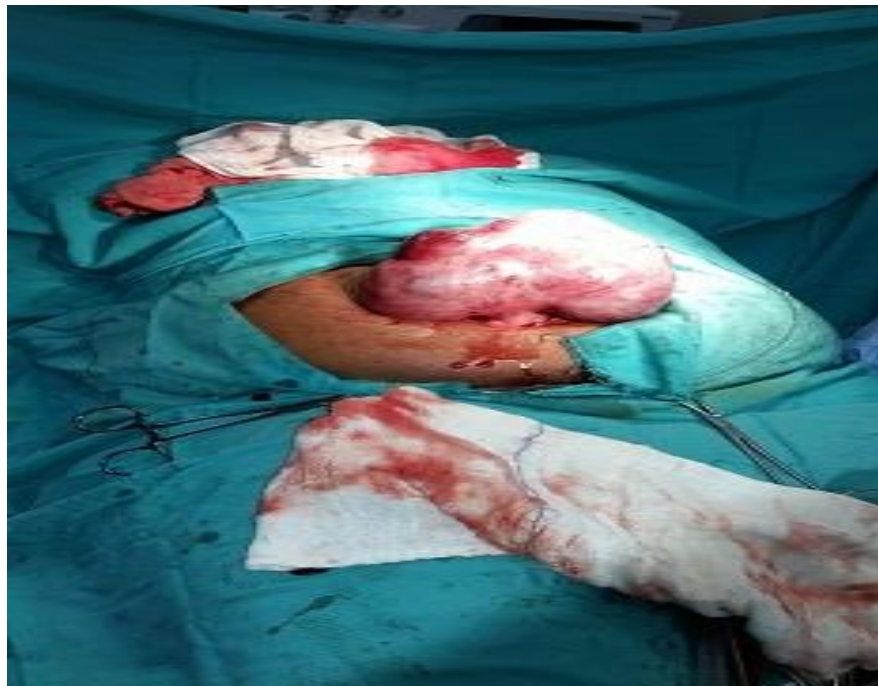


Figure 2: Laparotomic finding. Necrobiosis of uterine myoma

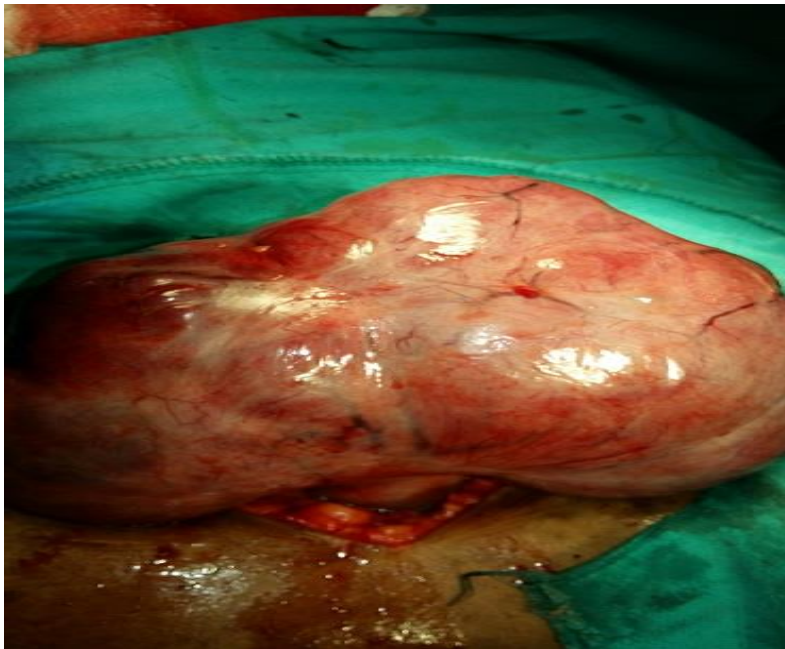


Figure 3: *Necrobiosis of uterine myoma. Anteroposterior view.*

Monitoring and results

At 18 hours after the operation, oral feeding is started and urinary catheter is removed. The patient was hospitalized for 7 days with the administration of the antibiotic and general measures. She discharged without difficulties and was followed up by outpatient consultation every 15 days, and once a month by ultrasonography, maintaining a normal pregnancy until 20 weeks, after which she stopped attending the consultation. About four weeks later, she was located through a native health worker who helped reincorporate her to follow-up. She remained the rest of the normal time, at 38 weeks she was admitted and an elective cesarean section was performed. The product was a 4200 gram newborn male with good vitality. He graduated on the 5th day, both with a satisfactory evolution. She was followed in the health area until 2 months without complications.

Discussion

Uterine fibroids are a fairly common pathology in women. Normally they do not usually cause serious problems during pregnancy, although these pregnancies are normally controlled by the High Risk Obstetric Unit [4].

Cases similar to the one presented are described by other authors such as Moslemi et al [5] who describe a 36-year-old female, primigravida, who consulted at 11 weeks of gestation due to abdominal distension, edema in the lower extremities and scarce vaginal bleeding, and De Dios Perera et al [6] who present the clinical case of a 27-year-old patient with 17.2 weeks of pregnancy, who was under follow-up at the Gynecology consultation at the Mariana Grajales Coello Provincial Gynecological Hospital in Santiago de Cuba for presenting a symptomatic uterine myoma with Acute abdominal pain due to necrobiosis, which required urgent surgical resolution and the pregnant woman evolved satisfactorily.

Care for pregnant women with uterine myoma should preferably be conservative, as shown in the consulted literature; [7] therefore, perigravid myomectomies should be avoided. When there is an uncomplicated fibroid, it is not indicated to remove it by surgery during pregnancy or in the course of a cesarean section. In early pregnancy, leiomyomas smaller than 5 cm in diameter are often undetectable [8].

Myomectomy carries risks of haemorrhage and abortion, which is why it is only reserved for specific cases that do not respond to expectant management, as occurred in the case presented above, criteria coinciding with other authors [5,9].

The medical treatment of fibroids is a recent strategy and is attractive to many gynecologists because of its ease and fewer complications when compared to surgery, especially when the main intention is the preservation of fertility or the desire to preserve the uterus [10].

The current recommendation and experience indicate that it should be performed in the second trimester of pregnancy, although there are cases reported in the first trimester. Even these patients would have a better obstetric outcome than those treated expectantly.

References

1. Phelippeau J, Fernández H. (2016). Fibromas uterinos. *EMC-Ginecología-Obstetricia*. 52(4);1-6.
2. Donnez J, Dolmans MM. (2016). Uterine fibroid management: from the present to the future. *Human Reproduction Update*. 22(6):665-686.
3. Cantella Suito R, Brazzini A A, Brazzini M M, Ramón JC, Hurtado R J, Quispe A E, et al. (2016). Embolización de arterias uterinas para manejo de miomatosis: experiencia con pacientes. *Rev Per Ginecol Obstet*. 62(3):229-234.
4. Luna Ríos J, Ortíz Ortíz N, Cáceres Ferro D, Zambrano C, Mendivelso Duarte F, Barrero L. (2017). Guía de práctica clínica para el diagnóstico y tratamiento de la miomatosis uterina en Clínica Colsanitas. *Rev Méd Sanitas ene*. 20(1).
5. Moslemi Y Ima, Alarcón C Verónica, Soto P Zandra, Mancisidor S Karina, Sanchez A Santos, Peñalosa R Luis. (2016). Miomectomía en gestante de 14 semanas: a propósito de un caso. *Rev. chil. obstet. Ginecol*. 81(2):130-134.
6. De Dios Perera Rolando, Piñeiro González Yilian, Palacios Joglar José Manuel. (2020). Miomectomía en una gestante. *MEDISAN*. 24(5):886-896.
7. Sánchez Redonet EM, Vázquez Cabrera J, Salas Castillo L. (2019). Miomectomía durante el embarazo. *Rev Cubana Obstet Ginecol*. 45(3).

8. Yang LC, Chaudhari A. (2020). The use of hysteroscopy for the diagnosis and treatment of intrauterine pathology. *Obstet Gynecol.* 135(3):138-148.
9. Hernández H, Gervaise A, Garbin O, Levaillant JM. (2016). Histeroscopia quirúrgica. *Ginecol-Obstet.* 52(2).1-20.
10. García-Puente García A. (2016). Eficacia de los nuevos tratamientos para el mioma uterino. [Tesis]. Universidad de Salamanca. España.



This work is licensed under Creative Commons Attribution 4.0 License

To Submit Your Article Click Here:

Submit Manuscript

DOI: [10.31579/2692-9406/096](https://doi.org/10.31579/2692-9406/096)

Ready to submit your research? Choose Auctores and benefit from:

- fast, convenient online submission
- rigorous peer review by experienced research in your field
- rapid publication on acceptance
- authors retain copyrights
- unique DOI for all articles
- immediate, unrestricted online access

At Auctores, research is always in progress.

Learn more <https://www.auctoresonline.org/journals/biomedical-research-and-clinical-reviews->