A case of a cervical fibroid in pregnancy with fertility sparing myomectomy

G. Crawford, L. Megaw.

Department of Gynaecology, King Edward Memorial Hospital, Western Australia

Introduction

Cervical fibroids in pregnancy are uncommon, accounting for <1% of all uterine leiomyomas. The vascular supply of the gravid uterus and elevated levels of steroid hormone can cause growth of fibroids in pregnancy. Obstetric complications include haemorrhage, obstructed labour, infection and necrosis. We describe a case of a large sessile subserosal cervical fibroid diagnosed in pregnancy.

Case Report

A 40 year old primigravida with a multifibroid uterus was referred in early pregnancy with recurrent vaginal bleeding. Vaginal examination revealed a smooth mass within the vagina, obscuring the cervical os. Ultrasound at 19 weeks revealed a cervical fibroid measuring 23x26mm. At 33 weeks gestation the fibroid had grown to 57x53x51mm protruding into the vagina and below the fetal head. The pregnancy was otherwise normal. The fetus was cephalic and demonstrated normal growth. Given the size of the fibroid, its location abutting the internal os, below the level of the fetal head, and its firm texture, it was felt that the likelihood of vaginal delivery was low. The patient was offered Caesarean section which she declined. At 40+5 she presented in spontaneous labour with an intrapartum haemorrhage of 200mL's. Placental abruption could not be ruled out and the patient delivered via uncomplicated emergency caesarean section. At 5 months postpartum the fibroid had grown to >6cm and the patient was experiencing fibroid prolapse during bowel motions and intermenstrual bleeding. A vaginal myomectomy was done to address her symptoms and preserve fertility. Histopathology showed a benign leiomyoma. 6 weeks postoperatively, the cervix had healed with good vaginal length and menstrual cycles had returned to normal. The patient is currently trying to conceive, with the recommendation of a 12-18 month pregnancy interval and cervical length surveillance in pregnancy.

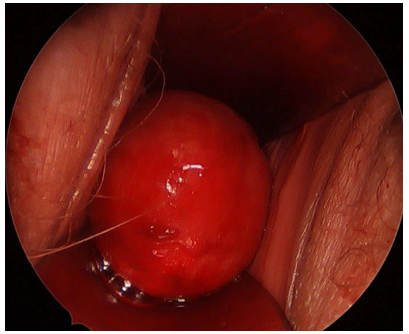

Fig. 1 cervical fibroid within vagina

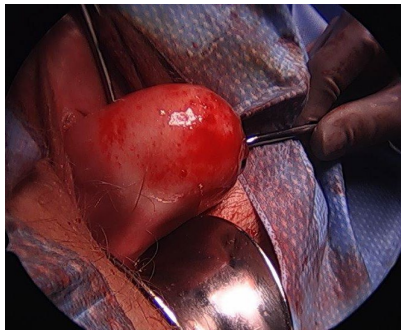

Fig. 2 Cervical fibroid

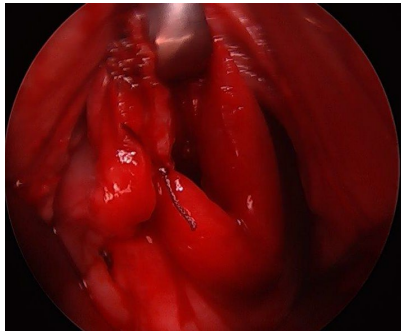

Fig. 3 Cervix at end of myomectomy

Conclusion

This case demonstrates the classic symptoms of a cervical fibroid, intrapartum complications and post partum management. Management should be conservative during pregnancy unless severe pain, bleeding or infection due to the risks of preterm labour, rupture of membranes, and significant haemorrhage. Patients should be offered caesarean section for large fibroids that remain below the fetal head. Surgical resection of these fibroids is technically challenging, owing to difficult access and close proximity to rectum, bladder and ureters, to which these fibroids can often be adherent. post partum surveillance should be undertaken with consideration of myomectomy for those who remain symptomatic and wish to preserve fertility