CASE REPORT DOI: 10.15713/ins.bhj.98

A Unique Way of 2nd Trimester – Medical Termination of Pregnancy in a Case of Pregnancy with Huge Fibroid – A Case Report

ABSTRACT

Second trimester termination of pregnancy by surgical route is highly effective with a low complication rate. Uterine abnormalities can complicate a procedure due to distortion of normal anatomy. In this case presentation, hysteroscopic and sonography guided termination of pregnancy is performed and was effective.

Key words: MTP – Medical termination of pregnancy, USG – Ultrasonography, G sac – Gestational sac

INTRODUCTION

Medical termination of pregnancy (MTPs) are legal in India (MTP act 1972). First trimester MTPs are either done medically or surgically and many of second trimester MTP are done due to fetal anomalies. Cervical dilatation is an important part in surgical MTP, and it becomes challenging in some cases where cervix is not visualized due to distorted anatomy of utero-cervical canal.

Sometimes, there are situations in which uterine anomalies or uterine fibroid can complicate MTP due to distorted normal anatomy.[1]

Fibroids may obstruct the utero-cervical passage and, so delivery necessitates hysterotomy. An obstructing cervical fibroid is an indication for delivery by cesarean section.[2]

However, there is little literature on the management of termination of pregnancies complicated by fibroid.

CASE HISTORY

About 32 years primigravida, married for 3 years presented to us at 14 weeks of gestation with fibroid with multiple fetal anomalies.

Patient was diagnosed with fibroid in pregnancy at 7 weeks of gestation with ultrasonography (USG) suggestive of huge subserosal fibroid arising from anterior wall of the uterus just above the cervix, extending below the umbilicus with total mass measuring 13 × 10 × 15 cm.

Fibroid was situated just above the cervix, and hence, it was obliterating the internal Os due to its mass effect.

Patient was a known case of type 2 Diabetes mellitus and was in follow-up with diabetologist for sugar control and patient was also a known case of polycystic ovarian disease.

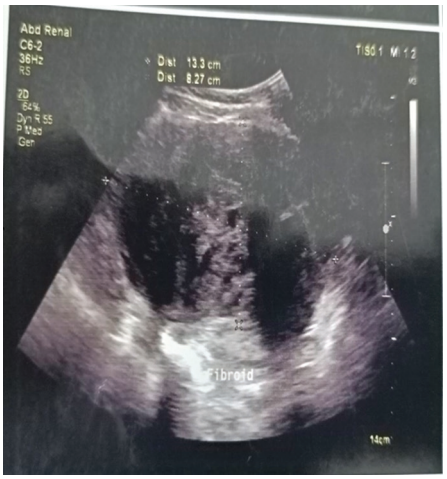
She presented to us at 14 weeks of gestational age after scan, which showed multiple fetal anomalies with amniotic band.

On examination, she had a large fibroid uterus that filled her pelvis (Uterus-22 weeks in size), and her cervix was not visualized or palpated.

Rajkumar Salunke, Shashi Goyal, Prathima Chipalkatti, Prashant Bhamare

Department of Obstetrics and Gynaecology, Bombay Hospital Institute of Medical Sciences, Mumbai, Maharashtra, India

Corresponding Author:
Rajkumar Salunke, Department of Obstetrics and Gynaecology, Bombay Hospital Institute of Medical Sciences, Mumbai, Maharashtra, India
E-mail: salunkerajkumar294@gmail.com



Patient was counselled regarding the need for MTP.

A high risk written informed valid consent was taken with the arrangement of blood and blood products.

Patient was given tablet misoprostol 600 mcg per vaginal to begin with and then repeated every 4 hourly till the total dose of 2000 mcg; but the Os didn't dilate. Hence, decision for suction evacuation under sonographic guidance was taken. Under sonographic guidance Cervical dilatation was completed with great difficulty due to distorted anatomy and the procedure was abandoned due to the risk of creating a false

passage and risk of perforation. At the end of procedure, fetal cardiac activity was absent on USG.

Patient was posted for hysteroscopy and sonography guided MTP on the next day and misoprostol 400 mcg per vaginal was put 4 h before the procedure.

A high risk written informed consent was taken with arrangement of multiple blood products. She was also explained regarding need of myomectomy after MTP and Si Opus Sit (SOS) chances of hysterotomy SOS chances of hysterectomy, chances of intensive care unit admission were explained.

Hysteroscope was put under vision with finger guidance and the sac was visualized, then the products of conception (POC) were grasped and removed with ovum forceps; and then suction evacuation was done under sonographic guidance. A relook hysteroscopy was done to ensure complete removal of POC.

Post-operative stay was uneventful.

On discharge, patient was advised laparoscopic myomectomy after 3 months; after resumption of her menses and was discharged.

DISCUSSION

To the best of our knowledge, this is the rare case report of an obstructive fibroid at the time of performing a uterine evacuation for 2nd trimester MTP. With the growing uterus, through mass effect, the fibroid likely obstructed the cervical canal, creating a challenge in dilating the cervix for the required procedure.

Foley's catheter may be used for cervical ripening when cervical dilators prove ineffectual.[3] Foleys catheter was not tried in this patient because cervix could not be visualized without anesthesia and due to the location of the fibroid internal Os was obliterated.

In other situations, with obstructing fibroids, a hysterotomy is typically done rather than a dilation and evacuation because it allows for definite tissue removal rather than having trouble reaching the tissue and increases the risk of retained products. A hysterotomy, on the other hand, is associated with a greater risk of morbidity than dilation and evacuation, as well as increases the risk in later pregnancy. An obstructing fibroid is a clear reason for a cesarean section in term pregnancies, since it may prevent the baby from descending.[4]

In our case, cervix not responded to misoprostol induction and so the decision was taken for suction evacuation under sonographic and hysteroscopic guidance. Hysteroscope was introduced under vision and an intact G sac was seen and then ovum forceps was introduced and POC grasped and removed and then suction evacuation was done. Chromosomal analysis could not be done due to financial problems.

A well-equipped multispeciality hospital or a tertiary care is required to ensure patient's safety when performing a 2nd trimester MTP with huge fibroid in pregnancy, as hemorrhage risk is significant. The combination of appropriate patient counselling, MTP under hysteroscopic and sonographic guidance was the key in saving this patient from the morbidity of hysterotomy.[5] Further to the patient's benefit, we have advised laparoscopic myomectomy that may prevent other complications in a subsequent pregnancy.

Patients with a significant fibroid uterus requested to terminate pregnancy in the first trimester, according to published case reports. A woman with a 21-cm uterus and eighteen total fibroids was given methotrexate and 800 mcg vaginal misoprostol, according to Crenin's case report.[6] Two days later, this woman returned to the clinic and her termination was successful. Another set of four cases who were given methotrexate and vaginal misoprostol, and all of them had effective terminations with no serious complications.[7]

This unique way of doing hysteroscopic MTP has saved patient from uterine scar and further complications.

CONSENT

Written consent was obtained from the patient.

REFERENCES

1. Gibson E, Schreiber CA. When uterine leiomyomas complicate uterine evacuation. Contraception 2010;82:486-8.
2. James D, Steer PJ, Weiner CP, Gonik B. High Risk Pregnancy: Management Options. 5th ed. New York, USA: Cambridge University Press; 2017.
3. Hackett GA, Reginald P, Paintin D. Comparison of the Foley catheter and dinoprostone pessary for cervical preparation before second trimester abortion. Br J Obstet Gynaecol 1989;96:1432-4.
4. Abam D, Kasso T. Uterine Fibroids and Pregnancy: A Review of the Challenges. London: IntechOpen; 2007.
5. Basu JK, Basu D. The management of failed second-trimester termination of pregnancy. Contraception 2009;80:170-3.
6. Creinin MD. Medically induced abortion in a woman with a large myomatous uterus. Am J Obstet Gynecol 1996;175:1379-80.
7. Schaff EA, Wortman M, Eisinger SH, Franks P. Methotrexate and misoprostol when surgical abortion fails. Obstet Gynecol 1996;87:450-2.

How to cite this article: Salunke R, Goyal S, Chipalkatti P, Bhamare P. A Unique Way of 2nd Trimester Medical Termination of Pregnancy in a Case of Pregnancy with Huge Fibroid – A Case Report. Bombay Hosp J 2022;64(1):42-43.

Source of support: Nil, **Conflicts of interest:** None