Case Report

A huge polypoid uterine myoma causing severe primary postpartum haemorrhage. A report of one case

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Abstract

Complications from uterine myomas in pregnancy could occur antenally, intrapartum or in the puerperium. One of such was diagnosed in a 36-year old para 2+0 who had successful gestation to term delivery in co-existence with a huge fibroid polyp and had spontaneous vaginal delivery of a life baby. She however developed severe primary postpartum haemorrhage prompting emergency postpartum digital vaginal myomectomy which was very helpful.

Introduction

Myomas are detected in about 2% of pregnancies and one of ten pregnant women with myomas may manifest with complications referable to myomas during pregnancy, delivery and the puerperium. Such complications include necrobiosis with pains, abortions, preterm premature rupture of the membranes, preterm deliveries, abnormal lies and presentations, increased caesarean delivery rates, postpartum haemorrhage and endomyometritis. In order to prevent these complications some have performed antenatal myomectomies in selected cases. Huge uterine myomas are not frequent encounters in Post Partum Haemorrhage. For huge myomas, operative removal may be associated with increased morbidity and so is not a choice procedure.

Case Report

A 36 year old para 2+0 presented to the delivery suite with labor pains of 5 hours duration at a gestational age of 38 weeks and 6 days. This pregnancy was booked and was uneventful. Her two previous pregnancies and deliveries were supervised and were all normal. When assessed on admission, contractions were adequate and her cervix was 6 centimeters dilated. She progressed and had a spontaneous vaginal delivery of a live male infant weighing 3800 grams with good Apgar scores 4 hours later. The third stage of labor was actively managed and her immediate postpartum blood loss was 300 milliliters. Post evacuation the uterus felt flabby and atonic.

She had a pulse rate of 110 beats per minute and her blood pressure was 80/50 mmHg. Her urine output was adequate. The uterus was stimulated to contract with manual massage, administration of 0.5 milligrams of ergometrine followed by infusion of 40 IU of syntocinon per liter of 5% dextrose saline running at 30 drops per minute. The bleeding persisted despite these measures. A pelvic examination revealed normal vulvovaginal skin and an intact cervix 8 centimeters dilated. A prolapsing pedunculated fibroid measuring 10 x 6 centimeters with a narrow pedicle attached to the posterior wall of the lower uterine segment was felt. The uterine wall felt normal.

A clinical diagnosis of huge fibroid polyp with massive primary post partum hemorrhage was made. The fibroid was removed by gentle manipulation and finger fracture of the pedicle.
From the myometrium. Further manual exploration of the uterine cavity revealed an essentially normal uterine cavity with improved tone. The bleeding stopped and she was transfused whole blood to correct anemia and shock. Her packed cell volume appreciated to 32%. She was also managed with antibiotics and analgesics and was discharged home. She was healthy on follow up at six weeks postpartum. The histology of the removed uterine mass was consistent with leiomyomata.

Discussion

Myomas may be the cause of significant post partum morbidity from many complications and life may be threatened by severe Post Partum Haemorrhage.

References: