

A simple new technique of performing myomectomy for a predominantly subserosal myoma quickly within few minutes

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Abstract

Removing a degenerated myoma located around the uterine cornu by an innovative technique shelling the myoma a little away from the base by choice of a low placed incision, advantageous in terms of no requirement of blood transfusion because of the reduction in the surgical time is described in a 24 years old lady demanding a fertility conserving surgery.

Mymectomy is an operative procedure that describes the removal just of the myoma alone, trying best to conserve the uterine integrity, an approach generally reserved for fertility reasons. A simple way of performing myomectomy with slight modification of technique is described for a predominantly subserosal degenerating myoma sitting around the uterine cornua which just took ample time of 2 minutes hence minimizing bleeding and non requirement of blood transfusion.

Case report

This case concerns a 24 year old with a history of a spontaneous second trimester abortion 5 months before, likely from a huge myoma complicating the pregnancy and was admitted for myomectomy with all the necessary preoperative investigations. When the abdominal cavity was opened, a huge 14x16cms myoma was found to be arising from left side of the uterus near the cornua with vessels running all over its entire capsule. On the account of enriched vascularity, an incision (Fig 1) was made by electrocautry all around the surface of myoma 4 cms from its base to minimize the blood loss, coagulating all the marginal bleeders coming on the way. A scalpel blade was run all around the myoma, shelling the myoma within 2 minutes. The raw bed of the tumour was closed routinely and capsule

approximated, without disturbing the left fallopian tube.

The blood loss was only 150 ml, without using any compression of uterine or the utero-ovaian system. Nor the traditionally described methergin or hypotensive anaesthesia was advocated during this swift procedure. She did not require any blood transfusion. The cut section of the myoma was filled with fatty material while the histopathological report confirmed it to be a myoma with cystic degeneration (fig 2). Her recovery was uneventful.

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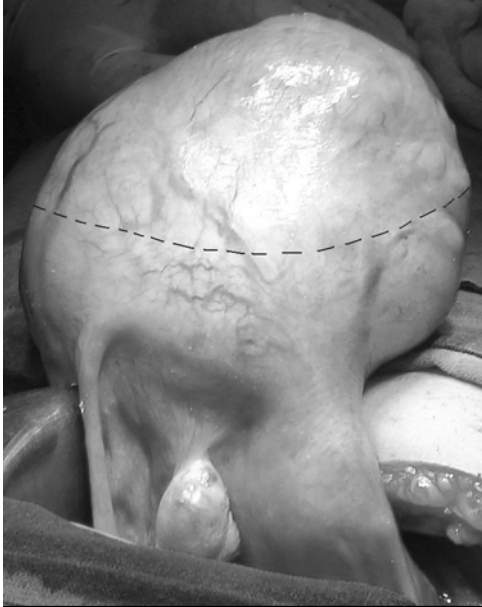


Fig 1: Myoma, in the base fallopian tube is seen, closure by is left ovary

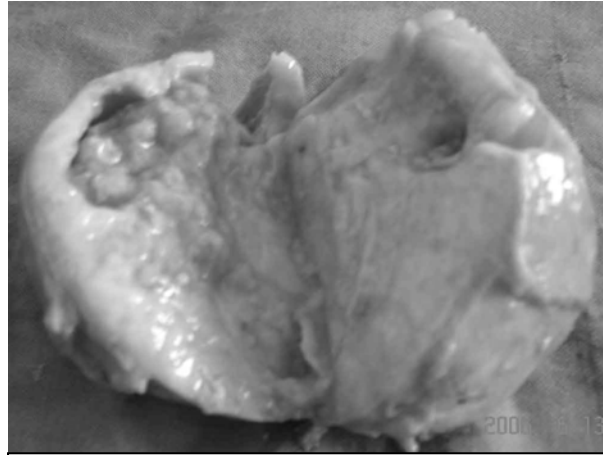


Fig 2: Cut section of the degenerated myoma.

Discussion

The technique adopted here for the myoma removal, slightly differs from most text books, which normally guides giving a nick in the highest point of myoma capsule, secondly holding the myoma by a tissue forceps and decapsulating the myoma as we go down serially from top to the base. These routine steps were not followed because of the vascularity on the myoma which could have involved more blood loss and time.

With this case it is well understood that, a low incision over capsule of myoma could be an appropriate time saving measure that ultimately minimizes blood loss. This adaptation is worthwhile as myomas are frequently seen in younger women with degenerative changes¹⁻³.

Myomectomy for degenerated myoma have not be described so frequently, whereas it has been described for large myoma or multiple myoma.³ This case deals with myoma, both large and degenerated.

Conclusion

A degenerated subserosal myoma can be removed intact by choosing a suitable incision that may not have to be necessarily beginning on the top of myoma as has been traditionally described.

Reference

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