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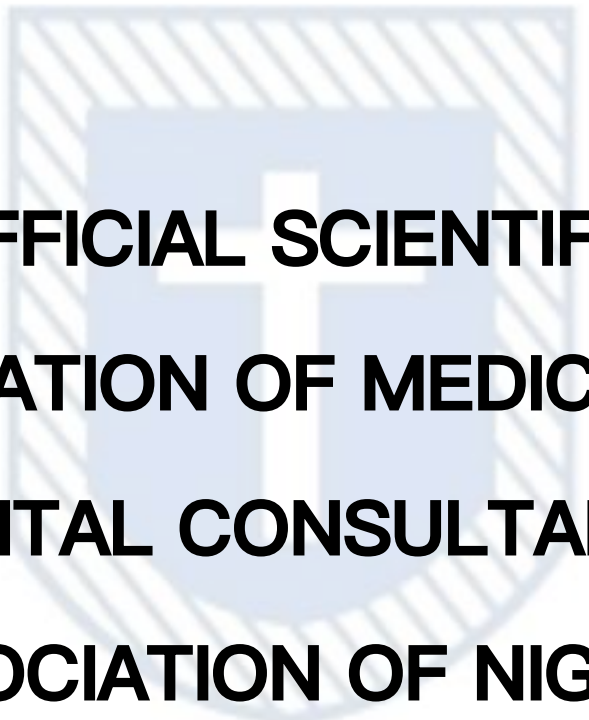
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The Postpartum Giant; Successful Removal of A 2.5kg Oval-Shaped Myoma Six Months after Caesarean Section

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ABSTRACT

Background: Uterine fibroid removal post-pregnancy is via myomectomy, hysterectomy, and minimal invasive techniques like uterine artery embolization and focused ultrasound. Myomectomy is often preferred for fertility

preservation, however, many gynaecologists do hysterectomy for huge fibroids to avoid life-threatening complications of myomectomy.

Objective: To report a rare case of 2.5kg solitary myoma enucleated during myomectomy 6 months post-caesarean section.

Case Report: Mrs. OR, a 36 year old teacher with tertiary education, Christian, Igbo, primipara with no living child having lost her only child from gastroenteritis one month post-caesarean section done on account of huge uterine fibroid, presented to gynaecology clinic on 25/07/2025 with 4 years history of progressively increasing abdominal swelling and ultrasound report of 20 x 16 cm intramural fibroid. There were associated pressure symptoms like urinary frequency and occasional constipation, but no associated pain, menorrhagia, or weight loss. Examination revealed mild pallor, mild pedal oedema, transverse suprapubic scar and a huge, firm, irregular, mobile, nontender, abdominopelvic mass equivalent in size with 32 weeks pregnant uterus. Diagnosis of huge fibroid was made and she was counseled, booked, prepared and treated with myomectomy on 02/08/2025 with enucleation of 2.5kg solitary intramural fibroid and transfusion of 2 units of blood. Postoperative period was uneventful, and she was discharged home on 05/08/2025 with postoperative haemoglobin of 10g/dl. Her 2-weeks and subsequent follow up visits were uneventful.

Conclusion: Myomectomy was successfully utilized to remove 2.5kg huge fibroid 6-months post-pregnancy to spare patient's fertility.

Keywords: Postpartum giant, Huge solitary myoma, Myomectomy, Six-months post-caesarean section.

Introduction

Uterine fibroid is the commonest benign gynaecological tumour in women of reproductive age.¹⁻⁴ It is the commonest benign gynaecological tumour and commonest indication for the two most common major gynaecological surgeries (myomectomy and hysterectomy) in Federal Medical Centre, Umuahia.⁵ Its problematic pattern of presentation portray it as an unmistakable, undeniable, remarkable menace causing poor quality of life on victims and health and socioeconomic challenge. Uterine fibroids most commonly affect the myometrium of the body of the uterus,⁶ are commonly multiple,⁷ usually cause irregular uterine enlargement, have uncertain aetiology, have uncertain incidence as up to 40% may be asymptomatic (incidence is higher in Blacks, age ≥ 30 years, nulliparae and positive family history but lower in smokers). International Federation of Gynaecology and Obstetrics (FIGO) classification⁸ includes 9

types based on fibroid location, helps in standardizing reporting and improving communication among clinicians and researchers, and serves as a guide for choosing the most appropriate treatment.⁹ **Type 0:** Pedunculated intracavitary fibroid; **1:** Submucosal with $< 50\%$ intramural; **2:** Submucosal with $\geq 50\%$ intramural; **3:** 100% intramural but in contact with endometrium; **4:** Intramural, completely within uterine wall; **5:** Subserosal with $\geq 50\%$ intramural; **6:** Subserosal with $< 50\%$ intramural; **7:** Subserosal pedunculated fibroid; **8:** Others, such as cervical or parasitic fibroids; **Hybrid types:** For example, 2 – 5 indicates a fibroid that is less than 50% submucosal and less than 50% subserosal.

Treatment of fibroids depends on presence of symptoms (menorrhagia, pain, abdominal swelling, infertility); age and reproductive intentions; and number, size and location of the fibroid. Most women with fibroids are asymptomatic (60-90%)⁷. Symptoms include menorrhagia

(commonest and occur in 30% of symptomatic patients), pain, pressure symptoms on urinary/GIT/pelvic veins and nerves, reproductive disorders (infertility, abortion, labour dystocia, PPH) and pregnancy - related disorders (red degeneration, abortion, preterm labour). Most asymptomatic patients require only periodic monitoring with imaging investigations (expectant management). Surgery is the definitive treatment for symptomatic patients, hysterectomy and myomectomy being the most effective treatment. Gonadotropin Releasing Hormone (GnRH) agonists suppress gonadotropin secretion and create a hypoestrogenic state as seen postmenopause. Alternatives to surgical treatment are uterine artery embolization and MRI-guided focused ultrasound ablation. Submucosal fibroids can cause infertility or miscarriage, hence require surgery regardless of size. Fibroids undergo degenerative changes such as hyaline degeneration (the commonest type),

cystic, red or carneous (most frequent in pregnancy), calcific (commonly in postmenopausal), mucoid, necrotic and malignant/sarcomatous in < 1% (0.13-0.29%) of fibroids and in this, 5-year survival rate is better than that for a true leiomyosarcoma of the uterus. Complications of fibroids include anaemia, cosmetic concerns from distended abdomen, pressure effects on urinary tract/Gastrointestinal tract/Pelvic vessels and nerves, infertility, miscarriage, labour dystocia, PPH. Africans have negative perceptions and misconceptions about common illnesses such as fibroids.¹⁰

This report aims to highlight the management strategies for a very rare and unique case of postpartum giant fibroid that coexisted with previous pregnancy for which caesarean delivery was done because of high risk of labour dystocia, and the fibroid was not removed then due to risk of torrential bleeding and caesarean hysterectomy.

CASE REPORT

Mrs. OR, a 36 year old teacher with tertiary education, Christian, Igbo, primipara with no living child having lost her only child from gastroenteritis one month post-caesarean section done on account of huge uterine fibroid, **Presented** to gynaecology clinic on 25/07/2025 with 4 years history of progressively increasing abdominal swelling and ultrasound report of 20 x 16 cm intramural fibroid. There were associated pressure symptoms like urinary frequency and occasional constipation, but no associated pain, menorrhagia, or weight loss.

Examination revealed mild pallor, mild pedal oedema, transverse suprapubic scar and a huge, firm, irregular, mobile, nontender, abdominopelvic mass equivalent in size to 32 weeks pregnant uterus. **Diagnosis** of huge fibroid was made and she was counseled, booked, prepared and **treated with myomectomy** on 02/08/2025 with enucleation of 2.5kg solitary

intramural fibroid and transfusion of 2 units of blood. **Postoperative period** was uneventful, and she was discharged home on 05/08/2025 with postoperative haemoglobin of 10g/dl. Her 2-weeks and subsequent **follow up visits** were uneventful. The histopathology report on the specimen confirmed uterine fibroid.

DISCUSSION

This is a case of a 36 year old primipara who lost her only child from gastroenteritis one month post-caesarean section done on account of huge uterine fibroid, and subsequently had myomectomy 6 months post-delivery, with enucleation of a huge 2.5kg solitary intramural oval-shaped fibroid with good outcome. The risk factors associated with higher incidence of fibroids in this patient when the initial diagnosis was made were her nulliparity, age 30 and above, and Black race.^{1,2,5} Fibroids are usually multiple⁷ unlike in the index case that was solitary. The huge/giant size of this solitary fibroid is also

very unusual as most fibroids in general and solitary ones in particular, do not grow that big,⁷ and tend to reduce in size after delivery of the baby.

The huge fibroid was the indication for the previous caesarean section in this patient because they are known to weaken uterine contractions, cause obstructed labour, uterine atony and postpartum haemorrhage.⁷ Uterine fibroids are found in 0.3-7.2% of pregnancies, are usually present before conception as in the index case, and may increase in size significantly during gestation. Fibroids are uncommon cause of abortion although women with fibroids have a higher incidence of spontaneous abortion. Other pregnancy-related disorders of fibroids are Red degeneration, preterm labour, malpresentation, mechanical obstruction, uterine dystocia, and postpartum haemorrhage.⁷

The management of this patient with myomectomy, a fertility-sparing procedure,¹¹ was indicated in order to enucleate the huge fibroid and free the uterus from the pregnancy-related disorders the fibroid could cause and the potential complications that persistence of the tumour could lead to, including malignant (sarcomatous) transformation.

Challenges in surgical management of giant fibroids utilizing myomectomy (as in the index case) include primary haemorrhage, reactionary haemorrhage, secondary haemorrhage, injury to surrounding structures (bladder, ureter, bowel, etc), increased risk of resorting to hysterectomy due to uncontrollable haemorrhage, thromboembolism, prolonged operation time, adhesion formation, wound sepsis, wound dehiscence, burst abdomen etc. These challenges were avoided in this patient via meticulous surgical, anaesthetic, antibiotic, antithromboembolic care and

therapy. Utilization of uterine tourniquet (size 24 Foley catheter) applied at the level of the cervix, utilization of single anterior uterine incision to enucleate the giant fibroid, and meticulous closure of the cavity where the fibroid was removed from, were strategies used to reduce blood loss in this patient successfully.

This rare case of postpartum giant 2.5kg solitary myoma was successfully enucleated not only to improve the patient's quality of life, but also to allow her plan future pregnancies devoid of the potential complications of such a giant myoma. The importance of adherence to the successful surgical management strategies highlighted herein cannot be overemphasized.

CONCLUSION

Figure 1: Distended abdomen due to huge 2.5kg solitary oval-shaped fibroid



Figure 2: Huge 2.5kg solitary oval-shaped intramural fibroid

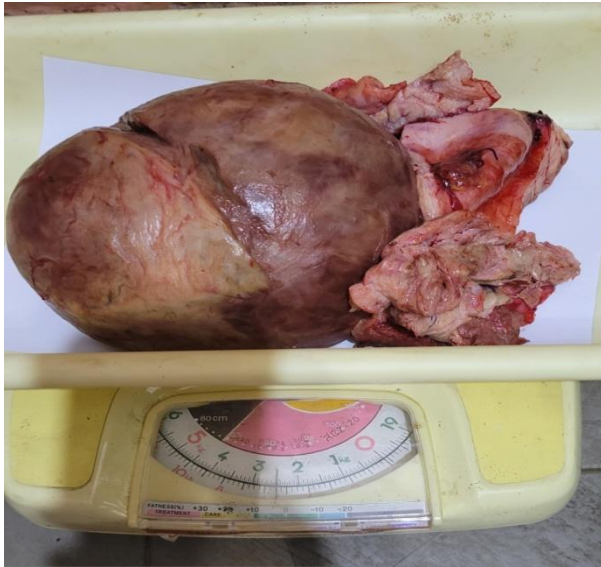
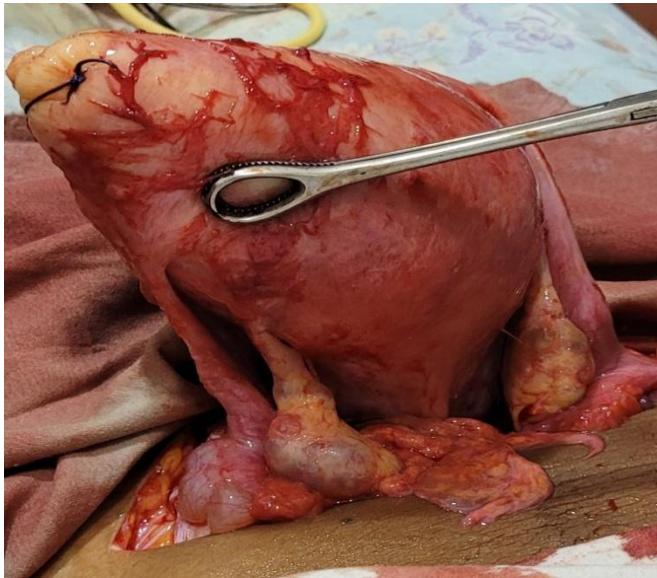


Figure 3: Huge solitary oval-shaped fibroid



Figure 4: Uterus after closure of the single anterior incision during myomectomy



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