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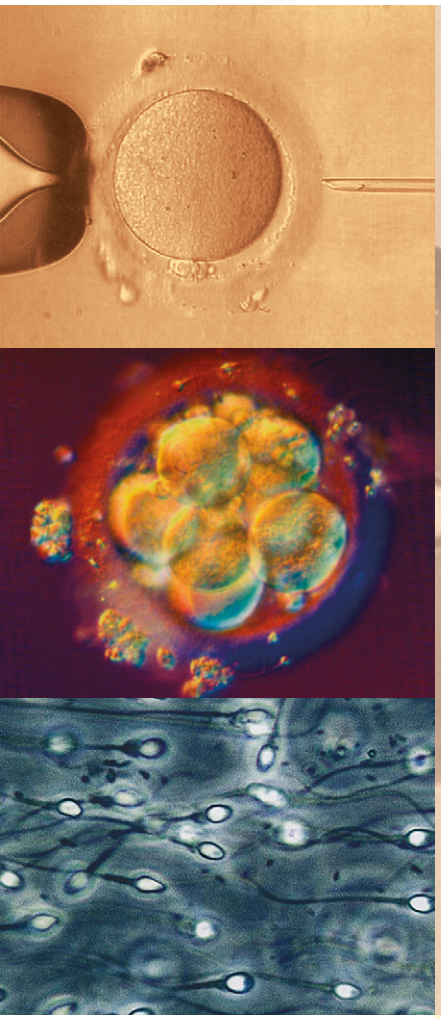

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Case Report: Spontaneous Restitution of Giant Myoma – Is it possible?

Z. Hrgovic[1], T. Rabe[2], D. Habek[3], A. T. Luetić[3]

We present a case of an unexpected complete regression of a giant uterine intramural myoma which was associated with infertility in a patient with consecutive 2 pregnancies with favourable outcomes.
A 55-year-old Caucasian woman was in a programme of assisted reproductive technology since she failed to achieve pregnancy in a period of 12 years. One intrauterine fetal demise after assisted conception cycle happened in the first trimester at the age of 41. Serial ultrasound examinations in a period of 3 years have revealed the growth of a large heterogeneous intramural myoma measuring 18 cm in diameter with abundant vascularisation. In vitro fertilization with intracytoplasmic sperm injection followed by blastocyst transfers was undertaken at the age of 42. The course of pregnancy was normal with intermittent pains and she had delivered vaginally on term.
Since the described myoma showed increase growth (around 25 cm in diameter) the patient was planned for hysterectomy which she did not consent and moreover spontaneously achieved pregnancy at the age of 44. The pregnancy outcome was again favourable with term eutrophic neonates. Postpartal anaemia treated with iron supplements. At the age of 50, an ultrasound examination revealed intramural myoma measuring 18 cm in diameter with rich vascularisation. After menopause the patient was referred for a gynaecological exam after 3 years, when the ultrasound showed resorbed intramural myoma measuring 1.8 cm without vascularisation. **J Reproduktionsmed Endokrinol_Online 2017; 14 (3): 124–5.**

Keywords: myoma, infertility, gynecology

Introduction

Uterine myoma are the most common pelvic tumors in women which are clinically apparent in approximately 12–25% of women of child-bearing age and noted on pathological examination in approximately 80% of surgically excised uterus [1, 2]. On the other hand, giant uterine fibroids that are defined as tumors > 11.4 kilograms are uncommon and a result of rapid growth of solitary or multiple mass. First symptom of the giant myoma is usually abdominal distension accompanied with heavy, prolonged and irregular menstrual bleeding, dysmenorrhoea, chronic pelvic pain, constipation and anaemia. Rapid fibroid growth could also be the sign of its malignant sarcomatous alteration. Postmenopause is usually the period of physiological reduction of myoma size due to the low estrogen and progesterone levels, while its growth could be caused by the higher estrogen levels or its malignant alteration [3–5].

Location of the myoma within the uterus has direct impact on fertility and pregnancy outcome. Submucosal and intramural myoma are associated with lower fertility rate and first trimester miscarriages, while subserosal myoma do not have impact on reproduction. Since it is estimated that myomas are responsible for 1–3% of all infertile women, myomectomy is considered to be a surgical method of fertility treatment [1, 2].

Our report illustrates a case of an unexpected complete regression of a giant uterine intramural myoma that was associated with infertility in a patient with 2 consecutive pregnancies with favourable outcomes.

Case Report

A medical history of a 55-year-old Caucasian woman is described. She was in a programme of assisted reproductive technology since she failed to achieve pregnancy in a period of 12 years. Her partner was diagnosed with asthenozoospermia. One intrauterine fetal demise after assisted conception cycle happened in the first trimester at the age of 41. Serial ultrasound examinations in a period of 3 years have revealed the growth of a large heterogeneous intramural myoma measuring 18 cm in diameter with abundant vascularisation. Before additional assisted reproductive treatments, the patient was advised to undergo myoma excision which she refused. Beside abdominal distension and mild anaemia she did not complain of any other symptoms. In vitro fertilization with intracytoplasmic sperm injection followed by blastocyst transfers was undertaken at the age of 42 and resulted in pregnancy. The patient used polyvitamin supplementation, Utrogestan® and Gravibinan® intramuscular injection from the 5th gestational week. Due to the giant myoma abdomen was more distended than in normal singleton pregnancy regardless of the fact that the tumor did not change its size during gestation. Although the baby was planned to be born by caesarean section, since the patient had regular contractions with normal partogram, she was delivered vaginally on term with female neonates of adequate birth weight and Apgar scores. Placental expulsion was followed by moderate postpartum bleeding which was successfully managed by uterine compression and administration of oxytocin and ergotamine.

Due to the postpartum anaemia (haemoglobin 7.8 g/dl) the patient received 2 blood transfusions and was discharged 2 days after delivery with recommendation of iron supplementation therapy. Since the described myoma showed increase growth in the following year (around 25 cm in diameter) the patient was planned for hysterectomy, which she did not consent and moreover spontaneously achieved pregnancy at the age of 44. The pregnancy outcome was again favourable with male term neonates with normal birth weight and Apgar scores. Postpartum haemoglobin lev-

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el was 10.1 g/dl and the patient was discharged with iron supplements. Excision of the cervical polyp was done at the age of 50 due to the Pap smear result of atypical squamous cells of undetermined significance. At that time ultrasound examination revealed an intramural myoma, measuring 18 cm in diameter with rich vascularisation. Last menstrual cycle was at the age of 52 and consecutive climacteric symptoms were well controlled by phytoestrogens. The patient was referred for a gynaecological exam after 3 years when ultrasound showed resorbed intramural myoma measuring 1.8 cm without vascularisation, thin endometrial lining, visible and clear border between endometrium and myometrium with atrophic ovaries lacking folliculogenesis. At present, the patient is under treatment for hypertension without any gynaecological problems, while her sex hormone levels are typical for postmenopause.

Discussion

Although 2–4% of women with uterine myoma achieve pregnancy, the gestation could be complicated by miscarriage, premature birth, premature rupture of membranes, placenta praevia and invasive malplacentation, placental abruption and fetal malpresentation and malposition in 10–40% of cases [1, 6, 7]. Furthermore deliveries from pregnancies with intramural and submucosal myoma are at increased risk for postpartum haemorrhage, while several reports have been published describing spontaneous postpartum expulsion of submucosal myoma with severe postpartum haemorrhage demanding hysterectomy [1, 8]. The prevalence of postpartum hysterectomy in general is higher in women with uterine myoma.

There are several published cases regarding surgical treatment of giant myoma weighting from 12 to even 40 kilograms which are usually found in women at the end of child-bearing age who recover well after surgical treatment [3, 9–11]. Green and co-workers have described a rare case of complete obstruction of vena cava inferior by a gravid uterus with a giant myoma in the second trimester [1].

In a case of giant myoma in women of child-bearing age it is reasonable to perform an excision of myoma especially if the location is transmural or even embolisation [2, 3]. There are only few published reports about the spontaneous resorption of myoma or endometrial polyp in women of reproductive age. DeWaay and Tsuda have described the decrease in size of uterine myoma in women in perimenopause with correlation of their size and growth with vascularisation indicies [12, 13].

Conservative treatment of intramural myoma in women of reproductive age with ulipristal acetate is recommended and ongoing studies will probably show that both surgical and pharmaceutical treatment are beneficial in such cases with personalised approach and consideration of age, location and size of myoma and reproductive possibilities in each patient. Spontaneous resolution of giant myoma with diameter as in our case and intramural location has not been described in literature. Two pregnancies with favourable outcomes in our patient are additional fascinating findings. Spontaneous resolution of giant myoma is probably associated with perimenopausal/postmenopausal hormonal changes which resulted with extreme myoma shrinking in association with patient individual biological potential.

Conflict of Interest

None.

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