Case Presentation:
Pregnancy with a History of Fibroids

Case Presentation

Patient: A 32-year-old who identifies as female, G1P0 (first pregnancy, no prior deliveries).

Medical History: The patient presented at 12 weeks of gestation with complaints of severe pelvic pain and frequent urination. She had a known history of multiple uterine fibroids that were diagnosed two years prior but was asymptomatic until pregnancy.

Clinical Examination:
Vital Signs: Stable
Abdominal Exam: Enlarged uterus, palpable mass corresponding to fibroid locations
Pelvic Exam: Tender uterus without cervical dilation

Imaging:
Ultrasound at 12 weeks: Multiple fibroids; the largest measuring 8 cm located in the anterior uterine wall. Normal fetal anatomy and heartbeat were noted.

Diagnosis;
The patient was diagnosed with symptomatic uterine fibroids complicating pregnancy.

Management and Follow-Up;

- Pain Management: Acetaminophen and hydration. Recommended avoidance of NSAIDs due to potential adverse impact on fetal development.
- Monitoring:
  - Serial ultrasounds to monitor fibroid growth and fetal development.
  - Bi-weekly follow-up visits to reassess symptoms and fetal progress.
  - Advised to limit physical activity to reduce the risk of preterm labor.

Potential Complications:

- Increased risk of preterm labor and preterm premature rupture of membranes.
- Elevated risk for placental abruption due to reduced placental perfusion.
- High likelihood of delivery by cesarean section due to fibroid location obstructing the birth canal.

Outcome:
At 38 weeks, the patient experienced worsening pain and signs of preterm labor. The patient was advised of the need for planned cesarean delivery to ensure maternal and fetal well-being. During delivery, the largest fibroid was noted but not removed to prevent postpartum hemorrhage. A healthy male infant was delivered with APGAR scores of 8 (at 1 minute) and 9 (at 5 minutes). The postpartum period was uneventful, and the patient was discharged on postoperative day 2 with a recommendation for follow-up of postpartum fibroid management.

Discussion:
Fibroids during pregnancy may pose significant challenges, including increased pain, risk of miscarriage, preterm labor, and delivery complications. Management often involves a multidisciplinary approach with regular monitoring and symptom management. Surgical intervention for fibroids during pregnancy is rare and is typically reserved for life-threatening complications due to an elevated risk of severe bleeding and adverse pregnancy consequences.

Conclusion:
This case highlights the importance of vigilant prenatal care and individualized management plans for pregnant patients with fibroids. Regular monitoring and timely intervention can ensure favorable outcomes for both the mother and the fetus.

Sources:

BJOG-Intern J Obst Gynecol. Epidemiology of uterine fibroids: a systematic review.
Best Practice & Research Clinical Obstetrics & Gynaecology. Clinical presentation of fibroids.

Supported by an unrestricted educational grant from Pfizer.

AMWA
The Vision and Voice of Women in Medicine

Case Presentation:
Endometriosis

Case Presentation:
Ms. AB, a 32-year-old nulligravid woman, presents with severe dysmenorrhea, pelvic pain, and dyspareunia. Her symptoms have progressively worsened over the past five years, despite multiple trials of oral contraceptives and nonsteroidal anti-inflammatory drugs. She reports a family history of endometriosis and expresses concerns about her fertility.

Assessment:
To confirm a diagnosis of endometriosis and to assess the extent of the condition, Ms. AB undergoes diagnostic laparoscopy. Intraoperatively, dark cysts are visualized on both ovaries and adhesions are noted in the pelvic sidewalls and rectovaginal septum. A biopsy is conducted to confirm the presence of endometrial glands and stroma in the ectopic lesions. This histological confirmation is considered the gold standard in making a diagnosis of endometriosis.

Management:
The management of endometriosis aims to alleviate symptoms, preserve fertility (as indicated by the patient), and prevent disease progression. Ms. AB's treatment plan involves a multimodal approach:

- Pain Management: She is prescribed a combination of analgesics, including nonsteroidal anti-inflammatory drugs and possibly opioids for breakthrough pain.

- Hormonal Therapy: Given her desire for fertility preservation, Ms. AB opts for hormonal suppression with gonadotropin-releasing hormone (GnRH) agonists to induce a hypoestrogenic state and reduce lesion size.

- Surgical Intervention: Given the presence of extensive disease and symptomatic endometriomas, she undergoes laparoscopic excision of endometriotic lesions, adhesiolysis, and cystectomy.

- Fertility Counseling: Ms. AB is counseled regarding the potential impact of endometriosis on fertility and the available options for assisted reproductive technologies if conception proves challenging.

Follow-Up:
Ms. AB's postoperative course is uneventful, with significant improvement in her pelvic pain and dysmenorrhea. She is advised to continue hormonal therapy for suppression of disease recurrence and to optimize her chances of conception. Regular follow-up and monitoring of symptoms, ovarian reserve, and disease recurrence are planned.

Conclusion:
Endometriosis is a complex and multifactorial condition. A tailored treatment plan focused on addressing pain, concerns of fertility, and disease burden is essential to improve outcomes and quality of life for the patient.

Sources:

Diagnosis of endometriosis in the 21st century. Climacteric
ESHRE Endometriosis Guideline Group. ESHRE guideline: endometriosis. Hum Reprod Open.

Supported by an unrestricted educational grant from Pfizer.

AMWA
The Vision and Voice of Women in Medicine