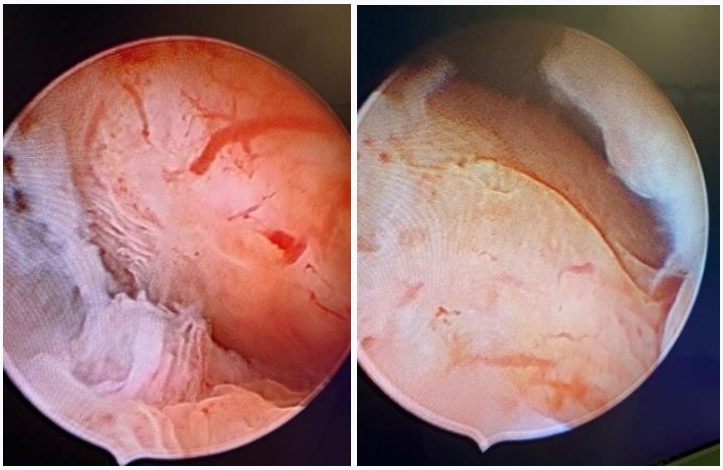
TO LEAVE OR NOT LEAVE MYOMA IN CAVITY AFTER MYOMECTOMY. IS A SINGLE BIOPSY OF MYOMA ENOUGH?

Fraga Campo, Silvia; Sevilla Ros, José; Laguna Herrera, María; Martín Oliva, Virginia; Artime Gómez-Albo, Elena; Díaz Bidart, Yurena
Servicio de Ginecología y Obstetricia. Hospital Universitario Infanta Elena. Valdemoro. Madrid. Spain

Introduction: In the literature there are studies that evaluate the safety of leaving a submucosal myoma in the uterine cavity after performing a hysteroscopic myomectomy in consultation. In> 90% of cases, at 3 months there isn´t evidence of myoma on subsequent ultrasound control.

Advantages	Disadvantage
It decreases discomfort by shortening the operating time since you don´t have to be fragmenting the fibroid or entering or leaving the uterine cavity to extract these fragments. No increase in complications intra or post hysteroscopy has been objected.	We don´t have a complete anatomopathological study of the fibroid (since it is left in the cavity) so it´s advisable to take a biopsy of the myoma during hysteroscopy

Clinical case: 48-year-old woman, with hypermenorrhea and anemia (Hb 9.8). MH 8/28. Gynecological examination shows a hypertrophic and mobile uterus.
TV ultrasound: uterus 100 x 52 mm, with an intracavitarian image of 25 x 23 x 23 mm according to submucosal myoma type 0, normal ovaries
Diagnostic hysteroscopy in consultation: Type 0 submucosal myoma of 25 x 25 mm (LASMAR 3 classification)



Myomectomy was performed with a bipolar electrode, leaving the myoma intracavitary after taking a biopsy with an anatomopathological result of leiomyoma, without signs of malignancy.
12 days after the hysteroscopy, the patient came to the emergency room due to leucorrhea and pain. The cervical os was dilated and 4 x 3 cm of tissue came out, which was referred to pathology. Subsequent ultrasound showed an empty uterus.
Pathological result: 50 x 28 mm fragment, in which a cell proliferation of fused pattern with atypia and severe pleomorphism with 7 mitoses / field with some atypical mitoses is observed.

It shows signs of ischemia without being able to rule out tumor necrosis. Immunohistochemical study was performed with Ki67 and H3, which was inconclusive due to poor preservation of the sample. Smooth muscle actin (diffuse staining), desmin (focal staining) and S100 (negative) were also performed. The histological findings and the poor preservation of the specimen did not allow to rule out malignancy, so an extension study was performed, which was negative (MRI and CT) and total hysterectomy with double adnexectomy by laparoscopy was performed, with anatomopathological results without evidence of malignancy. So far, revisions have been normal.

Conclusion Although it is considered safe to leave the myoma in cavity after performing a myomectomy by hysteroscopy with biopsy of the myoma, we should consider taking multiple biopsies and not just a single biopsy. Especially in case of large myomas and women > 45 years old despite the low possibility of STUMP tumors (mesenchymal smooth muscle tumors of uncertain malignant potential) (as in our case) or sarcomas. Another option would be to perform myomectomy with morcellator to obtain a complete anatomopathological study of the myoma, but this is not always an available option.

Keywords: myoma, myomectomy, biopsy, STUMP tumors