

## OUTPATIENT HYSTEROSCOPIC MYOMECTOMY: MULTIPLE DEVICES FAILURE

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### AIM

It seems that hysteroscopic resection is the gold standard treatment for submucosal myomas, especially in those women who are interested in preserving their fertility.<sup>1</sup> It is known that a careful hysteroscopic management of uterine fibroids can lead to an improvement of the symptoms as well as fertility outcomes.<sup>2</sup>

Nevertheless, hysteroscopic procedures do not always achieve the complete resolution of the pathology during the first intervention. These techniques have the disadvantage of recurrence in some cases, especially in those cases with several myomas or when they are big size. So occasionally there is a need for further surgery.<sup>2</sup>

### METHODS

We report the case of a 42 years-old nulliparous woman that was referred to our centre due to severe hypermenorrhea and chronic pelvic pain caused by uterine fibroids. She had gestational desire, so at the time of the first appointment she had already carried out oocyte cryopreservation.

First of all, a vaginal ultrasound was performed. We observed a 51x15mm submucosal myoma FIGO type 1, and a 127x95mm intramural fundic myoma. A magnetic resonance imaging was also performed, supporting similar findings.

### RESULTS

She was scheduled for abdominal myomectomy to remove intramural fibroid, and then a hysteroscopic myomectomy was scheduled for the submucosal one. In the first outpatient hysteroscopy we observed a big submucosal myoma of almost 5cm of size in the posterior wall of the uterus, affecting >50% of the cavity. Diode laser was used achieving partial decapsulation of the myoma. The intervention had to be interrupted because the big size of the myoma that was occupying almost all the cavity.

Since this intervention, more hysteroscopies had been performed using different devices. Two hysteroscopies were performed using hysteroscopic morcellators. Then, four more office hysteroscopies were carried out using diode laser.



1. Hysteroscopic myomectomy using diode laser



2. Hysteroscopic myomectomy using a morcellator

Despite of several hysteroscopic attempts using different devices, the images show the persistence of the myoma, that appears totally intracavitary and with a considerable decreased of the size.

During this period of time, the patient is still interested on preserving fertility. Due to the decreasing size achieved in the last procedures and the wish of the patient, she agrees attempting another surgical intervention using a resectoscope.

In each intervention it is noted that the total decapsulation of the myoma is imminent, however none of them achieved its complete resection for exceeding the maximum time recommended or because of the technical limitations due to the fibroid size and location.

During follow-up vaginal ultrasounds have been performed.



3. Last vaginal ultrasound during follow-up

### CONCLUSIONS

The literature describes that the risk of recurrence is correlated to the size of the myoma, especially in those cases when the diameter is higher than 5cm.<sup>1</sup> Another factor that is associated with recurrence is the degree of intramural penetration of submucosal fibroids; it is known that if intramural penetration is higher than 50%, it is more likely to fail in complete excision.<sup>3</sup> Other risk factors have been demonstrated, such as the number of fibroids and the total uterine size.<sup>1</sup>

The management of these cases can be challenging. We assume that carefully repeated myomectomy can be performed provided that the patient is well informed about the risks and alternatives, that vaginal ultrasound follow-up is performed, and as long as fertility wants to be preserved.

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