Myoma arising in a Cervical Stump

June 29, 2011
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Introduction

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Case Report

A 49 year-old patient with a history of previous laparotomic myomectomy and one caesarean section, performed 12 years before, followed by supracervical hysterectomy for uterine rupture, referred to our practice complaining about urinary symptoms and mild abdominal pain. A myoma arising in the cervical stump measuring 8 cm in width was diagnosed both by the pelvic examination and vaginal ultrasound. The myoma appeared to be fixed in the pelvic cavity, with absence of lateral movements. Cervical biopsies and cytology were benign. After 1 year, the myoma had increased of about 3 centimetres and a laparoscopy was planned.

Intervention

At laparoscopy, the myoma occupied entirely the lower pelvis, completely covered by the overlying peritoneum. Thick adhesions between the descending colon-sigma, the left ovary and the myoma were present. Adhesiolysis was performed to free the bowel and the ovary from the myoma.
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Published on Physicians Practice (http://www.physicianspractice.com)

Video 1
The ureters were identified. The peritoneum covering the myoma was opened, starting from the left side and reaching the vesical space.
To allow a better mobilization of the myoma, the left uterine artery was identified and coagulated. The enucleation of the myoma was therefore easily carried out.

Video 3
The right uterine artery was coagulated and the trachelectomy completed by vaginal way.

Video 4
A conflict arises in regard to preservation of the uterine cervix during hysterectomy. Alternative procedures, such as supracervical laparoscopic hysterectomy or classic intrafascial supra-cervical hysterectomy, have been recently proposed. Patients undergoing laparoscopic supracervical hysterectomy have been reported to have shorter operating times, shorter hospital stays, and less morbidity than those who underwent other types of hysterectomy. A less morbid approach can be advocated, in appropriate candidates, particularly if the procedure is readily accomplished by an increased number of physicians. Furthermore, some have argued that supracervical hysterectomy better preserves bladder and sexual function. However, for routine cases, the available literature does not confirm that one procedure is superior, regardless of the route of access.

The main disadvantage of subtotal hysterectomy over total one is the fact, that in 1 per 1000 women develops carcinoma in cervical stump.

The practice of routine preservation of the cervix at laparoscopic hysterectomy should be reconsidered. In fact, symptoms related to the cervical stump requiring further surgery frequently occur following a laparoscopic supracervical hysterectomy. Twenty-five percent of the patients continued to menstruate, and 10% had symptoms of discharge. Careful long-term analysis of results demonstrates a high complication rate reporting symptoms related to the cervical stump in 24% of patients, all requiring further operations. Adhesions, especially between the bowel and the cervical stump, endometriotic lesions, cervical pathologies (chronic cervicitis, SIL, mucocoeles), myomas and prolapse have been reported at long-term follow-ups.

Nevertheless, it has to be stressed that cervical stump removal can be accomplished laparoscopically by an experienced surgeon.

Conclusion

Although preservation of the cervix with laparoscopic hysterectomy for benign diseases was satisfactory in most of the cases, several women had complications of the remaining cervix. Special attention should be paid to the careful treatment of the cervical stump. Further prospective studies are needed to evaluate the advantages of retaining the cervix at laparoscopic hysterectomy.
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