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Hysteroscopic resection of type 3 myoma: a new challenge?



Perrine Capmas^{a,b,*}, Audrey Voulgaropoulos^a, Guillaume Legendre^a,
Anne-Gaëlle Pourcelot^{a,c}, Hervé Fernandez^{a,b,c}

^a Service de Gynécologie Obstétrique, Hôpital Bicêtre, GHU Sud, AP-HP, F-94276 Le Kremlin Bicêtre, France

^b Inserm, Centre of Research in Epidemiology and Population Health (CESP), U1018, F-94276 Le Kremlin Bicêtre, France

^c Faculty of Medicine, Univ Paris Sud, F-94276 Le Kremlin Bicêtre, France

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ABSTRACT

Objective: Type 3 myomas are intramural within contact with the endometrium but lack any cavity deformation. There is no guideline for management of symptomatic type 3 myoma. The aim of this study was to evaluate the feasibility of symptomatic type 3 myoma hysteroscopic resection.

Method: This retrospective study included symptomatic women (mainly pain, infertility or bleeding) who obtained an operative hysteroscopy for type 3 symptomatic myoma from June 2010 to December 2014 in the gynaecological unit of a teaching hospital.

Result: Thirteen women with an operative resection using bipolar electrosurgery of type 3 myoma during the study period (June 2010 to December 2014) were included in the study. Two women had a hysterectomy 6 and 12 months after the procedure and one woman had an open myomectomy 30 months after the procedure for the recurrence of abnormal bleeding. Postoperative office hysteroscopy show a postoperative synechiae in 3 women out of 8. Incomplete resection was also obtained in 3 women out of 8.

Conclusion: Hysteroscopic resection is a potential alternative to traditional surgery for type 3 myoma. This procedure must be confined to skilled surgeons because it is a difficult procedure. A postoperative office hysteroscopy is recommended in women of reproductive age.

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Introduction

Myoma is a benign tumour that is mainly revealed by menorrhagia, pelvic pain and/or infertility [1,2]. The gold standard for management of symptomatic myoma is surgery but for type 3 myoma, the type of surgery is not clearly defined. The type of surgery (laparotomic, laparoscopic or hysteroscopic) is dependent on the size, number, type of myomas and the surgeons' skill as well as the symptoms, age and preference of the women [3].

Hysteroscopic resection is a safe, minimally invasive and cost effective method for the resection of type 0, 1 or 2 myomas. Hysteroscopic resection allows an alleviation of symptoms and a return to a normal cavity prior to future pregnancy, even if failure of treatment and early recurrences occur. French guidelines based upon a literature review conclude that the limit for hysteroscopic myoma resection is 4–6 cm for type 2 myoma [2].

The most recent classification for myoma is from the International Federation of Gynaecology and Obstetrics (FIGO 2011) [4]. Complete intracavitary myoma is type 0, while more than 50% of intracavitary myomas are type 1 and less than 50% of intracavitary myomas are type 2, as previously classified by the European Society for Human Reproduction and Embryology (ESHRE). Type 3 myomas are intramural within contact with the endometrium but lack any cavity deformation (Fig. 1) [4].

While guidelines for type 0, 1 and 2 myoma are clear, those for type 4, 5, 6 and 7 (intramural and subserosal) are discussed, there is no guideline for symptomatic type 3 myoma. In a literature review, we did not find any data regarding the feasibility of hysteroscopic resection for type 3 myoma.

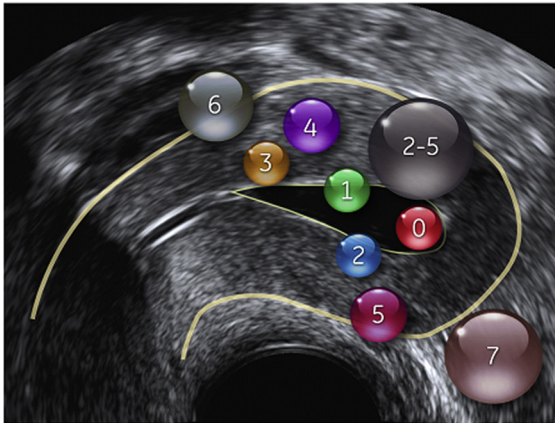
The aim of this study was to evaluate the feasibility of type 3 myoma hysteroscopic resection.

Materials and methods

This retrospective study included women who had an operative hysteroscopy for type 3 symptomatic myoma (menorrhagia or

* Corresponding author at: Service de Gynécologie Obstétrique, Hôpital Bicêtre, 78 Avenue du Général Leclerc, 94275 Le Kremlin Bicêtre Cedex, France.
E-mail address: perrine.capmas@aphp.fr (P. Capmas).

A- Sagittal view.



B- Coronal view.

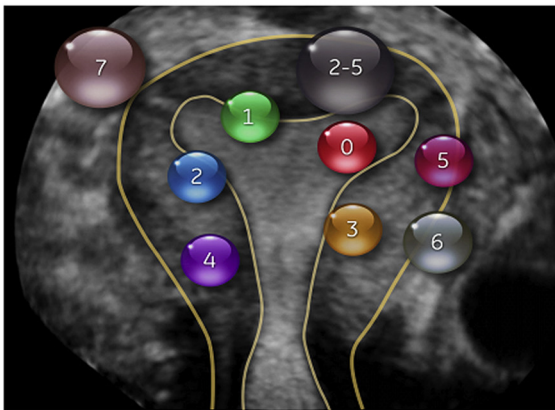


Fig. 1. Sonographic presentation of FIGO classification for myoma [3]. (A) Sagittal view. (B) Coronal view.

infertility) from June 2010 to December 2014 in the gynaecological unit of a teaching hospital. All the women with a symptomatic type 3 myoma during the period were included.

The following medical data were recorded: symptoms, size of the type 3 myoma, results from the preoperative sonography, use of a preoperative treatment by a GnRH analogue, number of surgeries for resection of the type 3 myoma and length of surgery, energy used for resection, sonographic per-operative guidance, control office hysteroscopy at 6 weeks and the result (synechia, remaining myoma) and, finally, satisfaction of the patients regarding their management (validate questionnaire).

Two experienced surgeons (achieving more than 100 operative hysteroscopies per year for more than 2 years as a resident) performed all of the procedures. Operative hysteroscopy was performed using a 26Fr hysteroscope equipped with a 30-degree lens (Endoskope; Karl Storz GmbH and Co., Tuttlingen, Germany). Saline solution (0.9%) was used as the distention medium with a fluid management system. Hysteroscopic resection for type 3 myoma began with an incision of the endometrium in front of the type 3 myoma with bipolar energy. Myoma type 3 is not visible inside the uterine cavity but can be located using sonography at the beginning of the surgery. Endometrial incision in front of the type 3 myoma is first performed with a 5 Fr twizzle electrode (Figs. 2 and 3) or by a knife after cervical dilatation. Enucleation of the myoma inside the cavity is then observed, sometimes requiring incision of endometrium and of the myoma with standard knife after cervical dilatation (Figs. 4 and 5). The resection is then performed using a bipolar cutting current (Fig. 6). The loop electrode is placed distal to the myoma, retracted

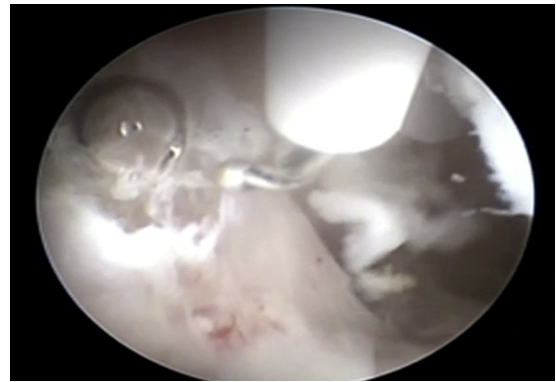


Fig. 2. Incision of endometrium with twizzle electrode.



Fig. 3. Twizzle 5 Fr electrode use for incision.



Fig. 4. Final incision of endometrium with the knife to obtain enucleation of myoma.



Fig. 5. Incision of myoma with the knife to facilitate resection.

towards the cervix and should be visualized throughout the all procedure to avoid uterine perforation. Resection is done from the intracavitary portion of the myoma until myometrium. Healthy

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