A Successful Live Birth with In Vitro Fertilization from a Woman with a Huge Uterus Due to Recurrent Multiple Uterine Fibroids after Abdominal Myomectomies

Chun Yang*, Chunyan Chen#, Jing Cai, Yanhui Li and Ying Gao

Department of Obstetrics and Gynecology, Union Hospital, Tongji Medical College, Huazhong University of Science and Technology, Wuhan, 430022, China

*Authors contributed equally to this work

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Introduction

Uterine fibroids, or leiomyomas, are the most common benign tumor of the uterus, occurring in up to 77% of women. Estimated to be present in 27% of infertile women, they may be a sole factor responsible for only 2-3% of infertility cases [1-3]. Uterine fibroids may interfere with sperm migration and ovum transport by (1) anatomic distortion of the cervix or the tubes, (2) enlarging or deforming the uterine cavity, (3) interfering with ovum capture, and (4) impairing the uterine contractility [4]. In addition, the presence of fibroids can cause implantation failure by (1) physically changing the shape of endometrium, (2) preventing discharge of intrauterine blood, (3) reducing blood supply to endometrium, and (4) altering the normal endometrial environment by local inflammation and bleeding [5-7].

The recurrence rates of uterine fibroids in patients undergoing primary myomectomy are between 15-45% within a 5-10 year period [8,9]. Particularly, patients with multiple uterine fibroids and those in the third decade of life showed an increased risk of symptomatic recurrence after surgery [10]. After myomectomy the pregnancy rate was about 20-50% in patients with otherwise unknown cause of infertility. However, more than 50% of patients remain infertile 5 years after primary myomectomy [8,11-13]. The postmyomectomy pregnancy rate was negatively associated with the number and size of the removed myoma [11].

Small-to-moderate uterine fibroids, regardless of their location, are likely not to impact outcomes of IVF [14]. However, submucosal and intramural fibroids causing distortion of the endometrial cavity have been associated with decreased pregnancy rate as well as increased risk of miscarriage following IVF [15,16].

Here, we describe a successful pregnancy and live birth following IVF treatment in a woman with huge uterus harboring recurrent multiple fibroids who had twice undergone abdominal multiple myomectomy.

Case Report

A 30-year-old woman with a 6-year history of primary infertility presented to our unit with a desire to become pregnant. Her body weight was 62kg and height was 167 cm. The menstrual cycle was 28 days. The sizes of ovaries were 41×18 mm² (right) and 24×17 mm² (left). The routine semen analysis of the patient’s husband was normal.

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IU was administrated followed by oocyte retrieval 36 hours thereafter. A total of 20 oocytes were retrieved, and eighteen of them were found to be metaphase II. Fifteen embryos were available on day 3. Due to enlarged ovaries, all of the embryos were cultured to day 5, and six blastocysts of 4BB and one of 4CB were available according to Gardner grading; the sizes of the ovaries were 84×63 mm² (right) and 63×58 mm² (left); the endometrium thickness was 14 mm; the uterine size was 98×95×92 mm³. Transfer with two blastocysts of 4BB was performed without difficulty. The other five blastocysts were vitrified. The patient’s serum β-HCG was 22.27 IU/L twelve days after the embryo transfer (ET). But unfortunately, it became negative six days later.

In February 2013, the patient demanded to receive frozen-thawed-ET. Nevertheless, transvaginal ultrasound showed a further enlarged uterus (106×97×94 mm³) with more than twenty intramural uterine fibroids with maximum diameters of 16-39 mm. To decrease the uterus size, the patient received GnRHa treatment for 3 months. Twenty eight days after the last administration of GnRHa, when the uterine size was 89×90×90 mm³, the patient began to receive oral estradiol valerate (4 mg daily). Eighteen days later, the endometrium thickness was 9 mm and the uterine size was 103×100×99 mm³. Progesterone 40 mg/d, 60 mg/d, 80 mg/d, 80 mg/d, 80 mg/d, and 80 mg/d were intramuscular injected in the next 6 days, respectively. Then two frozen-thawed blastocysts of 4BB were transferred. Twelve days after the ET, serum β-HCG was 110.86 IU/L and rose to 397.25 IU/L four days later. Intrauterine single fetal heart beat was confirmed by ultrasound observation 30 days after the ET. Unfortunately, the patient underwent a miscarriage of 8 gestational week.

In November 2013, the patient demanded to receive the second cycle of frozen-thawed-ET. However, the uterus was even larger (127×96×125 mm³). Then the patient was given GnRHa treatment for three months again. Transvaginal ultrasound revealed more than twenty intramural uterine fibroids with maximum diameters of 22-41 mm and uterus size of 117×90×122 mm³. Thereafter, the patient received oral estradiol valerate 4 mg per day for 16 days. Sixteen days later, the patient’s uterus size was 134×95×122 mm³ and endometrium thickness was 10 mm. Her serum progesterone was 0.09 ng/ml, and E2 was 246.00 pg/ml. Then progesterone was administered in doses of 40 mg/d, 60 mg/d, 80 mg/d, 80 mg/d, 80 mg/d, and 80 mg/d in the following six days followed by ET with two 4BB blastocysts. The β-HCG was 121.45 IU/L 12 days after the ET and rose to 553.37 IU/L four days later. Fetal heart beat was confirmed by ultrasound observation 40 days after the ET. The uterine size was 167×148×180 mm³. The patient successfully delivered a healthy male infant weighing 3400 g at 39 weeks of gestation via cesarean section. APGAR score was evaluated at 8. No neonatal problems have been reported. Hysterectomy was performed due to postpartum hemorrhage.

**Discussion**

This is a case report of successful pregnancy and live birth with extremely huge uterus and recurrent multiple intramural fibroids, following two abdominal myomectomies and IVF treatment, although the recurrent multiple fibroids continued to grow up during IVF despite the GnRHa treatment prior to each IVF cycle.

Indeed, submucosal fibroids can adversely affect implantation and pregnancy rates in assisted reproduction cycles [17,18]. Intramural fibroid of 5 cm or less in diameter halves the chances of an ongoing pregnancy after assisted reproduction [15]. In addition, intramural or submucosal fibroids increase the rate of spontaneous abortion in IVF cycles [19]. Sunkara et al. [20] performed a meta-analysis to clarify the effect of fibroids on pregnancy outcomes after IVF, in which 19 studies involving 6087 cycles were analyzed. They found the presence of intramural fibroids without uterine cavity involvement was associated with a significant reduction in live birth rate and clinical pregnancy rate. Another meta-analysis investigating the influence of fibroids location on IVF outcomes reported that submucosal fibroid strongly interfered with the pregnancy rate after IVF, while intramural ones exhibited only modest negative effects [21]. A recent study suggested that non-cavity-distorting fibroids did not affect IVF/ICSI outcomes, whereas intramural fibroids greater than 2.85 cm in size significantly impaired the delivery rate of patients undergoing IVF [22]. In our patient, an enlarged uterine cavity and multiple intramural intramural fibroids should be responsible for her chemical pregnancy and miscarriage, which may be explained by altered uterine vascular perfusion, myometrial contractility, endometrial receptivity, embryo migration or myometrial/endometrial gene expression.

Thus, it appears to be generally accepted that submucosal, and possibly intramural and subserosal fibroids decrease implantation rates and that their removal might solve the problem [17,23]. Approximately
50% of the women with infertility and myoma become pregnant after myomectomy. However, it is still not easy to solve the current dilemma of management of intramural myoma: myomectomy or IVF? Many previous studies have suggested that myomectomy can improve pregnancy rate and reduce abortion rate [16,24]. Moreover, the impact of previous myomectomy on IVF outcome was also investigated. Narayan et al. and Surrey et al. both described IVF outcomes of patients after myomectomy for submucosal fibroids were not different compared with patients without fibroids [25,26]. However, considering the effects of myomectomy for recurrent fibroids on fertility in particular, there is little literature available. A prospective cohort study of reproductive outcome after a second myomectomy for recurring myomas suggested 9 of 58 (15.5%) women became pregnant after the second surgery and only 5 (56%) had live births [27]. It is not recommended to perform myomectomy with more than seven large fibroids because the surgeon can miss the smaller fibroids after the uterus has been incised and repaired in too many places. In light of the poor fertility results of our patient, who had underwent twice abdominal myomectomies, another myomectomy is not advisable to perform. On the other hand, assisted reproduction should be a valid alternative form of treatment.

A recent study suggested that women with very long (>9.0 cm) uterine lengths are less likely to experience live birth [28]. Extremes of uterine length may signify anatomical variations that contribute a decreased likelihood of implantation. GnRH agonists cause myoma shrinkage by inducing hypoestrogenemia. In our patient, GnRHAs was used before ET to facilitate implantation by reducing the fibroids and uterine sizes. However, the GnRHa treatment increases the likelihood of a recurrence of fibroid [29]. Fortunately, our patient had conceived successfully with a huge uterus which size was 134 mm × 95 mm ×122 mm.

In conclusion, our case suggests that for women with huge uterus and multiple fibroids, or otherwise unexplained infertility, assisted reproduction might lead to pregnancy and live birth, even if previous myomectomy and GnRH agonists treatment didn’t exhibit beneficial effects on fibroids.

References