# SUBMUCOSAL MYOMA IN PREGNANT WOMEN. THEIR FEATURES AND TREATMENT.

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***Annotation****: Myoma is the most widespread benign tumor in the world and also it is second most common gynecological diseases after pelvic organs inflammation.*

***Аннотация****: Миома — самая распространенная доброкачественная опухоль в мире, а также второе по частоте гинекологическое заболевание после воспалений органов малого таза.*

***Annotatsiya****: Mioma dunyo bo'yicha eng keng tarqalgan xavfsiz o'smalardan biri hisoblanadi va u ginekologik kasalliklar Ichida chanoq a'zolari yallig'lanishidan keyingi o'rinda turadi.*

***Key words****: myoma, fibroid, benign tumor, hysterectomy*

***Ключевые слова:*** *миома, фибромиома, доброкачественная опухоль, гистерэктомия*

***Kalit so'zlar:*** *mioma, fibroid, xavfsiz o'sma, gisterektomiya*

**Abstract:** Leiomyoma (fibroids) or uterine myoma (hysteromyoma) is a monoclonal tumor that develops from a single mutant smooth muscle cell of the vascular wall without the ability of growth control. Myoma has most common five types: intramural fibroids, subserosal fibroid, submucosal fibroid, pedunculated fibroid, intracavity fibroid, which is based on tumor growth in relation to the muscular layer of the uterus and the localization of myoma in different parts of the uterus. The most dangerous type is submucosal fibroid, because it causes heavy bleeding. Risk factors of myoma are age, hormonal therapy after menopause, obesity, tamoxifen intake, genital inflammatory diseases. Sometimes myoma is asymptomatic disease for a long time, but it is often accompanied by abundant and prolonged menstruation, having the nature of bleeding. Ultrasound research is the main method of screening and primary diagnosis of hysteromyoma. Ultrasound examination allows determining the number, localization, diameter, structure, echogenicity of nodes. The variants for uterine myoma treatment are diverse-surgical, radiological and medical.

**Methods and materials**

In April, 2025, the patient M., 32 years old, was delivered by ambulance to the Regional obstetric and gynecological center of Tashkent from the Central regional hospital. The patient had pregnancy period of 36 weeks+4 days, complaints of cramping pains in the lower abdomen, pain in the lumbar region and bloody discharge from the genital tract.

The disease history: this pregnancy was 5th, 2 pregnancies of the patient ended by well-time labor, and 2 pregnancies – by artificial abortions without

complications. The history of gynecological diseases included hysteromyoma, which was diagnosed in 2019, and then the patient was not observed by gynecologist. This pregnancy occurred spontaneously, proceeded against the threat of pregnancy termination and was complicated by gestational pyelonephritis at the 21st week of pregnancy. Ultrasound research at 11 weeks determined subserous uterine leiomyoma, but the patient was registered for pregnancy only at 20 weeks. Ultrasound research in the period of 21 weeks of pregnancy diagnosed low placentation and the size of the subserous myomatous node 70x85 mm. General condition was satisfactory. Blood pressure was 120/80 mm Hg, pulse 74 beats per minute, rhythmic. The patient's abdomen was enlarged due to the pregnant uterus; hypertonus of the uterus is registered. The position of the fetus was longitudinal, the head lied above the entrance to the pelvis. Fetal heartbeat was muffled, rhythmic – 144 per minute. Bleeding of genital tract was in a volume of 50 ml. Clinical diagnosis was pregnancy of 36 weeks+4 days.

The myomectomy was performed by means of a 5.5-mm Karl-Storz (Tuttlingen, Germany) continuous flow office hys- teroscope under local anesthesia using a paracervical block. The formations were resected by means of a rigid scissors and forceps and submitted for histopathologic examination. When resection was not possible during the diagnostic hys- teroscopy, in cases with multiple myomas, and in those with residual lesions or myomas >3 cm in diameter, the patient was scheduled for operative hysteroscopic examination under general anesthesia.

**Result**

It was diagnosed total premature detachment of the normally located placenta, uterine leiomyoma. The patient urgently underwent cesarean section, during which a live premature fetus weighing 2530, 46 cm tall was extracted for the head with

Apgar score of 7-8 points, then – supravaginal amputation of the uterus without appendages.

Intraoperative blood loss was 700 ml. The resulting macropreparation was presented by uterine body, submucous node of 10x10 mm on a wide base was determined along the back wall in the bottom on the left, there was a partially placental site on the node (Figure 1). The postoperative period (early and late) proceeded without complications, the patient with the child were discharged from hospital on the 7th day.

After a detailed history and thorough clinical examination, all of the patients received a complete infertility workup including semen analysis, assessment of ovulation by midlu- teal serum progesterone level, assessment of ovarian reserve by cycle day 3 serum FSH level, postcoital test (PCT), and hysterosalpingography (HSG). The initial suggestion of diag- nosing submucous myoma was made by HSG for most of the cases within 1 year. Laparoscopy was performed primarly for all patients to assess the pelvis for causes of infertility. Those with pelvic lesions were excluded from the study.

In those with a healthy pelvis, hysteroscopic examination was performed to assess the uterine cavity, confirm the diag- nosis, and assess the characteristics of the myoma including its size, number, location, and type. The classification pro- posed by the European Society of Hysteroscopy (9) was used in our study for identifying the type of leiomyoma by the degree of intramural development. Accordingly, type 0 was defined as the myoma with development limited to the uterine cavity (pedunculated myoma), type I was defined as the myoma with partial intramural development (endoca- vitary component >50%), and type II was defined as the myoma with predominantly intramural development (endo- cavitary component <50%).

All hysteroscopic examinations were performed by the same surgeon. No hormonal or antihor- monal treatment was given before and after the resection until complete healing had been proven by a “second-look” hysteroscopic examination at the clinician’s office.

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