Introduction
During fertile age, uterine fibroids occur in 30-50% of women, their incidence increases with age. Myomas disrupt the process of implantation and nidation due to deformation of the uterine cavity and also violation of the normal vascular endometrial supply. Submucosal and intramural myomas have a negative impact on fertility. The risk of uterine rupture in pregnancy after laparoscopic myomectomy is less than 1%. In this paper, we present a patient after both laparoscopic and hysteroscopic myomectomy, uterine ruptures in the first pregnancy, but after a live birth in the following pregnancy.

Method
A 36-year-old female patient was treated for sterility in the IVF center and she underwent laparoscopic myomectomy for myomatosus uterus. In January 2014, 4 myomas of 4-5cm in diameter were enucleated by posterior uterotomy from the posterior uterine wall. In November 2014, hysteroscopic endoresection of 4 submucosal myomas with a diameter of 2-3 cm from the posterior wall and uterine edges was performed. In March 2016, the patient underwent insemination in the IVF center and an acute caesarean section was performed in week 33 for hemoperitoneum and acute foetal distress; during this, a uterine rupture in the fundus was detected together with the death of the newborn. In 2018, the patient spontaneously became pregnant and the pregnancy was recorded as a high-risk one. During her pregnancy, the patient was monitored using imaging methods (ultrasonography and nuclear magnetic resonance). Preventively, she was hospitalized from week 28 of her gravidity with a planned C-section at week 32 of the pregnancy.

Results
By means of ultrasonography, the placental localization from the posterior wall reaching the inner gate and suspected for accrete growth was described. T2 Haste, T1fl2d sequences in three planes were made by the magnetic resonance method. Placenta praevia marginalis and the missing myometrium in the area of the uterine fundus and a bulging blanch sac have been described. The pregnancy was terminated by the planned caesarean section at week 30 in a hybrid operating room using prophylactic occlusion of arteriae hypogastricae followed by selective embolization of the arteriae uterinae. A male living newborn was delivered, without any signs of trauma or hypoxia, and was referred to neonatologists. The peroperative finding of dehiscence in the uterine fundus area of 2x2 cm was identical to that of magnetic resonance and ultrasonography.

Conclusion
Since there is not any recommendation for such cases, an individual approach is always necessary. Careful management of care for such risky pregnancies threatening not only the child’s life but also the mother’s one must be carefully considered.