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Uterine fibroids (leiomyomas)

Introduction

This leaflet gives you information about uterine fibroids which may answer some of the questions you might have following the discussion with the specialist.

Fibroids are common, benign (non-cancerous) growths of womb (uterine) muscle. They occur in around 25 in every 100 white women and 50 in every 100 black women. Fibroids do not always cause symptoms, but those that do, account for about one third of all hysterectomy operations.

Different types of fibroids

Fibroids are named depending on where in the womb they lie:

- **Intramural** - are fibroids within the muscle layer of the womb, which give the uterus (womb) a 'globular' feeling when examined (like early pregnancy).
- **Subserosal** - are fibroids that stick out from the outer surface of the uterus. They can grow quite large, but do not affect the size of the womb cavity. Subserosal fibroids are more likely to produce feelings of pressure rather than heavy periods or infertility.
- **Submucous** - are the least common fibroids and are likely to cause fertility problems. Sometimes they grow into the uterus, filling it and even growing out of the cervix.

What symptoms can fibroids cause?

The most common complaints of women with fibroids are feelings of pressure and heavy periods.

- An enlarged womb will put pressure on the bladder, giving you the urge to empty your bladder more often. It can also cause back ache, lower abdominal discomfort and pain when having sexual intercourse.
- Fibroids can cause very heavy periods, leading to a drop in iron levels known as iron-deficiency anaemia.
- About 25 in every 100 women with fibroids have fertility problems, but compared with other causes of infertility, this is fairly uncommon.

How are fibroids investigated?

Fibroids are found during a pelvic examination, when the uterus feels larger than expected with hard round lumps on its surface. An ultrasound scan can tell where the fibroids are located and give an idea of their size. Sometimes fibroids are seen during a laparoscopy (looking into the abdomen with a small telescope) or hysteroscopy (looking into the uterus with a telescope). Hysteroscopy is used for assessing submucous fibroids.

What are the treatment options?

If your fibroids are not causing any symptoms then treatment is not usually needed.

Fibroids which are smaller than the size of a 14 week pregnancy may not need surgery and can be monitored by ultrasound.

It is important to repeat a scan or examination in 6 months to rule out rapid growth (something which would prompt removal).

Women who are near the menopause will often not need surgery as the fibroids will shrink once there is a drop in the level of the hormone oestrogen.

Myomectomy (fibroid removal): If a hysterectomy is not wanted, a myomectomy can be performed. This is usually recommended only for woman who wish to preserve their fertility as there are risks of complications such as bleeding, needing to return to theatre and development of scar tissue which can lead to obstruction of the bowel. A myomectomy is major surgery; the fibroids are carefully removed and the uterus is repaired. It is most useful when there are 1 or 2 large fibroids. Haemorrhage (serious blood loss) from the operation can sometimes happen and in some cases a hysterectomy must be performed as an emergency to control the bleeding.

Hysterectomy (womb removal): This is the most effective treatment for fibroids that are giving symptoms. Most abdominal operations will be carried out through a low ‘bikini-line’ incision (cut), but if the uterus is large, an ‘up-and-down’ vertical incision may be needed.

Hysteroscopic resection: Submucous fibroids which project into the uterine cavity may be treated by passing a telescope into the womb and chipping away at the surface with a hot wire loop (hysteroscopic resection).

This is a day-case procedure avoiding major surgery, but may need to be repeated.

For some smaller submucous fibroids, it may be possible to perform an outpatient procedure using a thin mechanical device passed through a telescope which cuts through the fibroid and removes it. This is performed in the outpatient clinic and you will be able to go home shortly after the procedure.

Uterine Artery Embolisation: This is a procedure (also known as fibroid embolisation) that blocks the arteries which provide blood supply to the fibroids. Patients may have an MRI scan before this procedure to look at the fibroids in more detail.

The procedure is performed by an interventional radiologist (a specially trained doctor who performs minimally invasive procedures) while the patient is awake and usually takes about 2 hours. X-ray images are used to guide a thin tube (catheter) into the artery through the wrist or through a small incision in the groin. Once the artery to the fibroid has been identified, it is blocked off by passing small particles through the catheter to prevent blood flow to the fibroid. This will cause the fibroid to shrink. Over 90 in every 100 women will be relieved of their symptoms after embolisation. Most fibroids will shrink to about half their size after one year.

This procedure requires an overnight stay in hospital and strong pain relief will be given if any moderate pain or cramping is experienced.

Medical treatment

Hormone treatment using drugs called ‘gonadotrophin-releasing hormone analogs’ can shrink fibroids, but they have the side effect of making a woman menopausal, by switching off the ovary’s production of hormones. If this treatment is continued for more than 6 months, there are risks of bone-thinning (osteoporosis) and heart disease, as well as the other uncomfortable symptoms of menopause such as hot flushes, vaginal dryness and psychological symptoms. This treatment is most useful before having surgery. Hormone treatment may be preferred by women near to the menopause who are keen to avoid surgery.

Cancerous change in fibroids

This is something that can happen, but is extremely rare. It is thought to happen in about 1 in every 1,000 women with fibroids. Many cases of fibroids do not cause any problems so are not diagnosed, meaning that this figure must be an overestimation.

Rapid growth of a fibroid in a post-menopausal woman would cause concern and would be surgically removed.

Further information

Women’s Health
Website: www.womens-health.co.uk

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Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you asked to make a choice about your healthcare.



1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation.

***Ask 3 Questions** is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial.

Patient Education and Counselling, 2011;84: 379-85

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NHS **https://aqua.nhs.uk/resources/shared-decision-making-case-studies/**

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