MAVEN CENTRE
ADVANCED GYNAECOLOGY & WOMEN'S HEALTH

Suite 5.3, Level 5,
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Fibroids: patient information

What are fibroids?

Fibroids are non-cancerous overgrowths that arise from the uterine muscle (the 'myometrium'). White, whorled, spherical structures, fibroids vary in size, number and location (in relation to the uterine cavity).

Fibroids are extremely common. About 70% of women will have a fibroid present in their uterus, not all of them symptomatic.

What causes fibroids?

Fibroids grow from a single uterine muscle cell. No-one knows exactly what causes this 'myometrial' cell to develop into a fibroid. Fibroids are hormonally responsive structures, and grow under the influence of the female hormones progesterone and estrogen.

Risk factors for fibroids include:

- A genetic predisposition
- African and / or southeast Asian ethnicity
- Having your first period early < 10yo)
- Not having had any children
- Increasing age, up to menopause
- Higher BMI

Some women do not have any of the above risk factors, yet are still troubled by symptomatic fibroids.

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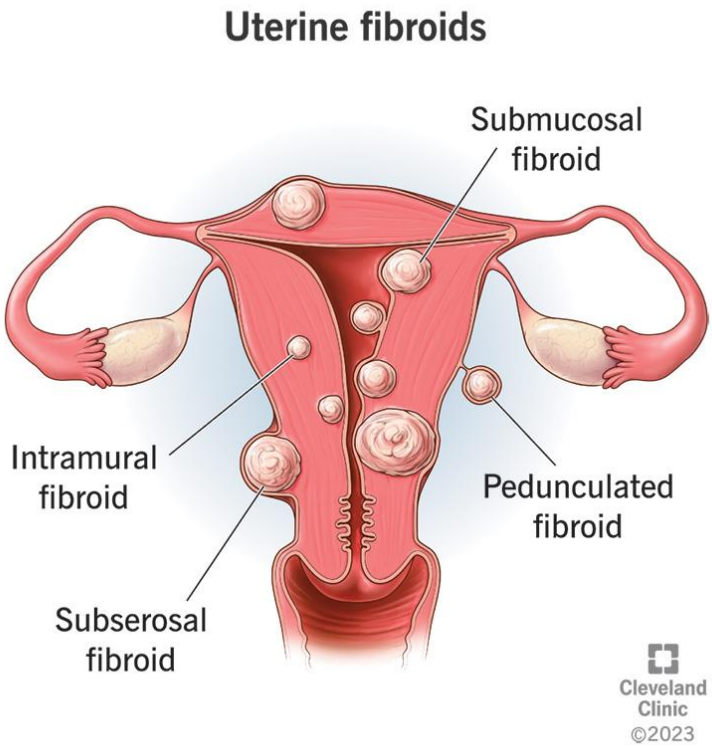
Types of fibroids



Fibroids are described in terms of their location:

- 'Submucosal fibroids' protrude inwards, into the uterine cavity
- 'Intramural fibroids' are centred in the muscular uterine wall itself
- 'Subserosal fibroids' protrude outwards from the outer surface of the uterus

Additional (quite rare) types of fibroids include those located in the cervix or broad ligament. If a fibroid looks like an apple on a stalk, it is described as 'pedunculated'.

What symptoms can fibroids cause?

Fibroids are often asymptomatic. They can cause different symptoms, based on their: number, size, and location (in relation to the uterine cavity). The most common symptoms are:

- Heavy and / or prolonged menstrual bleeding +/- iron deficiency anaemia
- Fertility issues, such as: lower conception rates; lower implantation rates; higher miscarriage rates; and technical difficulties at egg pick-up during IVF. Fibroids are thought to be the main causal factor in only 2% of women with infertility.
- Obstetric issues, such as: poor fetal growth; baby lying in 'breech', 'transverse' or 'oblique' position; premature birth; failure to progress during labour; and severe bleeding after birth
- Pressure symptoms, which include: abdominal distension / bloating; having to urinate more often; and constipation
- Severe rare symptoms, such as: blocking the ureters (the tubes from the kidneys to the bladder); painful sex; and blood clots forming in the pelvic veins

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How are fibroids investigated?

Fibroids can be suspected by a doctor feeling your tummy: they may feel an enlarged uterus, or even distinct subserosal fibroids.

To determine how many fibroids are present, their size and location, a transvaginal ultrasound is needed. This information guides management, including the surgical approach (if relevant). In specific situations (eg. if there are numerous huge fibroids), an MRI may be suggested.

If you have significant heavy bleeding, blood tests (such as a haemoglobin level and iron studies) may be suggested. If you have heavy menstrual bleeding and are ≥ 45yo, your gynaecologist may suggest having a biopsy of the uterine lining, in order to exclude any other causes of heavy periods.

Management of fibroids

Management of fibroids is very individualised, and is guided by:

- Your symptoms
- How long it is until menopause is likely to occur (average age is 51yo)
- Whether or not you are trying to conceive
- Whether or not you have completed your family

<u>Minimal symptoms and / or approaching menopause</u>

If your fibroids aren't causing any significant symptoms, they don't necessarily need any management at all: only you can be the judge of this. Annual ultrasound and gynaecological review could be considered.

Fibroids tend to shrink down after menopause. So, if you are approaching menopause and have mild symptoms, you may choose a 'watch and wait' approach.

<u>Heavy periods and you are trying to conceive</u>

If you are actively trying to conceive, hormonal options (which are all contraceptive) are not appropriate. Hence, appropriate non-hormonal options include:

- Iron supplementation, with tablets +/- an iron infusion (through an intravenous drip)
- Tranexamic acid, which is a medication you only take during your period. This has been shown to lighten periods by approximately 40%
- Hysteroscopic myomectomy: please see details below, in the 'Surgical options' section below

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Heavy periods, not trying to conceive at present, but want to in future

If you are troubled by fibroid-related heavy menstrual bleeding, and want to conceive at some stage in future, appropriate options include:

- Combined oral contraceptive Pill, which can lighten periods by approximately 50%
- Insertion of a progesterone-only ('Mirena') intrauterine device (IUD), which lightens peirods by approximately 80%. If your fibroids are submucosal, and distort the uterine cavity, your gynaecologist may need to perform a hysteroscopic myomectomy prior to inserting your IUD: see details below, in the 'Surgical options' section below
- Myomectomy: an operation to remove your fibroid(s), while retaining your uterus. Please see details in the 'Surgical options' section below

Fertility and / or obstetric issues, and want to conceive in future

Only submucosal and intramural fibroids (which are causing distortion of the uterine cavity) lead to fertility and / or obstetric issues. If this is the case for you, a myomectomy (operation to remove your fibroids, while retaining your uterus) may help to improve your fertility and / or obstetric outcomes in future. Please see details in the 'Surgical options' section below.

Pressure symptoms and want to have children

If your main symptoms are pressure symptoms (abdominal distension, urinary frequency, and / or constipation), and you want to conceive at some stage, appropriate options include:

- GnRH agonist medications, such as 'Zoladex' monthly injection or 'Synarel' nasal spray. These medications turn off your ovaries, and put you into a temporary menopause. In this context, they are used for 3 – 6 months to shrink the fibroids (by approximately 50%), prior to having a myomectomy (an operation to remove the fibroids but retain the uterus – please see details in the 'Surgical options' section below).
- Myomectomy operation to remove fibroid(s), while retaining the uterus: please see 'Surgical options' section below

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If your family is complete

There are several management options for fibroids that are only appropriate if your family is complete. For example:

- Endometrial ablation, which is when the uterine lining in burned. This is performed under general anaesthetic, and (in the context of fibroids) would be combined with a hysteroscopic myomectomy +/- Mirena IUD insertion
- Uterine artery embolisation (UAE), which is a procedure performed by interventional radiologists. The aim is to block the blood supply to the fibroids, causing them to slowly die and shrink. UAE leads to a 40% reduction in uterine size; 80% of patients with fibroid-related heavy periods have lighter periods as a result of UAE
- Hysterectomy, which is an operation to remove the uterus. Please see details in the 'Surgical options' section below

Surgical options

Surgical options to manage fibroids include:

- Myomectomy, which removes the fibroid(s), but retains the uterus
- Hysterectomy, which removes the uterus and fibroids together

Surgical excision is the only way to confirm that your fibroids are non-cancerous: it allows the pathology doctor to look at your fibroid(s) under the microscope, to confirm that they are benign.

Myomectomy

'Myomectomy' means surgical cutting out of a fibroid: the uterus is left inside. There are various approaches that gynaecologists can use to perform a myomectomy, including:

- Hysteroscopic myomectomy: when a small (5mm) video camera is inserted through the vagina and cervix, to visualise the submucosal fibroids protruding into the uterine cavity. Various surgical devices can then be used to shave down the fibroid(s), to normalise the uterine cavity.
- Laparoscopic myomectomy: when keyhole surgery is used to remove your fibroids
- Open (abdominal) myomectomy: when a single large (10 – 15cm) cut is made in your tummy

Gynaecologists take many factors into account to guide this decision, such as: the size and number of your fibroids; the location of your fibroid(s); and your gynaecologist's surgical skills and expertise. This is a very individualised discussion, based on your particular circumstances.

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Hysterectomy

Hysterectomy is the permanent surgical removal of the uterus (and fibroids contained therein). Hysterectomy is the only 'cure' for fibroids. Hysterectomy can be performed: vaginally; laparoscopically (using keyhole surgery); or abdominally, through a 10-15cm scar in your tummy.
If you are trying to decide between having a myomectomy or a hysterectomy, please discuss the pros and cons with a gynaecologist who can perform both operations. Somewhat counter-intuitively, a laparoscopic hysterectomy is actually a safer operation than a myomectomy.

Frequently asked questions

I have fibroids, but haven't yet tried to fall pregnant. Do I need to do anything about my fibroids?

You won't know if your fibroids are going to impact upon your fertility until you start trying to conceive! So, our general advice would be to start trying to fall pregnant. If you run into any fertility issues, a hysteroscopic myomectomy may be needed.

Is there anything you can do to slow the speed with which fibroids grow?

There is limited evidence that dietary changes (such as optimising green tea intake) may slow the speed with which fibroids grow. However, this will just slow the pace at which your symptoms worsen; it won't actually make your current symptoms any better.

Can fibroids be cancerous?

Very rarely, what is thought to be a fibroid on ultrasound may actually be a cancer of the uterine muscle, called a 'leiomyosarcoma' (or LMS). The odds of your fibroid actually being a cancer increase with age, as follows:

- 1 in 525 (if you are aged between 25 – 34yo)
- 1 in 380 (if you are 35 – 44yo)
- 1 in 250 (if you are 45 – 54yo)
- 1 in 150 (if you are 55 – 64yo)
- 1 in 120 (if you are 65 – 74yo)
- 1 in 100 (if you are 75yo or older)

If you're worried about your 'fibroid' being cancerous, please consult with your gynaecologist about additional testing that can be performed (a 'lactate dehydrogenase' blood test and an MRI). Surgical excision would be needed, to guarantee that your fibroid is not cancerous.

This pamphlet is a general overview of fibroids, and may not apply to everyone.
If you have any further questions, please speak to your gynaecologist.