GYNECOLOGIC PROBLEMS

Uterine Fibroids

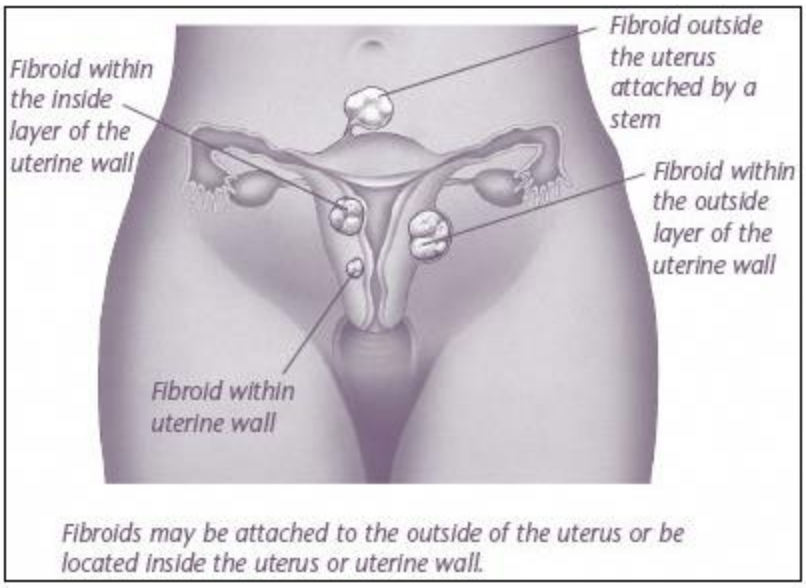
PATIENT EDUCATION

Uterine fibroids are benign (not cancer) growths in the ***uterus***. They are the most common type of growth found in a woman's pelvis. In some women, fibroids remain small and do not cause symptoms or problems. However, in some women, fibroids can cause problems because of their size, number, and location.

This pamphlet will explain

- types and causes of fibroids
- symptoms and complications
- diagnosis and treatment

Types of Fibroids

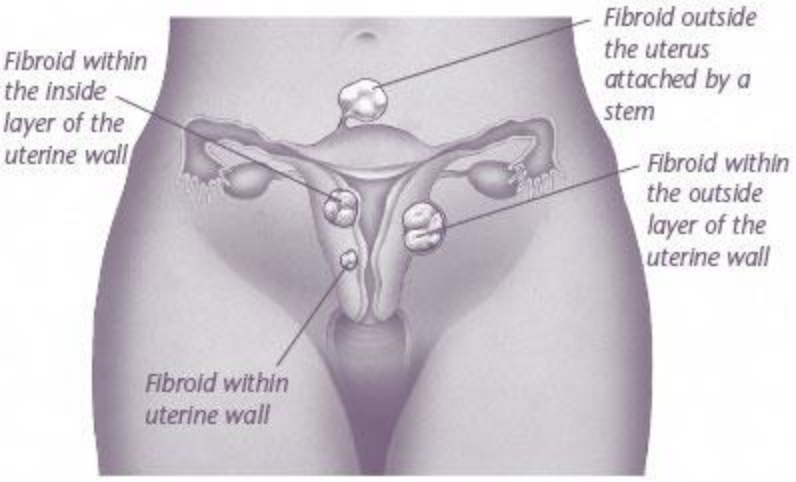


Fibroids may be attached to the outside of the uterus or be located inside the uterus or uterine wall.

Uterine fibroids are growths that develop from the muscle tissue of the uterus. They also are called leiomyomas or myomas.

The size, shape, and location of fibroids can vary greatly. They may be present inside the uterus, on its outer surface or within its wall, or attached to it by a stem-like structure.

Fibroids can range in size from small, pea-sized growths to large, round ones that may be more than 5–6 inches wide. As they grow, they can distort the inside as well as the outside of the uterus. Sometimes fibroids grow large enough to completely fill the pelvis or abdomen.



Fibroids may be attached to the outside of the uterus or be located inside the uterus or uterine wall.

A woman may have only one fibroid or many of varying sizes. Whether fibroids will occur singly or in groups is hard to predict. They may remain very small for a long time, suddenly grow rapidly, or grow slowly over a number of years.

Causes

Fibroids are most common in women aged 30–40 years, but they can occur at any age. Fibroids occur more often in African American women than in white women. They also seem to occur at a younger age and grow more quickly in African American women.

It is not clear what causes fibroids. Some research suggests that they develop from misplaced cells present in the body before birth. The female hormones ***estrogen*** and ***progesterone*** appear to be involved in their growth. Levels of these hormones can increase or decrease throughout a woman's life. For instance, menopause causes a decrease in estrogen. Fibroids often shrink when a woman enters menopause. Hormonal drugs that contain estrogen, such as birth control pills, may cause fibroids to grow.

Symptoms

Fibroids may cause the following symptoms:

- Changes in ***menstruation***
  - Longer, more frequent, or heavy menstrual periods
  - Menstrual pain (cramps)
  - Vaginal bleeding at times other than menstruation
  - ***Anemia*** (from blood loss)

- Pain
  - In the abdomen or lower back (often dull, heavy and aching, but may be sharp)
  - During sex

- Pressure
  - Difficulty urinating or frequent urination
  - Constipation, rectal pain, or difficult bowel movements
  - Abdominal cramps

- Enlarged uterus and abdomen
- Miscarriages
- Infertility

These symptoms also may be signs of other problems. Therefore, you should see your doctor if you have any of these symptoms.

Fibroids also may cause no symptoms at all. Fibroids may be found during a routine ***pelvic exam*** or during tests for other problems.

Complications

Although most fibroids do not cause problems, there can be complications. Fibroids that are attached to the uterus by a stem may twist and can cause pain, nausea, or fever. Fibroids that grow rapidly, or those that start breaking down, also may cause pain. Rarely, they can be associated with cancer.

A very large fibroid may cause swelling of the abdomen. This swelling can make it hard to do a thorough pelvic exam.

Fibroids also may cause infertility, although other causes are more common. Other factors should be explored before fibroids are considered the cause of a couple's infertility. When fibroids are thought to be a cause, many women are able to become pregnant after they are treated.

Diagnosis

The first signs of fibroids may be detected during a routine pelvic exam. A number of tests may show more information about fibroids:

- ***Ultrasonography*** uses sound waves to create a picture of the uterus and other pelvic organs.
- ***Hysteroscopy*** uses a slender device (the hysteroscope) to see the inside of the uterus. It is inserted through the vagina and cervix (opening of the uterus). This permits the doctor to see fibroids inside the uterine cavity.
- ***Hysterosalpingography*** is a special X-ray test. It may detect abnormal changes in the size and shape of the uterus and fallopian tubes.
- ***Sonohysterography*** is a test in which fluid is put into the uterus through the cervix. Ultrasonography is then used to show the inside of the uterus. The fluid provides a clear picture of the uterine lining.
- ***Laparoscopy*** uses a slender device (the laparoscope) to help the doctor see the inside of the abdomen. It is inserted through a small cut just below or through the navel. The doctor can see fibroids on the outside of the uterus with the laparoscope.

Imaging tests, such as magnetic resonance imaging and computed tomography scans, may be used but are rarely needed. Some of these tests may be used to track the growth of fibroids over time.

Uterine Fibroids and Pregnancy

A small number of pregnant women have uterine fibroids. If you are pregnant and have fibroids, they likely will not cause problems for you or your baby.

During pregnancy, fibroids may increase in size. Most of this growth occurs from blood flowing to the uterus. Combined with the extra demands placed on the body by pregnancy, the growth of fibroids may cause discomfort, feelings of pressure, or pain. Fibroids can increase the risk of

- miscarriage (in which the pregnancy ends before 20 weeks)
- preterm birth

Treatment

Fibroids that do not cause symptoms, are small, or occur in a woman who is nearing menopause often do not require treatment. Certain signs and symptoms may signal the need for treatment:

- Heavy or painful menstrual periods that cause anemia or that disrupt a woman's normal activities
- Bleeding between periods
- Uncertainty whether the growth is a fibroid or another type of tumor, such as an ovarian tumor
- Rapid increase in growth of the fibroid
- Infertility
- Pelvic pain

There are many treatment options for fibroids. The choice of treatment depends on factors such as your own wishes and your doctor's medical advice about the size and location of the fibroids.

- breech birth (in which the baby is born in a position other than head down)

Rarely, a large fibroid can block the opening of the uterus or keep the baby from passing into the birth canal. In this case, the baby is delivered by ***cesarean birth***. In most cases, even a large fibroid will move out of the fetus's way as the uterus expands during pregnancy. Women with large fibroids may have more blood loss after delivery.

Often, fibroids do not need to be treated during pregnancy. If you are having symptoms such as pain or discomfort, your doctor may prescribe rest. Sometimes a pregnant woman with fibroids will need to stay in the hospital for a time because of pain, bleeding, or threatened preterm labor. Very rarely, myomectomy may be performed in a pregnant woman. Cesarean birth may be needed after myomectomy. Fibroids decrease in size after pregnancy in most cases.

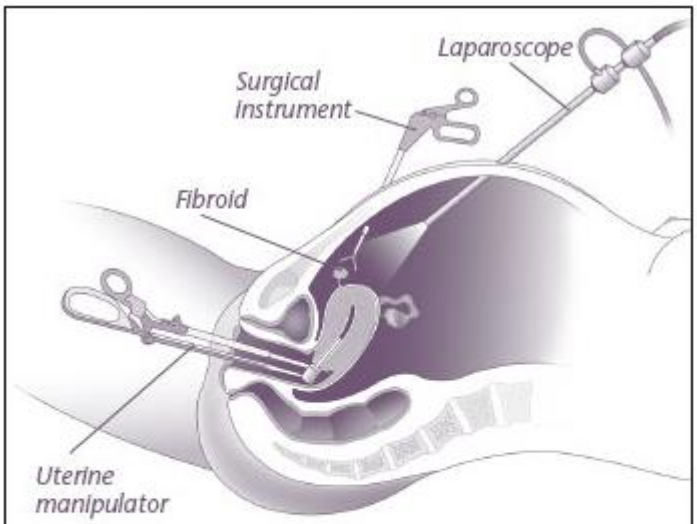
Medications

Drug therapy is an option for some women with fibroids. Medications may reduce the heavy bleeding and painful periods that fibroids sometimes cause. But, they may not prevent the growth of fibroids. Surgery often is needed later. Drug treatment for fibroids includes the following options:

- Birth control pills and other types of hormonal birth control methods—These drugs often are used to control heavy bleeding and painful periods. A drawback is that this treatment may cause the fibroids to increase slightly in size. For some women, the benefits of hormonal contraception outweigh the risk of this side effect.
- Gonadotropin-releasing hormone (GnRH) agonists—These drugs stop the menstrual cycle and can shrink fibroids. They sometimes are used before surgery to reduce the risk of bleeding. GnRH agonists have many side effects, including bone loss, ***osteoporosis***, vaginal dryness, and night sweats. For these reasons, they are used only for short periods (less than 6 months). After a woman stops taking a GnRH agonist, her fibroids usually return to their previous size.
- ***Progestin***–releasing ***intrauterine device***. This option is for women with fibroids that do not distort the inside of the uterus. It reduces heavy and painful bleeding but does not treat the fibroids themselves.

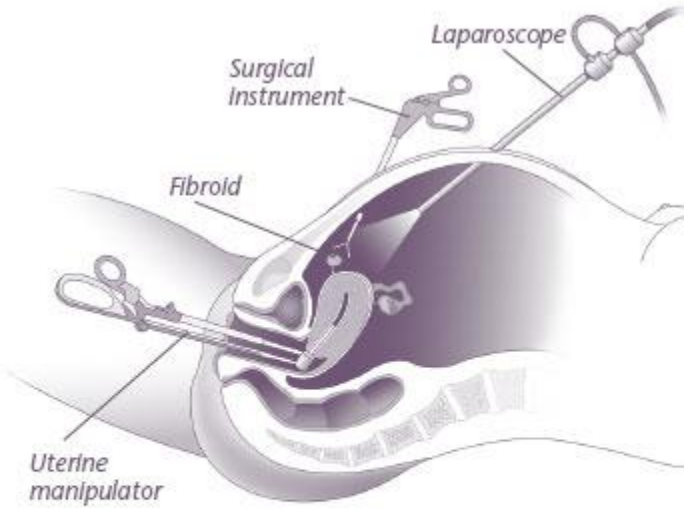
In addition to these drugs, many others are being studied for the treatment of fibroids.

Myomectomy



In myomectomy, fibroids are surgically removed. Shown here is a laparoscopic myomectomy, in which small cuts are made in the abdomen. A laparoscope is used to view the inside of the pelvis. Other instruments are used to remove the fibroids. Other ways to perform myomectomy are with laparotomy or hysteroscopy.

Myomectomy is the surgical removal of fibroids while leaving the uterus in place. Because a woman keeps her uterus, she may still be able to have children. If a woman does become pregnant after a myomectomy, the baby may need to be delivered by cesarean birth. Sometimes, though, a myomectomy causes internal scarring that can lead to infertility.



In myomectomy, fibroids are surgically removed. Shown here is a laparoscopic myomectomy, in which small cuts are made in the abdomen. A laparoscope is used to view the inside of the pelvis. Other instruments are used to remove the fibroids. Other ways to perform myomectomy are with laparotomy or hysteroscopy.

Fibroids do not regrow after surgery, but new fibroids may develop. If they do, more surgery may be needed.

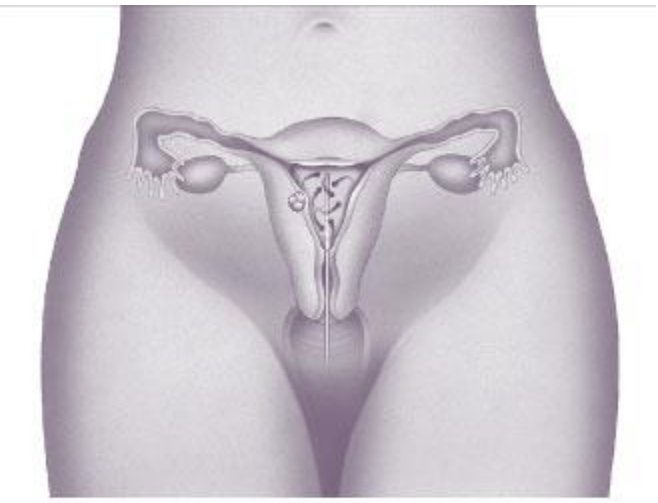
Myomectomy may be done in a number of ways:

- ***Laparotomy***
- Laparoscopy
- Hysteroscopy

The method used depends on the location and size of the fibroids. In laparotomy, an incision (cut) is made in the abdomen. The fibroids are removed through the incision. In laparoscopy, a laparoscope is used to view the inside of the pelvis. Other tools are inserted through another small incision to remove the fibroids.

Hysteroscopy can be used to remove fibroids that protrude into the cavity of the uterus. A ***resectoscope*** is inserted

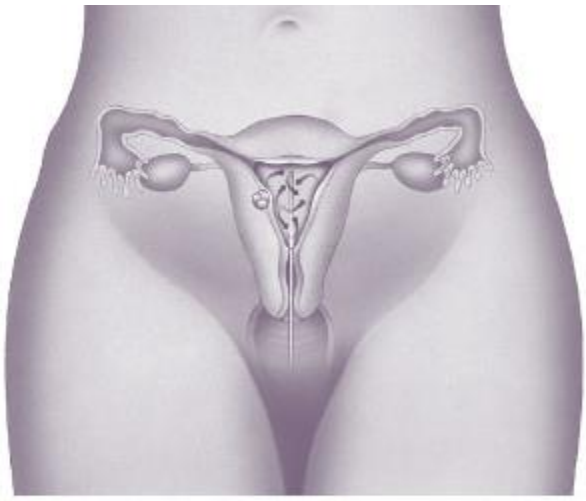
through the hysteroscope. The resectoscope destroys fibroids with electricity or a laser beam. Although it cannot remove fibroids deep in the walls of the uterus, it often can control the bleeding these fibroids cause. In most cases, an overnight stay in the hospital is not necessary.



Endometrial ablation. *For small* (less than 3 centimeters) *fibroids inside the uterus, uterine ablation may be an option. Shown here is one method that is used. A balloon is inserted into the uterus and is heated. The heat destroys the uterine lining, along with the fibroids.*

Myomectomy has risks, including bleeding and infection. Hysteroscopy may cause other problems related to the use of fluid during the procedure. Your doctor can explain all of the risks to you.

Endometrial Ablation



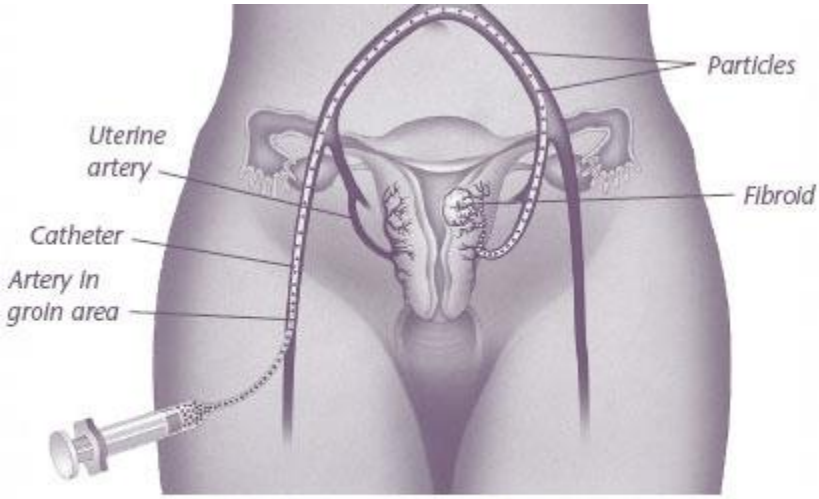
Endometrial ablation. *For small* (less than 3 centimeters) *fibroids inside the uterus, uterine ablation may be an option. Shown here is one method that is used. A balloon is inserted into the uterus and is heated. The heat destroys the uterine lining, along with the fibroids.*

Endometrial ablation destroys the lining of the uterus. It is used to treat women who have heavy menstrual periods. This treatment also is used to treat women with small (less than 3centimeters) fibroids.

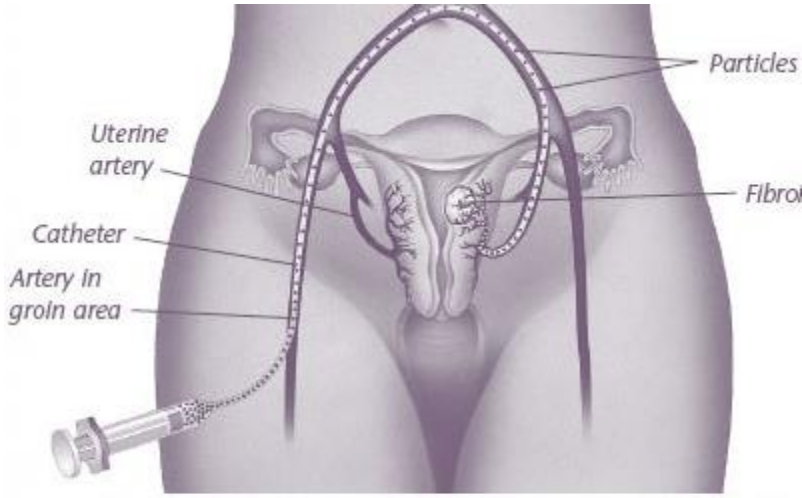
There are several ways to perform endometrial ablation. Most of them use some form of energy, such as heat, to destroy the uterine lining. Not all of the methods are used to treat fibroids. Two commonly used methods are the heated balloon and a method using microwave energy.

Risks of endometrial ablation include bleeding and infection. The device used to destroy the lining of the uterus may pass through the uterine wall or bowel, although this rarely happens. Most women are not able to get pregnant after they have this procedure.

Uterine Artery Embolization



Uterine artery embolization (UAE). In UAE, small particles are inserted into the uterine arteries. The particles stop the flow of blood to the fibroids, causing them to shrink.



Uterine artery embolization (UAE). In UAE, small particles are inserted into the uterine arteries. The particles stop the flow of blood to the fibroids, causing them to shrink.

Another way to treat fibroids is called uterine artery embolization (UAE). In this procedure, the blood vessels to the uterus are blocked, stopping the blood flow that allows fibroids to grow.

This procedure usually is performed by a specially trained radiologist. In some cases, it is done as an outpatient procedure. In other cases, you may need to spend a night in the hospital.

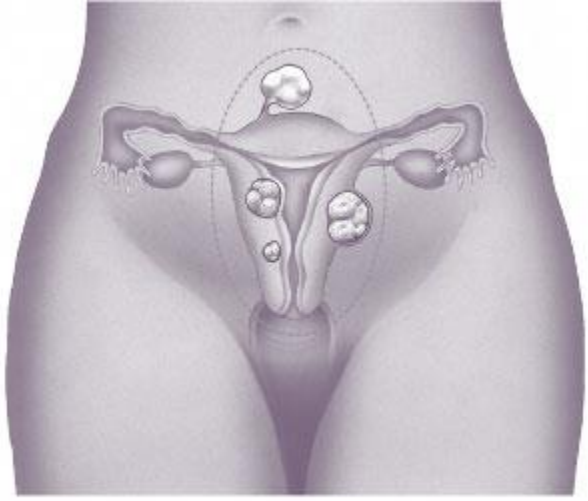
A small incision (cut) is made in your groin area. A tube called a catheter is passed through the large artery there until it reaches the small arteries that supply the uterus with blood. Tiny particles (about the size of grains of sand) are injected through the catheter into these arteries. The particles cut off the blood flow to the fibroid and cause it to shrink. The procedure works even if you have more than one fibroid.

Many women have cramping for a few hours after the procedure. Some women have nausea or fever. Medicine often can help treat these symptoms.

Complications are not common and include infection and uterine injury. Most women will resume regular menstrual periods shortly after the procedure. In about 40% of women older than 50 years who have UAE, menstrual periods do not return.

The effect of UAE on future pregnancies is not clear. Women who have had UAE may be at greater risk for ***placenta*** problems during pregnancy. Women who want to have children may want to consider other forms of treatment.

Hysterectomy



Hysterectomy. For very large fibroids that do not respond to other treatments, hysterectomy—removal of the uterus—may be done.

Hysterectomy is the removal of the uterus. The ovaries may or may not be removed. For this procedure, the uterus may be removed through an incision (cut) in the abdomen or through the vagina. The method used depends on the size of the fibroids. For pain relief, you may be given general anesthesia, which puts you to sleep, or regional anesthesia, which blocks out feeling in the lower part of your body. You may need to stay in the hospital for a few days after this procedure.

Hysterectomy may be needed if

- pain or abnormal bleeding persists
- fibroids are very large
- other treatments are not possible

If your doctor thinks you need a hysterectomy, he or she will first rule out other problems with the uterus, such as diseases of the uterine lining. A woman is no longer able to have children after having a hysterectomy.

Magnetic Resonance Imaging–Guided Ultrasound Surgery

In this new approach, ultrasound waves are used to destroy fibroids. The waves are directed at the fibroids through the skin with the help of magnetic resonance imaging. Studies show that women have improved symptoms up to 1 year after having the procedure. Whether this approach provides long-term relief is currently being studied.

Finally...

Uterine fibroids are benign growths that occur quite often in women. Fibroids may cause no symptoms and require no treatment. Sometimes, however, they need to be treated.

If you have uterine fibroids or have had them in the past, you should be checked by your doctor on a regular basis. Getting regular checkups and being alert to warning signs will help you be aware of changes that may require treatment.

Glossary

Anemia: Abnormally low levels of blood or red blood cells in the bloodstream. Most cases are caused by iron deficiency, or lack of iron.

Cesarean Birth: Delivery of a baby through an incision made in the mother's abdomen and uterus.

Estrogen: A female hormone produced in the ovaries.

Hysterosalpingography: A special X-ray procedure in which a small amount of fluid is injected into the uterus and fallopian tubes to detect abnormal changes in their size and shape or to determine whether the tubes are blocked.

Hysteroscopy: A surgical procedure in which a slender, light-transmitting telescope, the hysteroscope, is used to view the inside of the uterus or perform surgery.

Intrauterine Device: A small device that is inserted and left inside the uterus to prevent pregnancy.

Laparoscopy: A surgical procedure in which a slender, light-transmitting telescope, the laparoscope, is used to view the pelvic organs or perform surgery.

Laparotomy: A surgical procedure in which an incision is made in the abdomen.

Menstruation: The monthly discharge of blood and tissue from the uterus that occurs in the absence of pregnancy.

Osteoporosis: A condition in which the bones become so fragile that they break more easily.

Pelvic Exam: A physical examination of a woman's reproductive organs.

Placenta: Tissue that provides nourishment to and takes away waste from the fetus.

Progesterone: A female hormone that is produced in the ovaries and that prepares the lining of the uterus for pregnancy.

Progestin: A synthetic form of progesterone that is similar to the hormone produced naturally by the body.

Resectoscope: A slender telescope with an electrical wire loop or rollerball tip used to remove or destroy tissue inside the uterus.

Sonohysterography: A procedure in which fluid is put into the uterus and ultrasonography is used to view the inside of the uterus.

Ultrasonography: A test in which sound waves are used to examine internal structures. During pregnancy, it can be used to examine the fetus.

Uterus: A muscular organ located in the female pelvis that contains the developing fetus during pregnancy.

This Patient Education Pamphlet was developed by the American College of Obstetricians and Gynecologists. Designed as an aid to patients, it sets forth current information and opinions on subjects related to women's health. The average readability level of the series, based on the Fry formula, is grade 6–8. The Suitability Assessment of Materials (SAM) instrument rates the pamphlets as “superior.” To ensure the information is current and accurate, the pamphlets are reviewed every 18 months. The information in this pamphlet does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice, may be appropriate.

ISSN 1074-8601

To reorder Patient Education Pamphlets in packs of 50, please call 800-762-2264 or order online at sales.acog.org.

The American College of Obstetricians and Gynecologists
409 12th Street, SW

PO Box 96920
Washington, DC 20090-6920

45/321