Heavy menstrual bleeding/Fibroids

Miss Sanjay Kumari

Consultant Gynaecologist

Barnet Hospital &

Spire Bushey Hospital/ BMI Kings Oak/ Portland Hospital

HMB

- 1 in 20 women 30-49 consult GP (1.5 million)
- 20 percent of referrals

Case scenarios

- 36 years old, Para 2, menorrhagia for 6 months.
- 46 years old, Para 2, menorrhagia, Occasional IMB
- 25 years old, nulliparous, past PCOS, had Mefenamic/ Tx A 6 months, trying to conceive

No suspicion of structural or histological abnormality start Rx unless IUS

If yes examination, scan

Palpable fibroids, uterine length more than 12 cm- refer her

Lab tests Only HB No need for ferritin, TFT, female sex hormones, Von Willebrand's

Causes

- None
- Fibroids
- Adenomyosis
- Polyps
- Infection
- Precancerous
- Haematological

Investigations

- EB
- Scan
- Hysteroscopy?

Referral ?

Case history

29 years old with small fibroid 2.5 cm in size, had outpatient hysteroscopy and Mirena insertion at GP surgery 3 months ago.

Fibroids less than 3 cm in diameter or no fibroids

- Pharmaceutical treatment should be considered where no structural or histological abnormality is present, or for fibroids less than 3 cm in diameter which are causing no distortion of the uterine cavity.
- The healthcare professional should determine whether hormonal contraception is acceptable to the woman before recommending treatment (for example, she may wish to conceive).
- If history and investigations indicate that pharmaceutical treatment is appropriate and either hormonal or non-hormonal treatments are acceptable, treatments should be considered in the following order:
- LNG IUS provided long-term (at least 12 months) use is anticipated
- tranexamic acid or NSAIDs or combined oral contraceptives
- norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens.

Fibroids 3 cm or more in diameter

- Offer ulipristal acetate 5 mg (up to 4 courses) to women with heavy menstrual bleeding and fibroids of 3 cm or more in diameter and a haemoglobin level of 102 g per litre or below.
- Consider ulipristal acetate 5 mg (up to 4 courses) for women with heavy menstrual bleeding and fibroids of 3 cm or more in diameter and a haemoglobin level above 102 g per litre.

Ulipristal acetate

- Very common: endometrial thickening, amenorrhoea.
- Common: vertigo, nausea, abdominal pain, hot flushes, headache, fatigue, ovarian cyst, breast pain and tenderness, pelvic pain, musculoskeletal pain, acne, weight increase.
- Less common: dizziness, dry mouth, constipation, anxiety, urinary incontinence, alopecia, dry skin, hyperhidrosis, back pain, uterine haemorrhage, metrorrhagia, genital discharge, oedema, asthenia, increased blood lipids.
- Rare: epistaxis, dyspepsia, flatulence, ruptured ovarian cyst, breast swelling,

Non hysterectomy surgery

Endometrial ablation

- First generation
- Second generation

Newer methods not in use

Endometrial cryotherapy

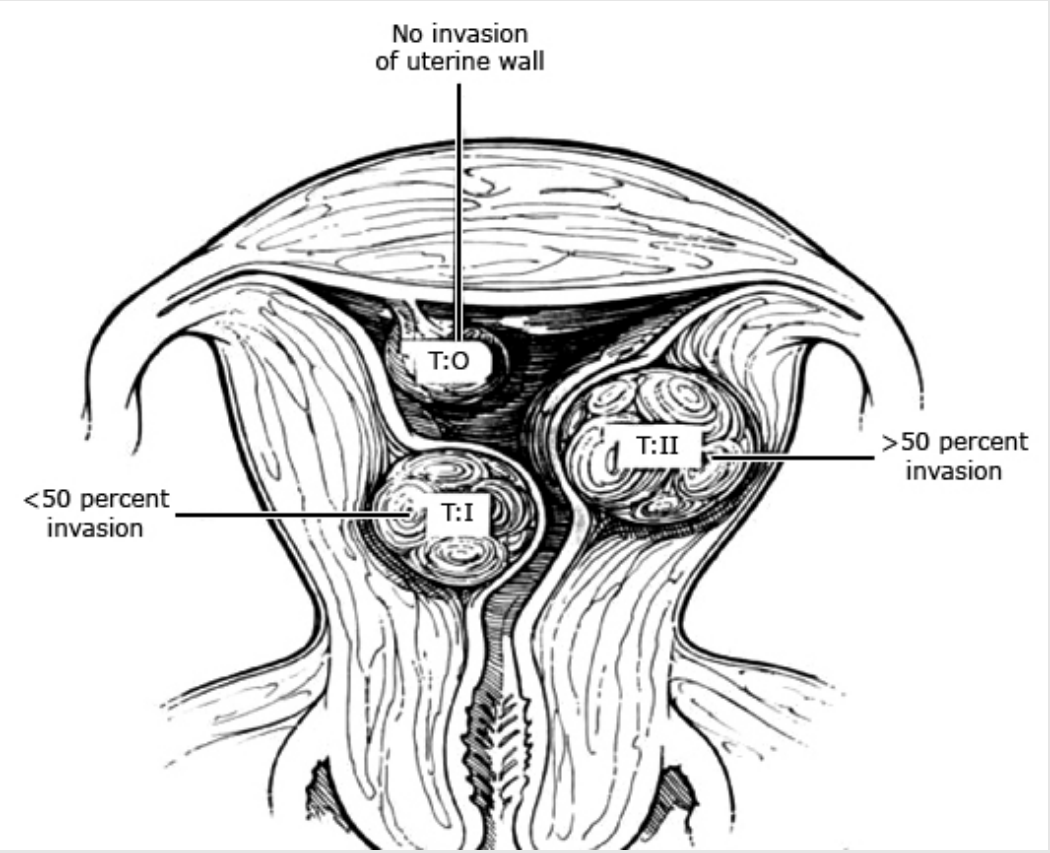
Photodynamic endometrial ablation

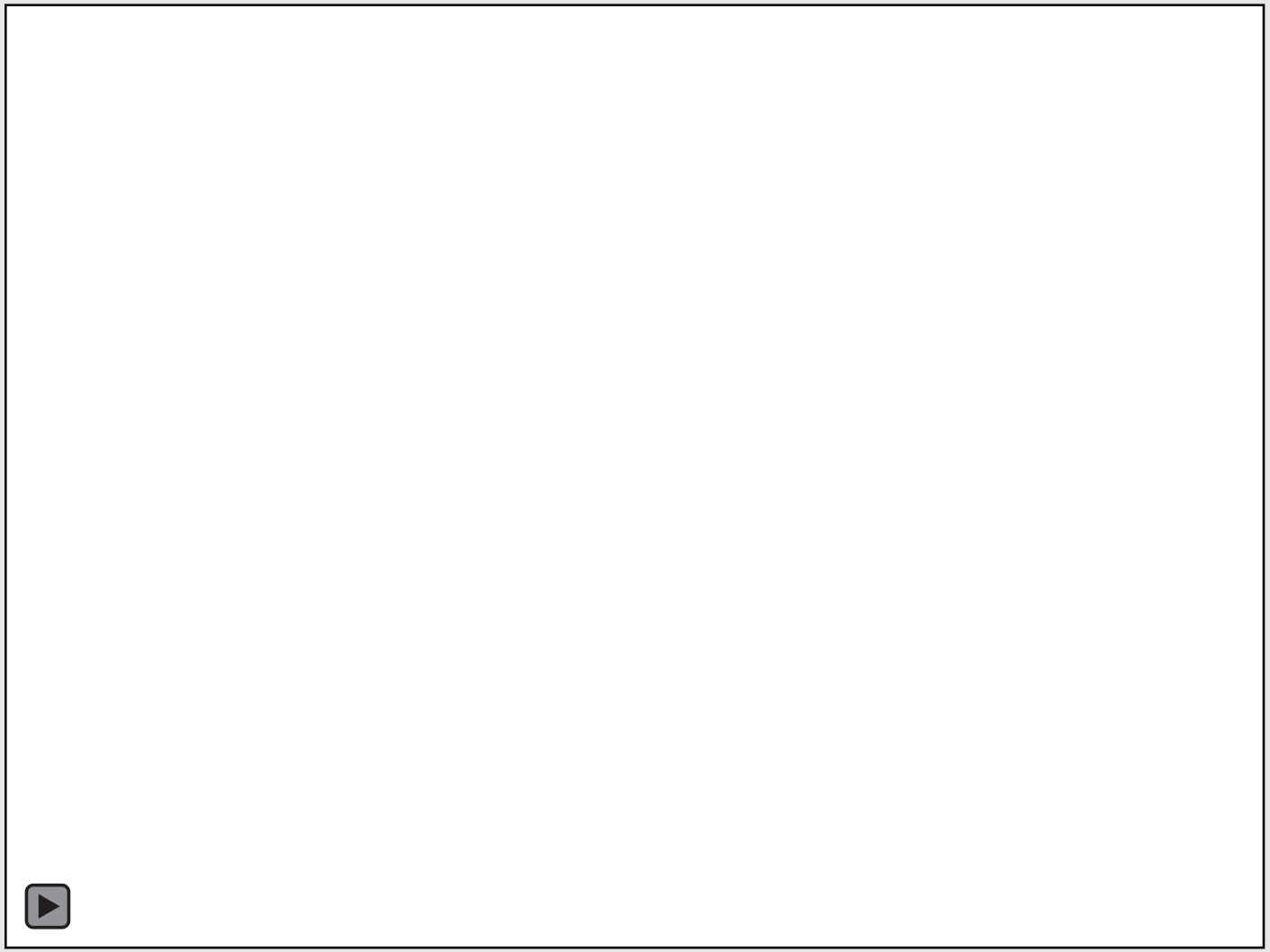
Minimally invasive methods for treatment of fibroids

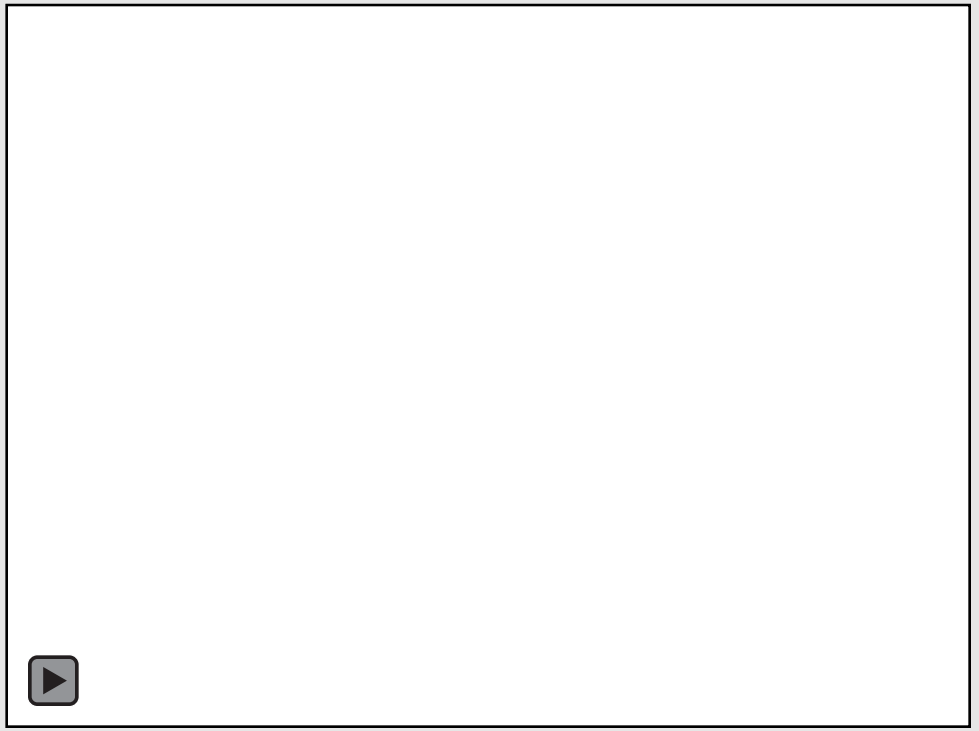
- Transcervical resection of the fibroids (TCRF)
- Hysteroscopic morcellation
- MR guided laser ablation
- Laparoscopic laser myomectomy

- UAE
- MRgFUS

The European hysteroscopic classification of submucous leiomyomas







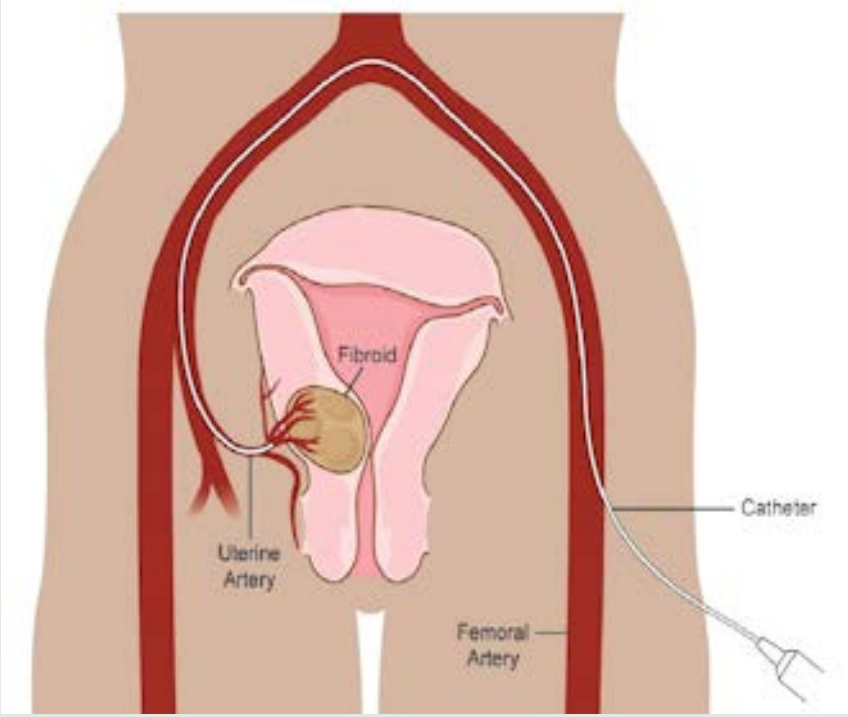
Large fibroids

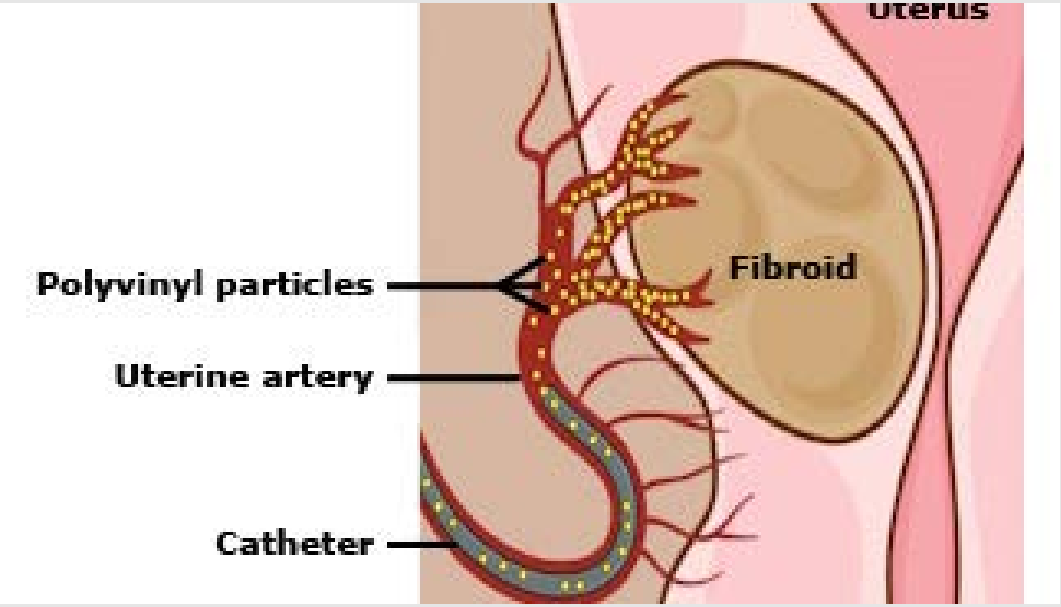
- For women with large fibroids and heavy menstrual bleeding, and other significant symptoms such as dysmenorrhoea or pressure symptoms, referral for consideration of surgery or UAE as first-line treatment can be recommended.
- UAE, myomectomy or hysterectomy should be considered in cases of heavy menstrual bleeding where large fibroids (greater than 3 cm in diameter) are present and bleeding is having a severe impact on a woman's quality of life.
- When surgery for fibroid-related heavy menstrual bleeding is felt necessary then UAE,myomectomy and hysterectomy must all be considered, discussed and documented.
- Women should be informed that UAE or myomectomy may potentially allow them to retain their fertility.
- Myomectomy is recommended for women with heavy menstrual bleeding associated with uterine fibroids and who want to retain their uterus.

UAE

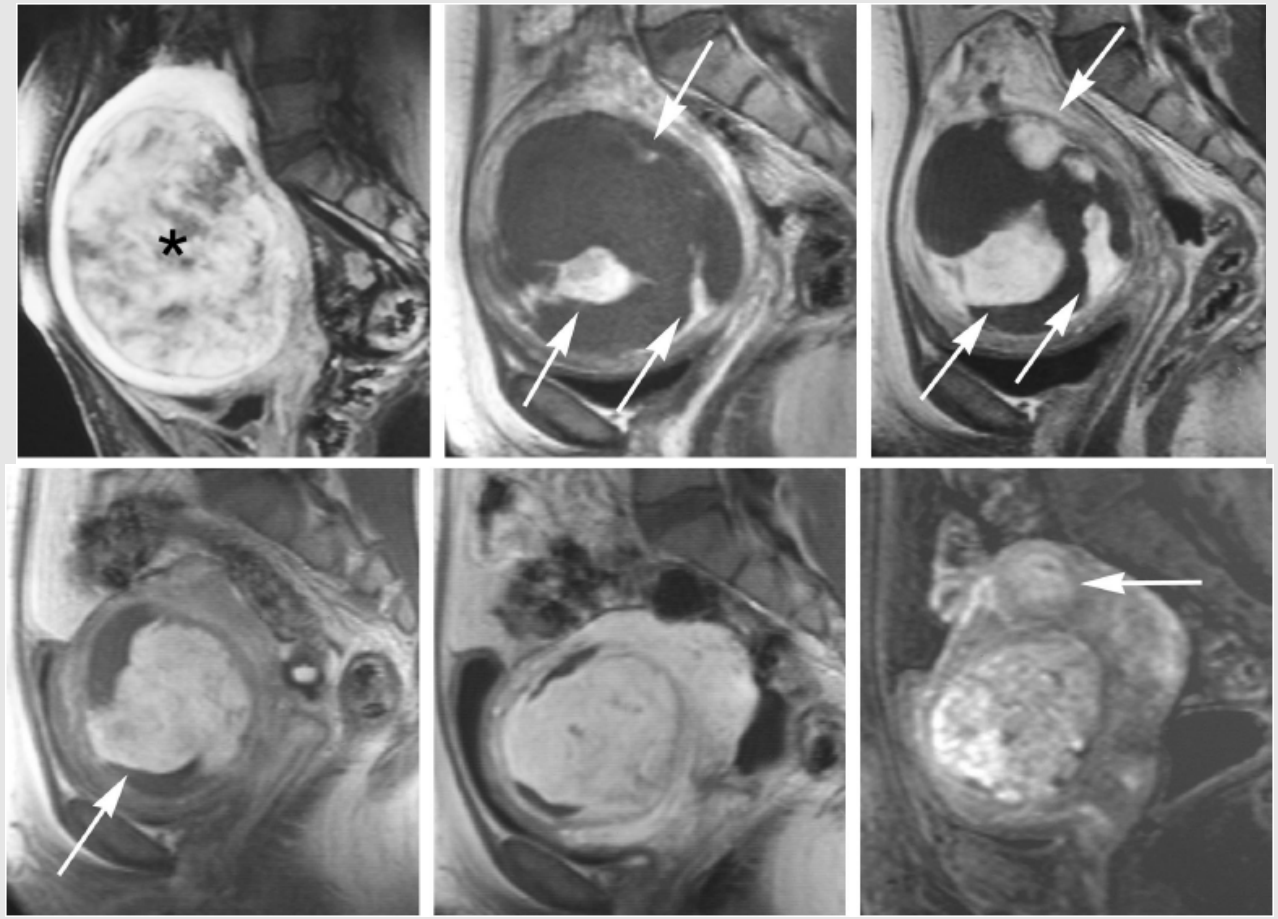
- Current evidence on uterine artery embolisation (UAE) for fibroids shows that the procedure is efficacious for symptom relief in the short and medium term for a substantial proportion of patients. There are no major safety concerns. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance and audit.
- During the consent process patients should be informed, in particular, that symptom relief may not be achieved in some women, that symptoms may return and that further procedures may therefore be required. Patients contemplating pregnancy should be informed that the effects of the procedure on fertility and on pregnancy are uncertain.
- Patient selection should be carried out by a multidisciplinary team, including a gynaecologist and an interventional radiologist.
- NICE encourages further research into the effects of UAE compared with other procedures to treat fibroids, particularly for women wishing to maintain or improve their fertility.

UAE


Fibroid
Uterine Artery
Catheter
Femoral Artery


Uterus
Polyvinyl particles
Fibroid
Uterine artery
Catheter

MRI after UAE



MRgFUS

- Current evidence on the efficacy of magnetic resonance image (MRI)-guided transcutaneous focused ultrasound for uterine fibroids in the short term is adequate, although further treatment may be required and the effect on subsequent pregnancy is uncertain. There are well-recognised complications but the evidence on safety is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance and audit.
- During the consent process clinicians should inform patients that their symptoms may not be relieved, that their symptoms may return, and that further procedures may therefore be required. They should also inform patients about the risk of skin burns. Patients contemplating pregnancy should be informed that the effects of the procedure on fertility and on pregnancy are uncertain.
- Patient selection should be carried out by a multidisciplinary team including a gynaecologist and an appropriate imaging specialist.
- The procedure should only be carried out by clinicians with specific training in this technique.
- NICE encourages further research into the efficacy of MRI-guided transcutaneous focused ultrasound for uterine fibroids. Research studies should report long-term outcomes, including the need for further treatment. Data on the incidence and outcomes of subsequent pregnancy in patients who choose this procedure because they wish to maintain or improve their fertility are particularly important.

Hysterectomy

- Hysterectomy **should not be used** as a first-line treatment solely for heavy menstrual bleeding. Hysterectomy should be considered only when:
- other treatment options have failed, are contraindicated or are declined by the woman
- there is a wish for amenorrhoea
- the woman (who has been fully informed) requests it
- the woman no longer wishes to retain her uterus and fertility.

FAQ-FIBROIDS

Woman with fibroids - Can I take the pill?

Use of low dose oral contraceptives (OCs) does not cause fibroids to grow, therefore administration of these drugs is not contraindicated in women with fibroids

My Aunt has problems with fibroids
Does it run in families ? Can I do any thing to prevent them?

Post menopausal woman with asymptomatic fibroid.

Can I take HRT? Will it Grow?

CASE HISTORY

- 62 years old woman, known fibroids and was started on HRT by GP.
- Presented with some spotting.

- A systematic review including five randomized controlled trials found that postmenopausal hormone therapy was associated with some myoma growth, but this typically occurred without clinical symptoms
- These findings were confirmed in a subsequent prospective study.Thus, the presence of leiomyomas is not a contraindication to use of postmenopausal hormone therapy and postmenopausal hormone therapy does not lead to development of new symptomatic fibroids in most women.

Woman with Subfertility – Please remove my fibroids?

CASE HISTORY

37 years old with asymptomatic fibroids trying to conceive.

CASE HISTORY

- Private patient
- 35 years old, intramural fibroid, had CS few months ago for breech.
- Seen in Portland hospital- booked for myomectomy

Submucosal Fibroids

Meta-analysis of 23 studies that compared infertile women with and without leiomyomas (including one randomized trial) Women with fibroids that were submucosal or intramural with an intracavitary component were less likely to become pregnant (RR 0.36, 95% CI 0.18–0.74) and more likely to have a spontaneous abortion (RR 1.7, 95% CI 1.4–2.1).

Intramural Fibroid?

Myomectomy to prevent miscarriage in future

Is my fibroid responsible for the Miscarriage?

CASE HISTORY

- Postnatal clinic appointment

- Primip 19 weeks pregnant, low lying fibroid with submucous component, ruptured membranes.
- Conservative management- sepsis-miscarried

Is my fibroid going to cause complications in my pregnancy and labour?

- Preterm labour and birth
- APH abruption
- Malpresentation
- Dysfunctional labour
- Increased CS rate
- PPH

Will my fibroid turn cancerous?

Has my fibroid turned cancerous?

CASE HISTORY

- 45 years old known fibroids for 2 years, had few scans, presented with pressure symptoms.
- Was trying to conceive for 1 year.
- Booked for myomectomy.
- Leomyosarcoma

- Complained!

Genetic evidence has been inconsistent over the years regarding whether sarcomas arise de novo or whether there is karyotypic evolution from leiomyomas to sarcomas, so called sarcomatous degeneration.

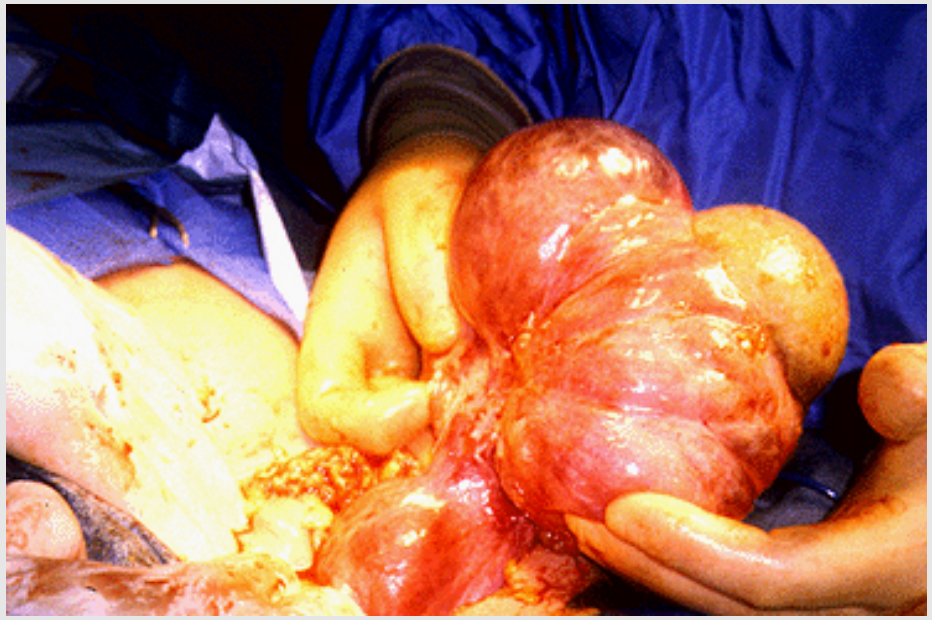
The consensus from genetic studies has been that most sarcomas arise independently .

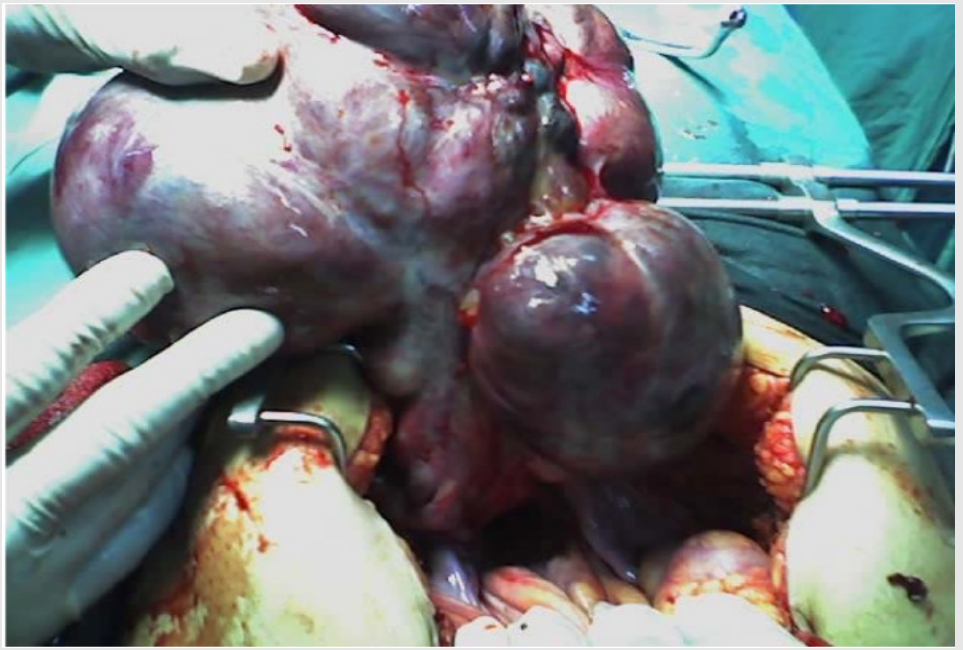
Sarcomas typically have complex karyotypes and aneuploidy, while leiomyomas have characteristic rearrangements, many of which are shared by other benign tumors .

SARCOMA VS. FIBROID

- Difficult to differentiate clinically.
- Large mass not increased risk of sarcoma.
- Rapid growth also does not mean sarcoma.
- Risk factors
  - Post menopausal status
  - Other risk factors
    - Previous pelvic radiation.
    - Familial leiomyomatosis with renal cell cancer

SARCOMA VS. FIBROID





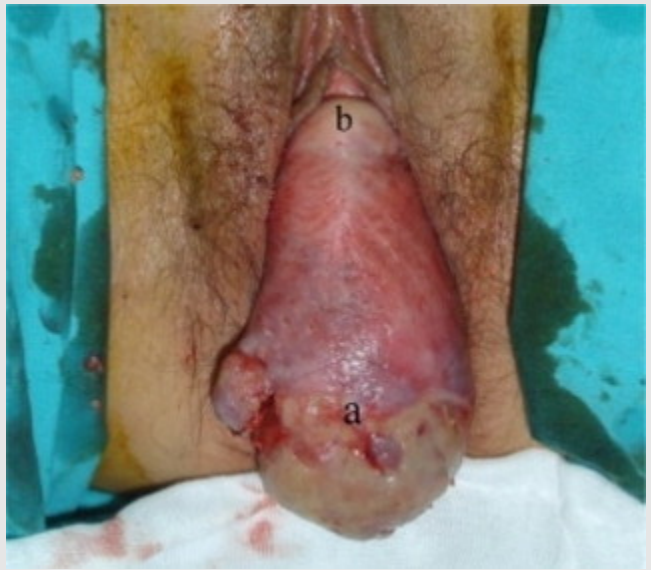
Incidental finding of prolapsing fibroid- What do I do?

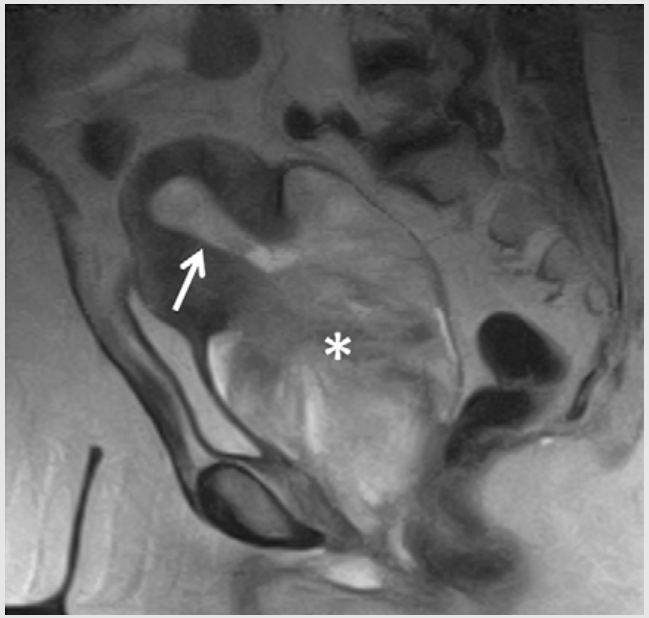
CASE HISTORY

- 38 years old, seen in GOPD with prolapsing fibroid.
- Booked for surgery
- Patient deferred it for 2 weeks.
- Admitted with septicaemia-ITU

CASE HISTORY

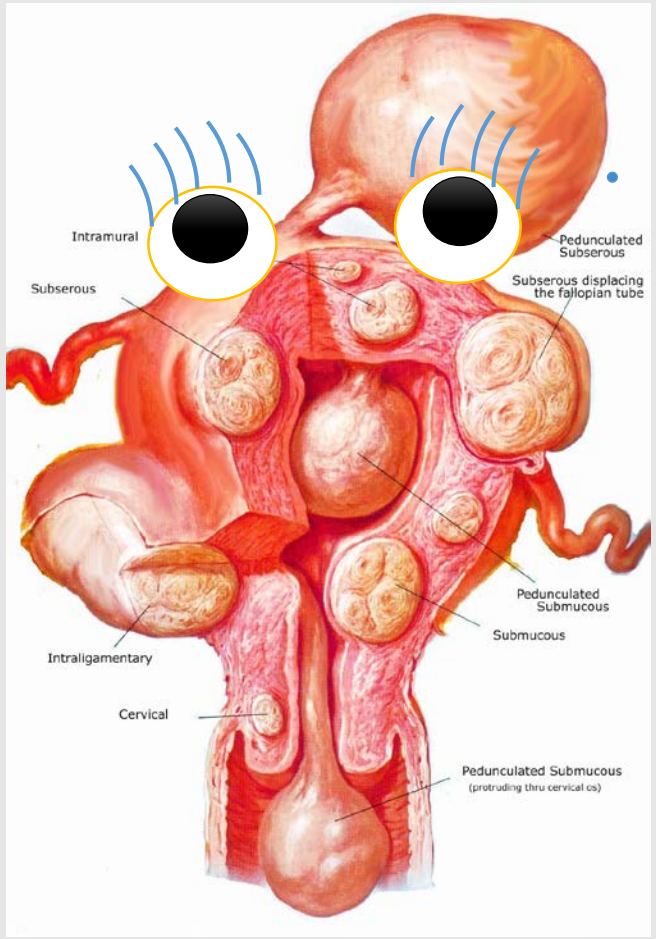
- 30 years old seen in A&E with menorrhagia
- Husband complained that he felt something was there in the vagina.
- Doctors exam?
- Seen in DSU for hysteroscopy 2 weeks later
- Prolapsing fibroid!


b
a


*

Doctor will my fibroid come back ?

Thank you !



I think I need a gynaecologist