

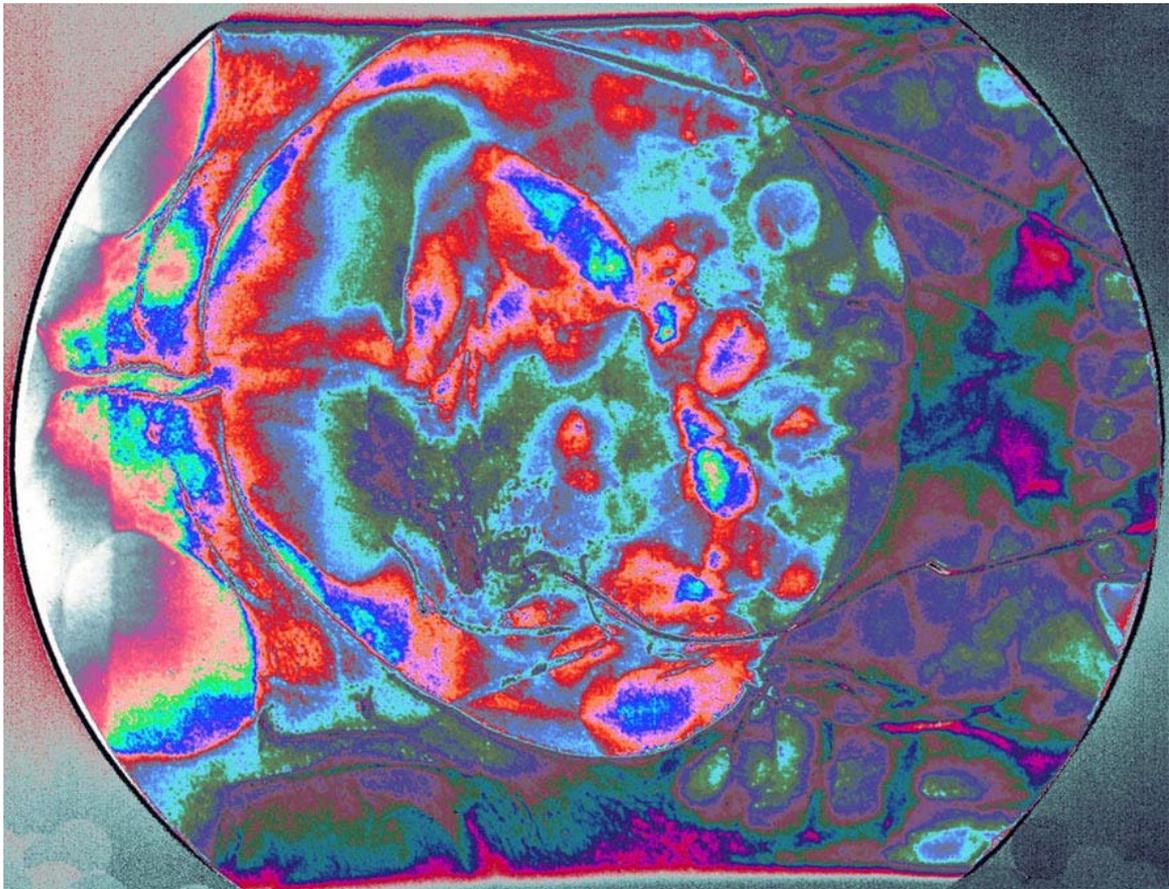
Chapter A1

Fibroid Tumours of the Uterus

What they ARE and What they DO

Fibroid tumours are very common. While they are benign, their impact on a woman's life can be anything but. For many women they cause only minor symptoms or no symptoms at all, but depending on their location, and sometimes size or number, they can cause very heavy menstrual bleeding, clotting and pelvic pain – leading women to seek treatment.

Fibroids often fail to respond to medical drug therapy and then surgical procedures are recommended. Fortunately there are also less invasive options to treat fibroids.



*–True Colours Shining Through–
An artist's impression of a Fibroid angiographic-roadmap
©2003 Jaap Roskam*

A1 Summary

What they ARE – an Overview

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Describes their prevalence, and outlines their location and how this affects the symptoms they can produce.

What they DO – typical Symptoms & possible Complications

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All symptoms are outlined in detail. Pain or pressure, heavy bleeding, and accompanying anaemia, are the most prevalent of these. If you are experiencing any of the described symptoms, you should consult your doctor.

Diagnosis –

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how Fibroids are detected & what Tests are truly necessary

There is a variety of tests available to determine that the presence of fibroids is the cause for your symptoms. Your doctor will first take a medical history and do a pelvic exam. An ultrasound exam is most commonly used to confirm the diagnosis of fibroids – and is reliable and painless.

Mainstream diagnosis and treatment of fibroids involves first a number of exams, mostly followed by an advise for hysterectomy, even if malignant processes are not determined. A few of these procedures are rapidly becoming obsolete for most cases, and patients should be well informed about both this and all available treatment.

Note

*As most physicians will have their favourite treatment that they will recommend, the information in this and the next chapter (*More about Fibroids – your Questions Answered*) will give you, in a way, a ‘second opinion’ and prepare you for making the best choice for treatment of your fibroids.*

Appropriate treatment may depend on location and sometimes size of the fibroids, or the severity of symptoms – but hysterectomy is in the large majority of cases not necessary and less invasive treatment can successfully eliminate symptoms and restore quality of life, with a minimum of risk.

What they ARE – An Overview

Describes their prevalence, and outlines their location and how this affects the symptoms they can produce.

What are fibroids and whom do they affect

Fibroids are non-cancerous (benign) growths that develop in the muscular wall (the myometrium) of the uterus and sometimes in the cervix. They are mainly composed of muscle tissue. Fibroids are also referred to as myoma or fibromyoma, leiomyoma and leiomyomata.

Uterine fibroids are the most common tumours of the female genital tract; they are diagnosed in half of all women, but have been found in 77 percent of uteri removed for reasons other than fibroids.

Fibroid tumours may start in women when they are in their 20s. Many women do not have symptoms but physicians are not able to predict if a fibroid will grow or cause symptoms later on. As much as 20-40 percent of women age 35 and older have uterine fibroids of a significant size and for African-American women this is 50 percent.

Most women do not begin to have symptoms until they are in their late 30s or 40s when a change in hormone balance occurs. (More about the causes of fibroid development in A2).

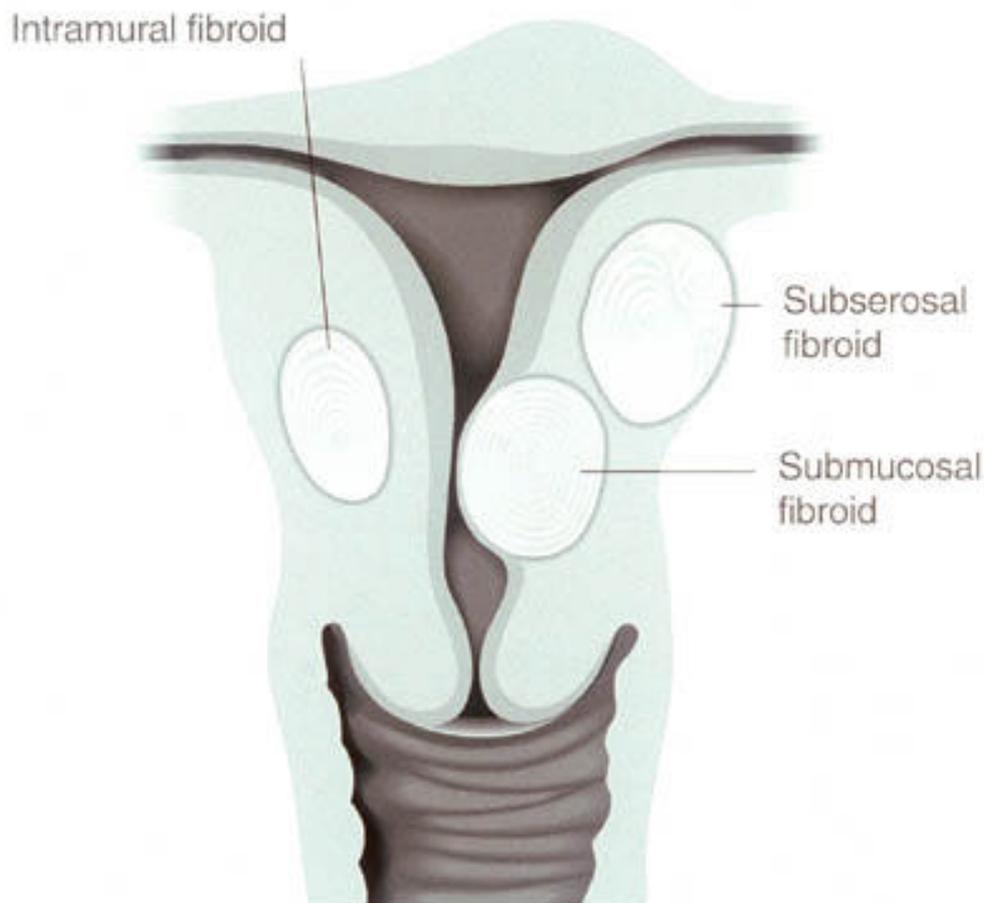
Types of fibroids

In most cases, there is more than one fibroid in the uterus. They can range in size from very tiny, as small as a baby pea or smaller, to as large as a grapefruit or even a basketball. Large fibroids can cause the uterus to grow to the size of a five-month pregnancy – but also with smaller sizes some women may look as though pregnant.

Fibroid size is irrespective of the severity of symptoms; it is mainly their position in the uterus that determines their impact, so small fibroids may cause more trouble than much bigger ones.

(For further description of fibroid sizes refer to paragraph: Diagnosis)

Fibroids can be located in various parts of the uterus. There are three primary types :



SUBSEROSAL FIBROIDS

...develop *under the outside covering*, or serosal surface, of the uterus and expand outward, giving the uterus a knobby appearance. They typically do not affect menstrual flow, but can cause pelvic pain, back pain and a general feeling of pressure. The subserosal fibroid can develop a stalk or stem-like base and protrude on the outside of the uterus – called a **PEDUNCULATED SUBSEROSAL FIBROID**. This may be difficult to distinguish from an ovarian mass. The correct diagnosis can be made with either an ultrasound or magnetic resonance (MR) exam. Pedunculated fibroids may twist and cause pain.

INTRAMURAL FIBROIDS

...develop *within the wall* of the uterus and expand inward, increasing the size of the uterus. They make the uterus feel larger than normal in a gynaecologic exam. These are the most common fibroids. Intramural fibroids can result in heavier menstrual bleeding and pelvic pain, back pain or the general feeling of pressure that many women experience.

SUBMUCOSAL FIBROIDS

...develop *partially in the cavity and partially in the wall* of the uterus, just under the endometrial lining, or on a pedicle protruding into the endometrial cavity – then called an **INTRACAVITARY or PEDUNCULATED SUBMUCOSAL FIBROID**. These are the least common fibroids, but they tend to cause the most problems. Even a very small submucosal fibroid can cause gushing, very heavy and prolonged periods, and bleeding between periods, while intracavitary fibroids may also cause severe cramping.

What they DO – typical Symptoms & possible Complications

All symptoms are outlined in detail. Pain or pressure, heavy bleeding, and accompanying anaemia, are the most prevalent of these. If you are experiencing any of the described symptoms, you should consult your doctor.

Fibroid symptoms that may require treatment

Most fibroids don't cause symptoms – but 10-20 percent of women who have fibroids do require treatment. Depending on location, size and number of fibroids, they may cause:

Menorrhagia

Heavy to very heavy, prolonged menstrual periods, often with clots. And sometimes irregular monthly bleeding i.e. bleeding between periods (called **Metrorrhagia**). Blood loss exceeding 80 mls is considered heavy. Counting the number of pads or tampons and their staining is a good way of checking if periods are heavy. My personal method was to initially weigh the pads using a letter-scale; the difference between a clean and a saturated pad in grams is just a little bit over the amount in mls. But if you regularly saturate pads or tampons in less than an hour, you can be certain your flow is too heavy. This can lead to:

Anaemia

Anaemia, or a low blood count, is the most common symptom that is associated with fibroids; mainly noted by paleness, fatigue, weakness, difficulty concentrating, and sometimes raised blood sugar levels. (More about anaemia in the next chapter, A2)

Dysmenorrhoea

Menstrual cramping and pain that can be severe or even labour-like. The pain that accompanies menorrhagia is often 'heavy and dragging', of the congestive type. (Find more about pain and how to deal with it in B6)

Pain with sexual intercourse

The presence of large fibroids may make intercourse uncomfortable and restrict coital position. This is different from pain during intercourse that is related to sexual dysfunction (like vaginitis) or a lack of lubrication. Do not expect gynaecologists to always know the difference, they may even suggest this is because you may be near menopause; however, a physically based lack of lubrication is usually caused by low oestrogen levels, while with fibroids you are likely to have an excess in oestrogen. As a response to expected sensitivity during coitus, a lack of sufficient lubrication may indeed result. When a fibroid is situated in the cervix, this may result in bleeding at the time of coitus.

Bulk related symptoms

Mostly, symptoms are irrespective of size, but in case fibroids get very large this may cause the following symptoms:

- Pain in the back, flank or legs if the fibroids press on nerves that supply the pelvis and legs.
- Pelvic pain: general pressure or discomfort on certain spots in the pelvis that is caused by the bulk or weight of the fibroids and uterus, pressing on nearby structures like the spine or pelvic bones. The amount of pain or pressure may be affected by a combination of position and posture.
- Increased frequency of urination, including the need to get up at night, typically results from pressure on the urinary system.
- Constipation and bloating may be the result of pressure on the bowel.
- Abnormally enlarged (distended) abdomen, caused by the bulk of the fibroids and resulting enlarged uterus. This is sometimes seen together with fluid retention and bloating caused by oestrogen excess, and can be misinterpreted as a progressive weight gain, or may appear like a pregnancy.
- Shortness of breath may result from a very large fibroid that presses on the diaphragm.

Infertility or miscarriage

Even non-symptomatic fibroids may cause infertility or miscarriage, simply because of their location. Fibroids that may block the birth canal are especially a problem that requires treatment, but some gynaecologists say that having fibroids during pregnancy will interfere in any case; by competing with the foetus for blood supply.

Fibroids can interfere with fertility when they are located near the fallopian tubes so that sperm cannot go up or the egg come down; or when a fertilised egg cannot implant in a section of the uterine wall occupied by a fibroid. And if a fertilised egg does implant far enough away to connect with the mother's blood supply, trouble can occur when the fibroid starts to grow in response to the tremendous input of oestrogen produced during pregnancy. At some point the fibroid and the foetus may begin to compete for the available blood supply. As a result the pregnancy may end. There are however also many cases of women with fibroids who carried to term and delivered healthy babies. (More in B3)

Bleeding after menopause

When you are already menopausal, and recurrence of bleeding occurs, this may be caused by fibroids but should be thoroughly investigated. The occurrence of other symptoms as well as any increase in fibroids in women after menopause may raise the suspicion of the presence of a sarcoma, as fibroids are expected to shrink after menopause. (Find more in A2)

Note that some of these symptoms can also be a sign of Endometriosis, a progressive benign condition whereby parts of endometrial tissue grow outside the uterus that can start to bleed. This condition is affecting 5-10 % of women. It can cause dyspareunia (pain during intercourse), dysmenorrhoea, low back pain and infertility.

A definitive diagnosis can be made only by means of Laparoscopy, but possibly a combination of biochemical markers and clinical assessment will eventually decrease the need for surgical confirmation.

(More information about Endometriosis and Adenomyosis can be found in: Further Reading).

Among other causes for pelvic pain is 'varicose veins' in the ovaries; this can be confirmed by ultrasound and treated with Ovarian Vein Embolisation.

Complications of fibroids that require immediate treatment

Pressure

Occasionally, an enlarged uterus may press on the ureter connecting the bladder to the kidney, resulting in partial blockage of urine flow from the kidneys.

Twisting

The narrow stalk of a subserosal fibroid growing outside the uterus may twist and cause severe pain and tenderness. Because this resembles the pain from appendicitis or a twisted cyst, it needs to be diagnosed properly. This is done by ultrasound or laparoscopy.

Red degeneration

This can occur when a fibroid outgrows its blood supply when it grows rapidly, for instance during pregnancy. Degeneration of the fibroid causes swelling and release of chemicals in a process similar to that which occurs in a heart attack. This is extremely painful, and may last for hours or days. The uterus may be tender to touch during this time. It does most often happen during pregnancy, but will not harm the pregnancy.

Infection

Infection in fibroids usually only may occur after childbirth or a caesarean section, but is very rare. Pain can be mild or severe, with usually other symptoms present that suggest infection; like fever, uterine and abdominal tenderness, and a raised white blood cell count.

Patient Stories:

My heavy bleeding, severe clotting and anaemia gradually got worse and worse over a period of years and no one seemed to be able to do anything to help. I went in for regular exams to my family practitioner and he told me he could feel the fibroids, but he didn't know what to do about it.

So, he referred me to a gynecologist. She said I was losing blood from somewhere and wanted me to have a colonoscopy. I kept trying to tell her about my heavy periods but she wouldn't listen to me. At one point she said she wanted to do a hysterectomy before she would do any other tests. Finally, she did an ultrasound and said I had a big fibroid and the only thing I could do was to have a hysterectomy. She scared the pants off me.

I've had fibroids since I was 30. I loved my gynecologist but she totally missed the point on this. I was bleeding two weeks at a time so she took me off 'the Pill' and my periods got somewhat better – at least they went down to one week. But I also had horrible cramping and lots of pressure, constant urination. She gave me a prescription to deal with the pain and I had a couple of D&Cs, but that made only my next period better. I saw a doctor on television once who talked about a laser myomectomy but I couldn't find anyone who knew how to perform that procedure. I saw one doctor who wanted to do a hysterectomy and, even though I don't plan on having more children, I didn't want to go through that. The hormonal issues are tremendous and I want to keep my parts – all of them. You don't cut off your hand to fix a broken fingernail. Then my fiancé saw a small item in the newspaper about a lecture that these two doctors were giving on the fibroid embolisation procedure. I went to hear it and it was amazing to me. This was more like what I wanted to do.

I didn't know I had fibroids. I went to my OB/GYN and he did some tests but didn't know what was causing the bleeding. Then he retired and I got copies of my records and I found an entry from 12 years earlier that said I had fibroids. No one ever told me.

A friend suggested I see a gynecologist she knew, and he knew about the embolisation procedure. He examined me and said I was a good candidate for it – he didn't give me any argument. He referred me to the doctor who does the procedure and within a month and a half I was scheduled for it.

Diagnosis – how Fibroids are Detected & what Tests are truly necessary

There is a variety of tests available to determine that the presence of fibroids is the cause for your symptoms. Your doctor will first take a medical history and do a pelvic exam. An ultrasound exam is most commonly used to confirm the diagnosis of fibroids – and is reliable and painless.

Mainstream diagnosis and treatment of fibroids involves first a number of exams, mostly followed by an advise for hysterectomy, even if malignant processes are not determined. A few of these procedures are rapidly becoming obsolete for most cases, and patients should be well informed about both this and all available treatment.

Detection and diagnosis

Fibroids are sometimes detected during a routine examination, but most women with symptomatic fibroids will seek treatment sooner or later – especially when associated symptoms like anaemia become evident.

Mostly, a blood test confirming iron deficiency or anaemia will be done. Coagulation can be checked at the same time, to determine if there is a disorder in the clotting of the blood, as 15-20% of excessive regular uterine bleeding can be due to coagulopathies. There is a number of other possible causes for menorrhagia and a low blood count (haemoglobin below 10 gm/dl), however under most circumstances these diseases present with other associated symptoms. These include cirrhosis, thyroid disease or severe sepsis.

Fibroids develop because of hormonal imbalances due to anovulatory processes, which may also cause bleeding disorders even before fibroids have developed. Anovulation may also have underlying physiological causes that need further treatment. (More about this in the next chapter, A2). When fibroids are indeed found, this is the most likely cause of the heavy bleeding and associated symptoms.

After discussing the medical history, fibroids can be first diagnosed during a gynaecologic internal exam [A], which enables the physician to feel if the uterus is enlarged. Following that, the presence of fibroids can be confirmed by an abdominal or pelvic ultrasound [B]. In most cases, a trans-vaginal ultrasound [C] is performed at the same time. This allows a better view of the fibroids and ovaries. Fibroids also can be confirmed using magnetic resonance imaging (MR or MRI) or computed tomography (CT) [D], but these are the least used modalities because of the higher costs involved. All these imaging techniques are painless diagnostic tests.

Diagnostic hysteroscopy can also be used, particularly to evaluate the presence of submucosal fibroids. This procedure, which can cause some discomfort, can be performed by a gynaecologist under local anaesthetics, but is mostly used in conjunction with a Dilatage and Curettage – called a “D&C and Hysteroscopy” [E] – and is done under a light general anaesthetic as a day procedure in hospital. This is still used by physicians to have a look at the fibroids and especially to rule out malignancy, but is becoming obsolete.

A Internal gynaecologic exam

This is done to determine the presence of fibroids. During an internal exam the size and shape of the uterus are investigated. The uterus or womb is normally a pear-shaped smooth-surfaced organ of about 8 cm in length. The thinner end represents the cervix or mouth of the womb, which can be felt at self-examination as the firm round tissue at the top of the vagina.

When fibroids are present the uterus will be bigger and lumpy or asymmetric, and is often compared to the size of a uterus in pregnancy.

Uterine size may be caused by a few dominant large fibroids or by multiple small fibroids.

Interpretation of a fibroid-uterus size as compared to the size of a pregnant uterus:

- 12 weeks = just up to the level of the pubic bone
- 16 weeks = 4 fingerbreadths above the pubic bone
- 18 weeks = 2 fingerbreadths below the navel
- 20 weeks = at the navel
- 24 weeks = 1 fingerbreadth above the navel
- 28 weeks = 3 fingerbreadths above the navel

This method of ‘sizing’ is complicated by the irregularity of the top of a fibroid-uterus – the top of a pregnant uterus is usually smooth and uniform. But this is the most common way gynaecologists record uterine size.

Gynaecologists use the following reference for normal uterine sizes:

	Front to Back		Side to Side		Length	
Never Pregnant:	2 cm	3/4"	4 cm	1 1/2"	6 cm	2 1/3"
Prior Pregnancy:	4 cm	1 1/2"	6 cm	2 1/3"	9 cm	3 1/2"

Normally, the size of the womb will be slightly increased after pregnancy during the menstrual years. Well into menopause, most uteri go back to the size of a ‘never pregnant’ uterus.

As you can see in the diagram above, the normal uterus is slightly flattened. A fibroid-uterus, on the other hand, tends to be spherical – and stated sizes are generally the diameter of the sphere. So, for example a 9 cm fibroid-uterus in a woman that has been pregnant before, is probably around 5 cm (2") larger in the ‘front to back’ measurement and 3 cm (1 1/2") larger in the ‘side to side’ measurement. Comparison to normal uterine size becomes more difficult when the uterus is irregularly distorted by multiple fibroids.

If hysterectomy is contemplated, some gynaecologists prefer abdominal surgery when the uterus is above a certain size.

An internal exam is usually followed by a pelvic and transvaginal ultrasound:

B Pelvic ultrasound

An ultrasound examination (sometimes called a sonogram) can confirm that fibroids are present and also provide information about size, location, and number, and possible abnormalities that require further investigation. This is the most used modality to evaluate fibroids.

The term 'ultrasound' refers to the ultra high frequency soundwaves used for this type of diagnostic scanning; ultrasound waves travel at 10-20 million cycles per second, compared to 10,000-20,000 cycles per second for audible sound. An ultrasound examination is a simple painless procedure in which a radiologist or sonographer moves a transducer across the outside surface of the abdomen; sound waves are transmitted through the skin and reflected back the same way radar on sonar does. Hard surfaces such as bone and denser tissues, like fibroids, return a stronger echo than soft tissue or fluids, giving harder surfaces a whiter appearance on the screen. The pattern they make is analysed by a computer, which projects a black-and-white television image of the area being examined and allows the sonographer to 'see' the size, shape and texture of the uterus and fibroids. These images can be printed on film for later evaluation.

Doppler ultrasound can be used to check the blood flow to fibroids; this may for instance be used when malignancy is suspected. Ordinary scans are 'pulsed' ultrasound, whereas Doppler techniques are continuous waves, which give much higher levels of exposure.

While ultrasound is considered to be safe, there are studies that have suggested that some effects are of real concern in living tissues. Especially when unborn babies are exposed during routine prenatal ultrasound investigations with Doppler ultrasound. Studies on mice show that exposure to ultrasound caused a reduction in cell division and a doubling of the rate of cell death, especially affecting the nervous system – something that would of course be of most concern in a developing foetus. Studies on humans have indeed shown adverse effects in newborn. Another effect is possible premature ovulation.

A very positive effect of ultrasound is its use for healing wounds and fractures.

With fibroid detection, the information gained from ultrasound is very useful, and can be considered a safe way of diagnosing fibroids in order to determine which treatment option is the most appropriate. It can also provide valuable information when compared with follow-up exams after uterine saving treatment. It is best to have it done in the same place for most accurate comparison.

A common way to describe fibroid size is by using comparisons with commonly used items, to help visualise the size. Fibroids are not always necessarily spherical in shape though.

A fibroid is considered 'large' at approximately grapefruit size, which is bigger than the largest dimension of the uterus (6-9 cm):

Average sizes of items used to describe fibroid size:

<u>Item</u>	<u>cm</u>	<u>Inches</u>
Pea	1 cm	3/8"
Walnut	3 cm	1 3/16"
Lemon	5.5 cm	2 3/16"
Apple/Pear	7.5 cm	3"
Orange	9 cm	3 1/2"
Grapefruit	11.5 cm	4 1/2"
Cantaloupe	25 cm	10"

It is important to realize that fibroid size is irrespective of the severity of symptoms; small fibroids may cause more trouble than much bigger ones, depending on their position in the uterus. However, the larger the fibroid, the more serious pressure symptoms may become.

C Transvaginal ultrasound

This type of ultrasound exam involves beaming the sound waves through a narrow transducer inserted in the vagina. It is mostly performed in conjunction with a traditional pelvic ultrasound and allows the sonographer a better view of the inside of the uterus. It is also possible to check behind the uterus for other fibroids or to examine the ovaries, for instance to see if they have been pushed out of place when hidden by large fibroids. There is generally little if any discomfort associated with this procedure, although a very small number of women seem to experience vaginal scans as 'diagnostic rape'. In most radiology departments there is a female nurse present when the procedure is performed by a male sonographer.

D MRI and CT

Magnetic Resonance Imaging (MR or MRI) or Computed (Axial) Tomography (CT or CAT) are less common but also painless diagnostic scanning techniques. Both use a table on which the patient slides into the machine. They can give accurate and clear information on the presence and size of fibroids and their blood supply.

In principle, MR is more accurate than ultrasound in evaluating exactly how the fibroids are doing before and after uterine saving treatment. However, the size of fibroids and their shrinkage before and after Fibroid Embolisation (UFE) is adequately visible on ultrasound, where the most important indication is if symptoms have abated. In case Myomectomy is performed and symptoms return, a better view is sometimes needed.

A clear advantage of MR is that it very accurately evaluates associated ovarian and tubal disease, which might alter or even contraindicate a procedure like embolisation. Also, it tends to make a Hysteroscopy and/or Laparoscopy to rule these out, unnecessary. In case embolisation is performed to treat the fibroids, and abnormalities are discovered during preliminary angiography (which is part of the procedure), the procedure will be discontinued. (For a description of angiography see B3). To rule out uterine malignancy, a Hysteroscopy is often performed anyway. There are however controversies around uterine biopsies, which we will discuss later.

CT uses relatively high doses of X-Ray, and MR is considered to be superior to Cat Scan in fibroid evaluation. MR uses strong magnetic field and radio waves to create the images and shows greater contrast between normal and abnormal tissues (especially soft tissue) than other imaging techniques – making it a valuable tool for diagnosing tumours, examining blood flow and viewing tissue damage.

The problem with MR is (at least, in Australia) that it is severely rationed due to the high cost of acquisition and operation – to the point that public hospitals can be charged with fraud by the Health Insurance Commission if they use it for detecting fibroids. It can be used only if pelvic cancer is suspected, but this will only be in a very small number of cases.

I believe it would certainly be a benefit if this technique could be used for evaluating fibroids, especially when uterine saving treatment is considered. It would make life easier for patients, when more invasive tests would be no longer necessary to rule out other disease processes, and doctors will not scare patients into surgery any longer. This will hopefully happen in the future – after all, there are unnecessary costs involved as it is now.

E D&C and Hysteroscopy

DILLETAGE AND CURRETAGE (D&C) is a procedure that is done under a light general anaesthetic and usually requires only a few hours in hospital. The physician first dilates or opens the cervix by passing a series of dilators (narrow instruments of increasing thickness) into the vagina and cervix, gradually opening the strongly contracted muscles of the cervix. Then a curette is inserted (a thin, spoon shaped instrument) to scrape the lining of the uterus. The procedure takes about 10 minutes, with 30 minutes in the recovery room.

Curettes used to be rigid stainless steel instruments, which caused a great deal of pain and made these procedures often difficult to perform. Modern curettes are flexible plastic suction catheters allowing sampling and scraping of the endometrium. This enables the gynaecologist to 'clean' the endometrial cavity and at the same time take a biopsy of the lining to be tested for malignancy.

Postoperative pain can occur as well as side effects from the used anaesthetic, and sometimes antibiotics are given to prevent infection.

HYSTEROSCOPY is performed with the use of a long, thin, probe-like instrument called a hysteroscope, which can be passed through the vagina and cervix into the uterus. It is equipped with a tiny viewing device and illuminates the uterus while the physician can check for growths and take samples of tissue. This procedure, which can cause some discomfort, can be done under a local anaesthetic in an office setting by a gynaecologist. (Editors note: my computer suggested to change this into; "A gynaecologist under a local anaesthetic in an office setting can do this procedure, which can cause some discomfort"...).

Most gynaecologists prefer to routinely perform both D&C and Hysteroscopy together as a day procedure under general anaesthetics.

THE USEFULNESS OF D&C AND HYSTEROSCOPY WHERE FIBROIDS ARE CONCERNED is disputable. The main reason these procedures are done when fibroids are present is to rule out malignancy. If there is no *clear* reason to suspect malignancy however, this is in fact redundant:

The incidence of leiomyosarcoma (malignant tumours) is very rare, and a biopsy is usually unrevealing – malignancy can easily be missed. Fibroids are non-cancerous growths. If malignancy is present, this is thought to be so in the first place; benign tumours do not transform to malignant ones. (More about this in A2)

Scraping or 'cleaning' (curettage) of the uterine lining is not going to restore a normal bleeding pattern while fibroids are present. The next period will be just as heavy due to the disturbing presence of the fibroids – the main cause for haemorrhaging. And it will only remedy endometrial hyperplasia (when the uterine lining has become too thick) to some extent for a few periods at best.

In Australia the procedure is still part of gynaecology education, and usually performed by an apprentice under supervision of the gynaecologist. In some European countries, D&C is no longer performed for most conditions – one gynaecologic information-line even openly named it a cost-raising procedure in most cases and mainly beneficial to gynaecologists.

Furthermore, while the surgical modality of hysteroscopy is useful to focus treatment in on the area of abnormality – this usually doesn't apply where various fibroids are present. While intracavitary (pedunculated submucosal) fibroids could be removed hysteroscopically, their incidence is very rare, and in case they are found they are usually not removed during this initial D&C and Hysteroscopy, for reason that the results of the examination needs to be discussed with the patient first. Fibroids in other locations of the uterus would need additional treatment in any case.

Personally I found this diagnostic procedure much more invasive than the fibroid embolisation (UFE) procedure which healed me from my fibroid disease.

D&C AND HYSTEROSCOPY, AND LAPAROSCOPY, WHERE OTHER DISEASE PROCESSES ARE SUSPECTED can sometimes be necessary. For instance, hysteroscopy or laparoscopy could rule out a suspicion of ovarian or tubal disease. When infection seems to be present, an endometrial biopsy – next to a cervical pap smear – could reveal chronic endometritis. A biopsy can either be done in an office hysteroscopy, or when this is not possible, by means of a D&C.

Laparoscopy is used mainly to detect Endometriosis. A laparoscope is an instrument similar to the hysteroscope that can be used to view the outside of the uterus; it is inserted through a small incision near the belly button – and often used in conjunction with other instruments inserted through similar incisions. Because of the expenses, laparoscopy is only performed when there is a clear indication for disease processes other than fibroids – and in my humble opinion this should be the rule for D&C and Hysteroscopy as well.

Furthermore, MRI may be just as useful in those cases and is less invasive. But a lot depends on the overall picture of symptoms and the possibilities the hospital has to offer. Diagnosis and treatment options should be discussed with your doctor.

In case Endometriosis or Adenomyosis are present next to fibroids, embolisation may improve those conditions as well.

D&C can sometimes be of use as well when ultrasound reveals no fibroids, and abnormal bleeding or other disease processes need further evaluation. Though it can usually be replaced by hysteroscopy. For instance, around 10% of women may have polyps; these are endometrial or endocervical growths different from fibroids and are either pedunculated (on a thin stalk) or sessile (broad-based). They are rarely diagnosed by ultrasound because they are difficult to discern from normal endometrial tissue. Polyps are usually asymptomatic, but endometrial polyps may cause postmenstrual and premenstrual spotting and sometimes other abnormal bleeding, and postcoital bleeding and pain during intercourse may occur with polyps near or in the cervix. Diagnostic exams like hysterosalpingography (an X-Ray with contrast fluid) or hysteroscopy or D&C may be the only reliable methods of diagnosis in this case, and rule out suspicion of other, possibly malignant, processes. Most polyps can simply be scraped off during a D&C procedure or resected with special tools via the hysteroscope, and are routinely sent to a pathology lab for evaluation.

CONCLUDING could be said that confirming the presence of fibroids can most easily be done with an ultrasound exam, or MRI where available. Together with a proper patient's history, this should provide an acceptable indication whether or not further tests are called for. Next, if uterine-sparing treatment is performed, follow-up evaluation could in the rare case quickly reveal other disease processes. This eliminates the need to do vaginal biopsies. Their unrevealing character is not enough to base a choice of treatment on. In case hysterectomy is the chosen treatment, this surgery is in itself the biggest 'biopsy' that you can have...

A patient:

I had been bleeding for more than three months and on the heaviest days, I couldn't even go out of the house. I would wear two pads at a time and would go through five and six bags of pads for one period. My gynaecologist did a D&C on me and the next day the bleeding came back again. She did a hysteroscopy and took a piece of the tissue of my uterus and told me the only thing I could do was have a hysterectomy. I was so depressed, I didn't want a hysterectomy because of the long recovery time and, to be honest, doctors frighten me.

That very night, there was a news program with a doctor talking about this new procedure for fibroids. I called his office the next day and he saved me! He was the first person to really listen to me.

Women should not be made to feel inadequate or even a nuisance whenever they seek more information about the treatment being offered.

THE NEXT CHAPTER

A2: More about Fibroids – Your Questions Answered

...deals with what causes fibroids...how symptoms are caused by them...what the difference is with malignant tumours...and how to stay healthy after treatment...

FOLLOWING IS A LIST OF CONTENTS OF ALL CHAPTERS :

YOUR BODY – YOUR CHOICE

It is a basic right to have control of your body
and make decisions about your health and health-care
on the basis of all available information,
free from the pressure of following
your physician's preferred treatment option.

DISCLAIMER

I have put all given information forward to my best knowledge and ability.

I can and will not accept responsibility for any misinterpretation or other inconvenience resulting from the information as provided.

I encourage every woman suffering from uterine fibroids to make her own decisions.

It is my sole intention to assist in this process, by providing information via the FibroidSolutions website,
which I compiled from publicly accessible resources, scientific publications, and personal experiences:

<http://www.fibroidsolutions.com>

Read more in the other chapters of www.fibroidsolutions.com :



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www.fibroidsolutions.com

**INFORMATION ABOUT UTERINE FIBROIDS
THAT MAKES A DIFFERENCE**