Fibroids & Fertility

Fibroid Embolisation Versus Myomectomy

A recent study comparing the fertility of women who had undergone uterine fibroid embolisation with those who had a myomectomy, showed similar numbers of successful pregnancies for both groups. Both myomectomy and fibroid embolisation have their own value in restoring the uterus to normal function. When to choose myomectomy and when fibroid embolisation? And what happens in the longer term. Also, what if fibroids are present during pregnancy?
Preserving Fertility

Women who seek to restore or improve fertility through treatment of their fibroid disease, will have to make a choice between fibroid embolisation or surgical removal of the fibroids through myomectomy. There are not many quality studies on fertility after either treatment even though there should be a broader experience with myomectomy. Large comparison studies for infertility are currently not available – and stated by physicians as very difficult to implement.

Though by observing what is known, we can come a long way in making a comparison between these two treatment options.

Concluding it can be said that both myomectomy and fibroid embolisation have their own value in restoring the uterus to normal function – depending on the number, size, and position of fibroids to be treated, as well as your overall health and personal preference.

Your Body – Your Choice

The overall risks with fibroid embolisation and myomectomy regarding future fertility may well be equal, and the two procedures a trade-off. Each situation will call for a different approach in deciding on appropriate treatment, and this will be adequately clarified to help you in your choice.

One thing is for sure: fibroid embolisation carries less overall risks, and fibroids cannot regrow, as each and every fibroid is treated – this in contrast to myomectomy.

It might be of support to other women if you could share your experiences regarding your treatment... and outcome.

Please keep us posted via the Forum on the website.

In the News

According to a Johns Hopkins Medical Institutions study being presented at the American 27th Annual Scientific Meeting of the Society of Cardiovascular & Interventional Radiology (SCVIR):

"After UFE, hormone levels remained the same, no patients had procedure-induced menopause and uterine wall was thicker – all good indicators for maintaining fertility."

In another study of women who wanted to maintain fertility, there have been 6 pregnancies in 10 women trying to conceive.

Note

For a description of both myomectomy and fibroid embolisation and a complete listing of their respective complications and side effects, please read the relevant chapters. The following information is in addition to all other information about both procedures. Also, all drawbacks mentioned for myomectomy, go for all forms of myomectomy, including laser treatment.
Preserving Fertility

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Though by observing what is known, we can come a long way in making a comparison between these two treatment options.

Successful pregnancies after embolisation

Up till recently, myomectomy has been the only option for treating fibroids in women who wanted to preserve fertility. But as an increasing number of patients opt for Uterine Fibroid Embolisation, this procedure has presented itself to be a viable alternative. This gives women a choice. Although myomectomy is still considered by many physicians to be the first choice for women who desire to preserve fertility, UFE may in some cases be a good or even better option.

There is an increasing number of women who have become pregnant after UFE and have successfully carried to term – and delivered healthy babies, even twins. The available data shows that normal myometrium remains normal after the fibroids are embolised, and sometimes even becomes thicker. Another important finding is that the main segments of the uterine arteries mostly re-canalise after embolisation (this is described in detail in B2: Healing Process). The most recent American studies report healthy myometrium in 99% of treated patients and no alteration in hormone levels in young women.

Longer-term data are available on patients who had this procedure for acute haemorrhage after childbirth, or for other medical reasons; they appear to have normal fertility. More invasive procedures have also been done because of post delivery haemorrhage – like tying off a uterine artery via a full surgical procedure, in fact devascularizing the uterus – and even in these cases subsequent pregnancies appear to be successful.

There’s one example known about a patient who became pregnant very soon after UFE and continued pregnancy without a problem; a longer recovery time is always recommended though.

Earlier studies in sheep showed a decrease in number of pregnancies and a lower weight in newborns after embolisation. A lower birth weight may be noticed in human babies after alcohol and drug abuse, but has not been established after embolisation! Since sheep do not ever suffer from fibroids, they perhaps differ in more ways from humans in workings of the reproductive organs.

This outcome is of a different consequence altogether, when considering that having fibroids may interfere with fertility and pregnancy anyway. So if you do have fibroids that need treatment, it is a matter of choosing the right type of treatment for your particular situation.

Comparisons between myomectomy and embolisation

A recent small scale study comparing the fertility of women who had undergone uterine fibroid embolisation with those who had a myomectomy, showed similar numbers of successful pregnancies for both groups.

Basically there is no reason to assume that a woman who has had fibroid embolisation should be unable to support a pregnancy. Both with myomectomy and embolisation the uterus will get more or less damaged, yet is able to recover. During myomectomy surgery, the fibroids can in most cases only be removed by cutting through the uterine wall, including blood vessels – which will compromise the integrity of the muscular wall. This can sometimes be less so with laser treatment but only in very skilled hands – as it has its own set of risks for damaging tissue other than the fibroid. The extend of damage to the uterine wall with myomectomy is in any case depending on the number and size of fibroids to be removed.
The so-called ‘realistic’ chance of preserving fertility after UFE is said to be not scientifically established, for reason that no large multi-centre study has been done as yet. Furthermore, comparison studies have failed thus far for lack of quality published literature on fertility after myomectomy. Mainly because the majority of patients have not sought to become pregnant after fibroid embolisation, physicians are unable to fully determine the long-term effects of UFE on the ability of a woman to have children. Therefore, most are very careful in making scientific statements; and very cautious in recommending UFE for women who plan to have children. ...It isn’t hard to see how these facts reinforce each other!

This causes many patients to be steered towards myomectomy if they want to preserve fertility, while this surgery is not without its own potential risks for affecting future fertility; like regrowth of fibroids, or adhesions of tissue and organs in the abdomen leading to pain and possible infertility – both calling for additional surgery, with increasing risks.

In addition, most gynaecologists feel a caesarean section is often the safest mode of delivery after large fibroids have been removed from a uterus, because uterine rupture can occur if the scar in the uterine wall gives way in labour. This is especially true after removal of intramural fibroids. And this involves yet another major operation.

Another consideration might be that there seems to be a large difference in skill amongst surgeons in applying preventative measures for adhesions and severe blood loss associated with myomectomy – sometimes serious enough to require transfusion, especially when you are already anaemic. For this reason many gynaecologists steer women away from myomectomy if no (further) pregnancies are planned. Myomectomy is said to be potentially more risky to do – especially when the gynaecologist thinks so ...

Gynaecologists who advocate myomectomy, and specialise in it, say otherwise. I’ve met both types of physicians and my experience was that the latter was also very positive about embolisation, while the gyn’s advocating hysterectomy simply didn’t tell me the truth about embolisation – as I later established. Most physicians cleverly arrange their statements: For instance, when a gynaecologist states that myomectomy is the only surgical treatment of myomas that preserve fertility, this is offcourse only true with the stress on surgical ...

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Also, remarks about volume reduction of fibroids after UFE being only 50% whereas removed fibroids are completely gone, is also only partly true; after embolisation, fibroid reduction is on average much more than that but of very little consequence, as in more than 90% of cases symptoms will be gone and (contrary to myomectomy) not a single fibroid will regrow or cause problems during or after pregnancy, whilst myometrium and uterine wall remain intact and capable of supporting pregnancy in the majority of cases.

If any type of myomectomy surgery is the best option in your case, by all means choose the best surgeon you can find or afford – but do inform yourself adequately.

It seems that many physicians, including some interventional radiologists, remain cautious about embolisation where fertility is concerned. However... ongoing studies show very positive news, as you will read furtheron.

Fibroids in pregnancy

Because of all the alleged uncertainties, some women opt for no treatment at all; there are even physicians who tell women to get pregnant as a ‘cure’, albeit temporarily – they can always have a hysterectomy after completing their family. I know that a lot of well thinking health care professionals will cringe at that, as this seems not a healthy consideration for the baby – optimal health of the mother (and both parents for that matter) is always better for the development of a new life.

Non-symptomatic fibroids might only need treatment if your gynaecologist determines that the location of the fibroid could become a problem during pregnancy or birth; it might for instance block the birth canal. But while at first gynaecologists believed that mainly submucous fibroids (in the cavity of the uterus) interfere with pregnancy and may cause a miscarriage, a number of newer studies have demonstrated that women who were previously unable to conceive, also became pregnant after intramural or subserous fibroids were treated – so it would follow that all types of fibroids may have an influence on the progress of a pregnancy.

And so, some gynaecologists say that a fibroid will interfere in any case by competing with the foetus for blood supply. They believe that most patients with untreated fibroids either cannot get pregnant or will not be able to sustain the pregnancy; Fibroids can interfere with fertility when they are located near the fallopian tubes so that sperm cannot go up or the egg come down.
A fertilised egg cannot implant in a section of the uterine wall occupied by a fibroid, and if it 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 (usually within twelve weeks). If the foetus is further away from the fibroid it may have adequate blood supply for a while, but may eventually have to compete for space with a growing fibroid, resulting in miscarriage (usually between the fifteenth and eighteenth week). This as reported by a few gynaecologists who specialise in myomectomy.

As is often the case, there are exceptions. Some women do not even know they have fibroids until they start to grow in pregnancy. Pregnancies are known to have been carried to term even with fibroids present.

The risks should well be weighed here:

Fibroids can grow quickly during pregnancy due to the high oestrogen level produced by the body to support the pregnancy – as fibroids ‘feed’ on oestrogen. They can also become very painful, due to Red Degeneration. This occurs in about 10% of fibroids: When the fibroid enlarges due to hormone stimulation, it can outgrow its blood supply causing the central area of the fibroid to degenerate – much the way it does after embolisation. With Red Degeneration however the process is much less complete, which may cause the fibroid to regrow later on. Embolised fibroids never grow again.

If fibroids start to grow quickly during pregnancy, treatment is not possible. Even though it is non-invasive for the mother, it might be harmful for the foetus, so embolisation is NEVER done in pregnancy, even if the fibroid becomes painful. Any possibility of pregnancy is an absolute contra-indication to the procedure. The treatment of a painful fibroid in pregnancy is bed-rest and pain-medication. It tends to quiet down quickly however.

Although rare, fibroids may become infected after natural childbirth or a Caesarean section – with mild or severe pain and other accompanying symptoms like fever and uterine and abdominal tenderness. A blood test will confirm this and adequate medication can be prescribed.

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**Your Body – Your Choice**

*The overall risks with fibroid embolisation and myomectomy regarding future fertility may well be equal, and the two procedures a trade-off. Each situation will call for a different approach in deciding on appropriate treatment, and this will be adequately clarified to help you in your choice. One thing is for sure: fibroid embolisation carries less overall risks, and fibroids cannot regrow, as each and every fibroid is treated – this in contrast to myomectomy.*

**Patient stories**

One story of a woman who had several myomectomies and recurring symptoms, and obviously did not want to have a hysterectomy after completing her family:

*The gynaecologist looked inside with a laparoscope and found terrible adhesions and scarring from my previous surgeries. I was so grateful that he knew about this procedure; the interventional radiologist had given me a lot of information about uterine fibroid embolisation and I was really interested when he told me how non-invasive it was. I’d been through so many surgeries and I didn’t want to go through another one. … I couldn’t believe that a week later I was up and about and walking about two miles a day. This was incredible to me – after my surgeries it took as long as six or eight weeks to recover. And my symptoms were gone. I had so much energy.*
Scientific or not, it might be of support to other women if you could share your experiences regarding your treatment... and outcome.
Please keep us posted via the Forum on the website.

**Choices, choices ...**

Both procedures seem to have similar overall risks of precluding future fertility:
There is an approximate risk of 1% of myomectomy conversion to hysterectomy, and a bit less than that with UFE. The same percentage goes for long-lasting amenorrhoea or early menopause after UFE in women under 40, against a similar number that could develop infertility from adhesions as the result of a surgical myomectomy.

**The risks may well be equal, and the two procedures a trade-off when fertility is an issue.**
It should be kept in mind however that myomectomy involves major surgery and comes with its own set of risks. Especially women for whom surgery poses an increased risk, might in any case be best off opting for fibroid embolisation.

To help you make an informed choice, the following issues are a consideration:

- The number, size, or position of the fibroids can sometimes make myomectomy difficult, and likely to result in hysterectomy.
- For women that have undergone multiple myomectomies and did develop adhesions causing tissue and organs in the abdomen to fuse together, a repeat myomectomy may not be advisable when fibroids are returning, because this may lead to infertility and further damage to pelvic organs. Embolisation may in those cases be the best option.
- Especially in women with quite a few small fibroids. embolisation eliminates all these drawbacks in the first place; each and every fibroid is treated in one go, even the smallest ones – while with surgical removal many smaller fibroids may be missed and grow at a later stage.
- In women with a single dominant fibroid that is easily accessible for surgery, it may be better to choose myomectomy if fertility is an important issue.
- In case of an intracavitary fibroid – or some types of submucous fibroids (partially in the cavity and the wall of the uterus) – with no other fibroids present, it might be the best choice to have it removed hysteroscopically (hysteroscopic resection is done through the cervix), because this has the least impact on uterine tissue. But just like with myomectomy, this calls for an experienced gynaecologist.
- A woman with multiple fibroids or ones that are difficult to approach surgically may well be best treated with UFE since this will, in this case, cause less distortion of normal uterine tissues. A more limited embolisation may be performed, or the embolisation may be done in stages some weeks apart, to have an even better chance of keeping a healthy uterus that may support a pregnancy. You should discuss this with your interventional radiologist.

Each situation will call for a different approach in deciding on appropriate treatment. As it is, straight answers will be hard to come by where fertility is concerned, from both gynaecologists and interventional radiologists, as each work in their own field of specialism. In any case, physicians will never ever guarantee anything, as medical practice can never have exact outcomes. When not enough sufficient research data is available, this makes it even harder, as they can officially only go by their own (limited) experience.
Recurrence of fibroids and other longer term concerns

Recurrence has regularly been reported after myomectomy; this is because not each and every fibroid might have been removed during surgery and these may start to grow at a later stage. With embolisation each and every fibroid is treated. Just like a surgically removed fibroid cannot regrow, embolised fibroids will never regrow – there is experience to support this from the early 1990’s on.

In individual cases it is theoretically possible that a brand new fibroid could appear in the uterine wall after treatment, which could give problems in a future pregnancy. However, fibroids do not seem to re-occur that rapidly; thus far in the cases reported it has not been observed after embolisation. (Find more on the related topic of regaining hormonal balance in B6: Natural Progesterone. Progesterone Cream may also be of aid in supporting a pregnancy, and in post-natal depression).

With Fibroid Embolisation, different materials for blocking the vessels have been tested for their outcome in preserving fertility. Temporary agents that resolve after some time have been used and were thought to be an even better choice in young women. But because they are relatively new, there seem to be some uncertainties about these materials, as different effects are reported.

An April 2002 report about PVA concludes: “in spite of embolisation of the uterine arteries with permanent agents, most patients show no change in myometrial enhancement, suggesting minimal ischaemic effects on the myometrium”. So until more is known, it might be safe to stick with the most widely used and best-documented permanent agent PVA. As far as I know, Interventional Radiologists in Australia mostly use permanent agents.

The newest material of calibrated microspheres, however, has some advantages over PVA that could perhaps be important when preservation of fertility is sought. However, whilst eliminating some of the disadvantaged of PVA, it has some disadvantages of its own. (Find more in-depth information on these materials in B2: Interventional Radiology).

After any procedure, it calls for some patience in women who seek pregnancy, as the body needs time to heal. After embolisation, it may take some weeks, or in individual cases months, for the uterine wall to restore to full strength. It may be wise to wait a few months before a pregnancy is attempted, also for reason to give the body time to ‘clean up’ the former fibroids after embolisation.

After surgery, healing may take somewhat longer, but much is depending on the size of fibroids removed and if any complications like infection or adhesions occur.

CONCLUDING it can be said that both myomectomy and fibroid embolisation have their own value in restoring the uterus to normal function – depending on the number, size, and position of fibroids to be treated, as well as your over all health and personal preference.

Time and dedicated scientific investigations will show more well-founded answers to all the above considerations. We will try and keep you informed via the website.


**In the News**

According to a Johns Hopkins Medical Institutions study being presented at the American 27th Annual Scientific Meeting of the Society of Cardiovascular & Interventional Radiology (SCVIR):

"After UFE, hormone levels remained the same, no patients had procedure-induced menopause and uterine wall was thicker - all good indicators for maintaining fertility."

In another study of women who wanted to maintain fertility, there have been 6 pregnancies in 10 women trying to conceive.

For more new facts look for "Recent press releases" in the website’s Further Reading section.

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**AT A GLANCE**

- Young women in their 20s and 30s benefit from uterine fibroid embolization (UFE) with no adverse affects, according to a Johns Hopkins study.

- After UFE, hormone levels remained the same, no patients had procedure-induced menopause and uterine wall was thicker, all good indicators for maintaining fertility.

- In another study of women who wanted to maintain fertility, there have been 6 pregnancies in 10 women trying to conceive.

- After UFE, fibroid symptoms were alleviated in at least 92 percent of patients in both studies.

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**UTERINE FIBROID EMBOLIZATION APPEARS TO BE GOOD OPTION FOR YOUNG WOMEN**

**BALTIMORE** – Women in their 20s and 30s who suffer from uterine fibroids can be helped with uterine fibroid embolization (UFE) while apparently preserving their fertility, suggests a Johns Hopkins Medical Institutions study being presented here at the 27th Annual Scientific Meeting of the Society of Cardiovascular & Interventional Radiology (SCVIR).

"All of the patients in the study were 39 or younger and were interested in preserving their fertility. In the past, these women didn't have a choice – the only option was myomectomy, although many weren't candidates," said Hyun S. "Kevin" Kim, M.D., assistant professor of radiology and surgery, and director of gynecologic intervention, Johns Hopkins Medical Institutions, Baltimore. "Now, many young women can be treated with UFE, most likely maintain their fertility, and they don't have to go through surgery."

In a related multi-center study, several women have become pregnant after undergoing a variation of UFE that earlier studies have suggested does not affect fertility. It is thought that fibroids inside the uterus may interfere with fertility either by preventing implantation of the embryo in the uterine wall, or by interrupting a growing embryo that has already implanted. Fed by hormones, fibroids sometimes grow quite large after a woman becomes pregnant and may leave no room in the uterus for a developing fetus. In many cases, if the fibroids can be shrunk or removed, a normal pregnancy can occur.

**Johns Hopkins Study**

In the Johns Hopkins study, 29 women ages 20 to 39 underwent UFE with plastic particles about the size of grains of sand, called PVA (polyvinyl alcohol). The particles are inserted in the arteries that feed blood to the tumor, preventing blood from reaching the tumor and causing it to shrink and die. Bleeding and heavy periods were alleviated immediately in 27 (93 percent); 1 patient was retreated and the problem abated, and 1 patient’s symptoms eventually resolved so that 1 year after the procedure, bleeding symptoms had been alleviated. None of the women experienced premature ovarian failure, which causes early menopause. Blood tests revealed no significant changes in fertility hormone levels after the procedure.

Although none of the women in the study have become pregnant, Dr. Kim says he knows several women are currently trying and he is optimistic that there will be pregnancies.
"These women had magnetic resonance (MR) imaging 6 months to a year after UFE, and in all cases, the uterine myometrium got thicker after UFE," said Dr. Kim. "That’s an encouraging sign in regards to fertility."

**Inova Alexandria/Albany Medical Center Study**

There have been a number of anecdotal reports of women becoming pregnant after UFE and researchers are now beginning to document fertility results. In a study at Inova Alexandria Hospital, Alexandria, Va. and Albany Medical Center, Albany, N.Y., researchers performed UFE on 65 women ranging in age from 23 to 52 years old, with an average age of 37, 85 percent of whom wanted to maintain fertility. Of 10 women who said they were actively trying to conceive, 6 have become pregnant, with one of those ending in miscarriage. Four women are currently pregnant, and one has delivered a healthy child. After having UFE, none of the women experienced procedure-induced menopause.

Excessive bleeding stopped in 41 of 43 patients who were followed (95 percent). Bulk symptoms, or a feeling of pressure or heaviness in the abdomen, were completely resolved or significantly reduced in 38 of 41 women who were followed (92 percent), after an average follow-up period of 1 year.

"We used gelatin-sponge particles, which are temporary, so that the uterine arteries can reopen quickly after the fibroid is treated, in order to support a pregnancy," said Keith M. Sterling, M.D., an interventional radiologist at Inova Alexandria Hospital, and associate professor of radiology at George Washington University School of Medicine and Health Sciences, Washington, D.C. "The women in their 20s and 30s who were actively trying to become pregnant after UFE have had good success."

UFE is a nonsurgical procedure in which an interventional radiologist makes a small nick (less than one-eighth an inch) in the skin of the groin to reach the femoral artery, inserts a catheter (a tiny tube) and guides it to the uterus while watching the progress of the procedure via a moving X-ray (fluoroscopy). The interventional radiologist then injects small plastic and/or gelatin sponge particles into the vessels supplying blood to the fibroid to cut off the blood flow, or embolize it. The right and left uterine arteries generally are embolized during the procedure.

Studies have shown that when gelatin particles are used, the fibroids die quickly, but the uterine arteries reopen within weeks or months of the procedure, whereas it may take months or years for the specific feeder arteries embolized with plastic particles to reopen, said Dr. Sterling.

[Editor's note: Also read the information above in "Recurrence of fibroids and other longer term concerns"].

Myomectomy involves surgical removal of the fibroids and can be performed several ways, most often as an open surgical procedure, or laparoscopically, in which the physician makes small incisions in the abdomen and uses a probe with a tiny camera and small surgical instruments to remove the tumor. Most fibroids that cause fertility problems are inside the uterus, and are difficult to reach via myomectomy without cutting the uterus open to remove them, which may compromise the integrity of the uterus, said Dr. Kim.

Co-authors of a study being presented by Dr. Kim are A.N. Wadhwani, A.C. Venbrux, A. Arepally and J.F. Geschwind.

Co-authors of a study being presented at the meeting by Dr. Sterling are: G.P. Siskin, M.M. Ponturo, K. Mandato, K.S. Rholl and J.M. Cooper.

An estimated 5,200 people are attending the SCVIR Annual Scientific Meeting in Baltimore. SCVIR is the professional society of interventional radiologists – physicians who specialize in minimally invasive, targeted treatments performed using imaging guidance. Interventional radiology procedures are an advance in medicine that replace open surgical procedures. They are generally easier for the patient because they involve no large incisions, less risk, less pain and shorter recovery times.
NEEDLE LEFT IN WOMAN'S VAGINA FOR 50 YEARS
Sydney Morning Herald - July 30 2003

A Taiwanese woman, who suffered sharp pain for more than 50 years whenever she had sex, was found to have a needle in her vagina.

A recent examination at a hospital found the rusty sewing needle.

It had been left inside the woman's vagina by a midwife 53 years ago after a caesarean birth.

"She has suffered so much all these years - all because of the carelessness of the midwife," the United Evening News quoted Dr Chen Yi-jen, from the Tri-Services Hospital, as saying.

Dr Chen said the 73-year-old woman gave birth by caesarean section in 1949.

After the operation, the midwife sewed up the wound with a needle, but accidentally left it inside.

"The woman said she heard the midwife murmur, 'Where is the needle?' The midwife looked for it on the floor, but did not find it. Later she forgot about it," Dr Chen said.

"She visited several doctors, but they did not find anything wrong with her. Recently she came to our hospital, and we gave her a CT (computed tomography) scan, and saw a needle in her vagina," he said.

Doctors removed the needle, which was rusty and dark. The woman is recovering.

DPA

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

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