

**Voiceover:** Welcome to Well Woman: Wise Choices, pod casts that empower women with information to make wise healthcare choices. Your hostess is Darline Turner-Lee, physician assistant, exercise specialist, owner and founder of Next Step Fitness, Inc.

**Darline Turner-Lee:** Hello and welcome to Well Woman: Wise Choices. I'm Darline Turner-Lee. Well Woman: Wise Choices are pod casts for women who want to be in the best possible health so that they can live their best possible lives. In this our third podcast we are taking a look at the invasive and surgical treatments for uterine fibroids.

Not long ago, the only treatment offered for uterine fibroids was a hysterectomy. Sure, it relieves the annoying and sometimes health threatening symptoms such as excessive uterine bleeding, cramping, urinary incontinence and bowel dysfunction. However, as I've previously stated, if a woman desires to have a child, then a hysterectomy certainly isn't for her. What are her alternatives? We looked at non-invasive treatments in the last podcast and will now review the more invasive treatments here. Remember, I am not recommending or advising any particular treatment. My goal is to introduce you to each treatment and for you to then have a frank and candid discussion with your clinician about which treatment is best for you.

Fibroids are classified according to where they are located within the uterus. Treatment of fibroids depends upon where the fibroids are located, how large they are and how much trouble they are causing. If fibroids are small and causing no problems there really is no reason to remove them. But when symptoms cause problems with daily life or fertility, then it's time to act.

**Intra-cavitary fibroids** - If a fibroid is within the uterine cavity, it is called intra-cavitary. These fibroids hang in the uterine cavity via a stalk and resemble upside down mushrooms. They may interfere with pregnancy by encroaching on the growing baby and may potentially cause complications with fetal development, labor and delivery.

**Submucosal fibroids** - Submucosal fibroids are usually just under the endometrial lining and can protrude into the uterine cavity as well as into the uterine wall. They can interfere with implantation and often cause repeat miscarriages.

**Intramural fibroids** - Intramural fibroids are completely within the muscle layer of the uterus. They are the most common type of fibroid and are responsible for heavy uterine bleeding and cramping. They may also cause miscarriage depending on how large they are and how much they extend into the uterine cavity.

**Subserosal fibroids** - Subserosal fibroids are located at the outer edges of the muscle layer and under the outer lining of the uterus. They may cause no symptoms what so ever. As they reside near the outer edges of the uterus, they don't usually cause increased bleeding or interfere with fertility. They can, however, press upon surrounding structures and cause problems. For example, a subserosal fibroid that presses down on the bladder may be the cause of urinary incontinence, urinary frequency or incomplete voiding. If a subserosal fibroid presses on the rectum, bowel function may be inhibited.

**Pedunculated fibroids**- Pedunculated fibroids are attached by a stalk to the outside of the uterus. They often cause no problems, but when they do cause problems, they are much like subserosal fibroids, pressing on or becoming tangled with surrounding structures.

So now that we know what we are working with, let's look at treatments.

A **hysteroscopy** allows physicians to take a direct look into the uterus. The hysteroscope, the instrument used, is a thin tool that is inserted through the cervix into the uterine cavity. Depending on the tip used, a hysteroscopy can be diagnostic or provide treatment. Hysteroscopes have small cameras on the ends that are hooked up to television screens in the examination or operating room. Once they are inserted into the uterine cavity, physicians have a bird's eye view of the uterus and can see what is causing the problem and make a diagnosis.

There are hysteroscope tips that treat conditions. For example, if a clinician notes an intra-cavitary fibroid or polyp during hysteroscopy, a cautery tip can be used to remove it while also controlling blood loss. The technology is so sophisticated now that many clinicians perform such procedures in their office. Whisk-like tips are called resectoscopes that can remove clusters of small fibroids, scar tissue, or even endometriosis. The great thing is the uterus remains intact and a woman may go on to get pregnant if she so desires.

Discuss with your clinician what can be done for your particular case and make sure your clinician is experienced using the hysteroscope and can treat your particular fibroids.

**Endometrial ablation** is another option, but one for women who do not wish to have (anymore) children. A hysteroscope is inserted through the cervix into the uterine cavity and using either a laser or resectoscope, the uterine lining is destroyed. Following ablation, women will have no further menstrual bleeding. The procedure can be done in the office and there is minimal bleeding, trauma or pain. In addition to the uterine lining being destroyed, some fibroids and polyps can also be removed at the same time.

**Uterine Artery Embolization (UAE)** is one of the newer treatments for fibroids. The procedure involves inserting a catheter like those used for heart catheterization into the artery in the groin and feeding the catheter through to the uterine artery. Then small pellets are inserted through the catheter and blood supply is blocked. Overtime, the fibroids shrink and dissolve. This procedure is effective for all types of fibroids *but is not for women who may later want to become pregnant.*

There are some negatives to UAE. As the fibroids are dying due to the lack of blood supply, there can be significant pain. Patients who have not stayed overnight often have to call their physicians for pain management or in severe cases, may be brought into the emergency room. This doesn't happen to everyone, but it is a fairly common occurrence. Additionally, there can be complications from the catheterization such as blood loss at the catheterization site, hematoma (a large collection of blood beneath the skin) development at the catheter site or even infection. Nerve damage has been reported, but in skilled hands, this should not be a problem.

**ExAblate** is the newest treatment for uterine fibroids. It is completely non invasive and combines two systems—MRI and Ultrasound. A magnetic resonance imaging (MRI) machine shows where the fibroids are in relation to other structures, determines the size of the fibroids to be treated, and monitors the temperature of the uterine tissue after heating. A focused ultrasound beam heats and destroys the fibroid tissue using high frequency, high-energy sound waves.

The procedures are best performed on women with only a few medium to large fibroids, who are not extremely thin or overweight and who are not claustrophobic. The procedure cannot be used to treat fibroids that are close to the bladder, bowel or other anatomic structures. The procedure can take up to 3-4 hours, but most patients have minimal pain or discomfort and are back to their regular activities in 1-3 days. There is the risk of burns to surrounding structures, but again, in capable hands, this is rare.

**Laparoscopic Laser Treatments** involve making small punctures in the abdomen in which to insert the laparoscope and then using lasers, destroy the fibroids. The benefits of this procedure are that it is minimally invasive, can be done as an outpatient, there is minimal blood loss, pain or trauma and women are back to their regular activities in just a few days. Other problems such as polyps, endometriosis and adhesions can be treated at the same time. Women may conceive after this procedure. The risks associated with the procedure are primarily due to the laparoscopy. There may be pain from the abdominal distention, nausea, bloating and vomiting. Risks from the laser are burns or damage to surrounding structures. Again, if performed by a skilled clinician, these risks are minimal.

**Myomectomy** is surgical removal of the fibroids. It was the first procedure that removed fibroids yet spared the uterus so that a woman can become pregnant. Over the years, myomectomy techniques have been refined so that there is minimal blood loss, minimal scarring and minimal down time.

The traditional **abdominal myomectomy** involves making an incision into the abdomen, opening up the abdominopelvic cavity and then removing (cutting) the fibroids out of the uterus. This procedure is still done by many gynecologists. However, there can be significant blood loss, pain and trauma and sometimes the scarring is so significant that women still can't conceive after the procedure. Some women develop wound infections and in rare cases there are complications and the procedure becomes a hysterectomy. The procedure takes anywhere from 4-12 weeks from which to recover.

**Laparoscopic myomectomy** involves making several small incisions in the abdomen and removing the fibroids in tact (if they are small enough) through the laparoscope or removing them after myolysis (destruction) with a laser or ultrasound waves. This procedure has much less blood loss and trauma and patients have a shorter recovery time. Because gas is used to distend the abdomen so that structures can be seen, there is a slightly more post operative pain, yet this quickly subsides. This procedure also produces less scarring.

**Mini-laparotomy myomectomies** surgically remove the fibroids but through the smallest incision possible. The technique behind this procedure is that a small bikini incision is made and the uterus is popped out through the incision onto the belly. No retracting instruments are used so there is no trauma or bruising to the skin or tissues and less pain for the patient. The surgeon then removes the fibroids, closes the cuts and places the uterus back into the pelvis.

This procedure can sometimes be done as an out patient, but is best done with an overnight stay. There is minimal pain and minimal blood loss and patients can be back to regular activity in as little as 2-3 weeks.

**Hysterectomy.** Well, what else is there to say? If you remove the uterus, you remove the problems, but there is no chance of conception. This should only be done in cases of severe symptoms not alleviated by other treatments and if the woman is sure she does not want to have any (more) children. If a woman is becoming anemic, having severe bladder and bowel problems or her uterus is so large she looks significantly pregnant, she may need a hysterectomy. If there is some question of her tumors looking cancerous (in which case they are not fibroids but something else!) then she may need the hysterectomy.

The less traumatic procedure is the **vaginal hysterectomy**. This can only be done if the uterus is not larger than a certain size. **Laparoscopic assisted vaginal hysterectomy** is becoming more popular as the surgeons can see structures clearly using the laparoscope and if necessary, destroy the fibroids or at least break them down prior to removing the uterus to reduce trauma and discomfort to the patient. Vaginal hysterectomy has a shorter recuperation, less blood loss and fewer complications. Again, it is only appropriate for women with a few fibroids, smaller fibroids and uncomplicated situations. Recovery is about 4 weeks.

The traditional abdominal hysterectomy is a major surgery. Today they are mostly done through bikini incisions, but sometimes a midline incision is needed from the navel to the pubic bone. As it concerns fibroids, abdominal hysterectomies are for women with multiple fibroids, larger fibroids or for women with other problems that cannot be managed without direct contact. Technology is allowing for less invasive hysterectomies and women are suffering far less trauma, blood loss, pain and recovery time. Still, recovery is about 8-12 weeks following a hysterectomy before women, but many women say that it takes 6 months to a year to feel fully healed.

There is another aspect of hysterectomy that I want to touch upon. The uterus is a target organ for hormones and many women find that once they have a hysterectomy, they note a decrease in sex drive (clinicians report up to 50%) and they may experience moodiness, irritability, crying, and depression. If the ovaries are also removed, women are post menopausal immediately following the procedure and may experience symptoms of estrogen depletion such as hot flashes, decreased mental acuity, insomnia and memory loss. All of these factors have to be considered and addressed prior to hysterectomy and plans for hormone replacement should be discussed.

So there you have it, the complete array of treatments for uterine fibroids. I've tried to provide you with as comprehensive a list as possible, but I may have missed a treatment so be sure to discuss all your options with your doctor. These podcasts are not meant to be exhaustive, but to present the current, most widely used methods of treatment for fibroids. I hope that you will take this information, review it for yourself and then review it with your gynecologist. Together you should be able to come up with a treatment plan that is best for you. You'll know what to expect and will be able to plan how and what you'll need during your recovery. As is always my goal, I want you to have as much information as possible to make wise health care choices.

Join us for our next podcast when I'll give an overview of many of the newer hormonal contraceptives. I'm Darline Turner-Lee and this is Well Woman: Wise Choices. Thank you for tuning in. Visit <http://www.nextstepfitness.com/podcasts/index.html>