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Fibroids or Uterine Leiomyomata

Uterine Fibroids are also called Myomas or Leiomyomata. Uterine fibroids are the most common solid pelvic tumors found in women. We do not know the exact cause of fibroids but there is evidence that there are genetic factors, hormonal influences and various growth factors that affect development of uterine fibroids. Most patients who have uterine fibroids can be followed throughout her life without needing any treatment. Although uterine fibroids are over 99% benign; they are the most common cause for female surgery. The risks of malignant change in a fibroid, called leiomyosarcoma is extremely rare with a less than 0.1 % incidence. The management of uterine fibroids is based on the patient's symptoms, clinical course and personal goals.

Uterine fibroids are found in almost 20-40 percent of all women in the reproductive age. Uterine fibroids are benign tumors originating from the smooth muscle cells of the uterus. They range in size from seedlings to very large tumors and can be single or multiple. Fibroid tumors found within the myometrium are called intramural, those externally extending to the serosa are called subserosal and those internally impinging on to the uterine cavity are called submucosal. Myomas can also be pedunculated off the surface of the uterus or extent through into the cavity and even thru the uterine cervix. When uterine fibroids become large they occupy more than one area of the uterus and can cause pressure on adjacent organs.

Myomas are known to be estrogen-dependent tumors. Approximately 85% of women with fibroids will note a 30% decrease in fibroid size after menopause. Most fibroids exhibit a growth period during the ten years before menopause, likely secondary to unopposed estrogen from anovulation. Fibroids also tend to grow approximately 30% in size during pregnancy. The changes in pregnancy usually reverse after delivery. Studies continue in the area of growth factors and suppressor genes on fibroid growth and cell suppression. Patients with symptomatic uterine fibroids deserve a workup and treatment. When fibroids are located near the endometrial lining, bleeding with or without pain is common. Heavy bleeding, clotting or spotting between periods is a very common side effect of uterine fibroids.

Pelvic pain from uterine fibroids can also occur from tumor degeneration from rapid growth, muscle spasm or torsion. If pain is the main complaint, the fibroids may be present along with endometriosis of the uterus also called adenomyosis. If adenomyosis is present, surgery alone may not be enough to cure the heavy uterine bleeding and chronic pelvic pain symptoms. Pelvic and abdominal pressure and increased abdominal girth are common complaints from uterine fibroids. As fibroids grow in size they can impinge on adjacent organs causing gastrointestinal and urinary symptoms as well as pelvic pressure. There is evidence that infertility can be caused by the presence of submucosal myomas or from distortion and obstruction of the uterine cavity and fallopian tubes. Patients undergoing in-vitro-fertilization have decreased implantation rates and increased miscarriages with the presence of any fibroids.

Patients who experience rapid growth in her fibroids have significant pain, pressure, bleeding or growth during the menopausal phase of life should seek medical care.

Uterine fibroids are well visualized by ultrasound evaluations. During the ultrasound examination the presence of hydronephrosis which means dilation of the ureters should be evaluated. Occasionally, an MRI is needed to evaluate the pelvic mass.

Patients with bleeding fibroids leading to anemia are at significant risk for a blood transfusion and emergency surgery. Patients should be under the constant care of their physician to avoid any emergency event. Patients may be given recommendations regarding hormonal control, iron therapy and shrinkage with Lupron therapy. On an individual basis, a procedure or surgery may be recommended to prevent or treat gynecological complications from uterine fibroids. Uterine ablation, morcellation of fibroids and uterine artery embolization are now used to control complications from uterine fibroids. An open laparotomy or laparoscopic uterine myomectomy may be recommended if preserving fertility is a priority. The removal of the uterus with or without the cervix can be performed by laparoscopy or laparotomy. Patients have a choice of a definitive surgical treatment or step wise plan to manage uterine fibroids.

Please refer to the patient information handout titled “Hysterectomy, myomectomy and alternatives.”