

Women's Healthcare of Illinois

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Uterine Fibroids: Myomectomy vs. Hysterectomy

Myomectomy is the surgical removal of uterine fibroids without hysterectomy. The following questions and answers discuss the issues involved in this type of alternative to hysterectomy.

What are Uterine Fibroids?

Fibroids are common benign tumors, which arise from the muscle tissue of the uterus; they may be single or multiple. About 25% of all women over the age of 35 have fibroids; among African-American women fibroids are even more common. These tumors may grow into the uterine cavity (sub-mucous fibroids); they may be located in the uterine wall (mural) or protrude outside of the uterine wall (sub-serous).

What Symptoms Do Fibroids Cause?

Sub-mucous fibroids are the type that most commonly cause significant problems; even small tumors located in or bulging into the uterine cavity may cause heavy bleeding, anemia, pain, infertility, or miscarriage. Mural fibroids (located in the uterine wall) and sub-serous fibroids (protrude outside the uterine wall) may reach a large size before causing symptoms. These symptoms may include pressure on the bladder with difficulty voiding or urinary frequency and urgency, pressure on the rectum with constipation, lower back and abdominal pain, as well as heavy bleeding.

What is the Conventional Treatment for fibroids?

Every year over 550,000 American women undergo hysterectomy, the majority for benign non-life threatening conditions. In 33% of all hysterectomies, the reason for surgery is problems related to fibroid tumors.

When fibroids are small and causing no symptoms, no treatment is required. In the presence of symptomatic or large fibroids, a woman who wishes to preserve her fertility may be offered a myomectomy, an operation that removes the fibroids while sparing the uterus. However, the conventional treatment for women 40 years of age and older is hysterectomy and bilateral oophorectomy (removal of both ovaries). Even women younger than 40 who have completed childbearing are usually offered hysterectomy. The rationale for this approach is as follows: hysterectomy and oophorectomy are viewed as definitive solutions for the presenting medical problem (i.e., bleeding, anemia, pain etc.) and as preventive measures against the risk of malignancy in the pelvic organs. The prevailing attitude is that a woman who does not desire more children, no longer "needs her uterus." Another justification for the conventional approach of hysterectomy is the fact that, depending on the number, location and size of fibroids, successful myomectomy requires more expertise and surgical skill than hysterectomy. When performed by a surgeon without extensive experience, myomectomy is more likely to result in prolonged surgery, significant blood loss requiring blood transfusion and other postoperative complications. Therefore; it is not surprising that the average gynecologist tends to offer hysterectomy as a treatment for fibroids, rather than myomectomy.

Changing Attitudes Among Women:

In recent years, as more women have become better informed on health issues, they have sought treatments that preserve the pelvic organs, especially in the presence of a benign disease. In addition, research has demonstrated that, while hysterectomy solves some problems, it may also lead to other problems. For example, following hysterectomy, there is an increased prevalence of problems related to sagging pelvic organs such as "dropped bladder" (in medical terms these are

known as genital prolapse, including vaginal vault prolapse, enterocele, cystocele and rectocele). These conditions may cause symptoms, such as urination and defecation disorders, and may require surgical repair. Several studies suggest that even without sagging of the vaginal walls, 20-30% of women develop after hysterectomy urinary leakage, urinary frequency or slow transit constipation.

It has been shown that after hysterectomy, even without removal of the ovaries (oophorectomy), women tend to enter menopause earlier, by as much as four years according to one study. Estrogen produced by the ovaries reduces the risk of coronary artery (heart) disease and osteoporosis (thinning and weakening of the bones). Studies indicate that hysterectomy before natural menopause, even without oophorectomy, increases the risk of heart disease up to 30%, according to one study, during the remaining premenopausal years. Hysterectomy with prophylactic (preventive) oophorectomy eliminates the risk of death from uterine or ovarian cancer (life long probability of death 1.3%), but increases the risk of death from heart disease (life long probability of death 33%) and osteoporosis. Estrogen replacement therapy may prevent the negative consequences of surgically induced menopause. However, a large proportion of women discontinue hormonal replacement therapy after a few months and therefore lose this protective effect.

The uterus has great psychological significance for many women. Although many women have no emotional difficulties after surgery, post-hysterectomy problems such as depression, anxiety and sexual dysfunction have been described. Some women complain of decreased quality of sexual response after hysterectomy, specifically, a change in the quality of orgasm. This change may be the result of the absence of rhythmic uterine contractions during orgasm. Finally, many women are strongly opposed, in principle, to the removal of any organs, genital or otherwise, unless absolutely necessary.

A Physician's Response:

My conviction as a physician is to respect the personal aspirations and viewpoints of every patient. If an informed patient wishes to preserve her uterus in the presence of a benign condition and if her medical problem can be safely resolved without hysterectomy, the physician should comply with the patient's desire, even if this involves referring her to another specialist.

Effective Treatment for Uterine Fibroids:

Myomectomy, when performed by an expert, is a safe and effective alternative to hysterectomy. This operation can usually be accomplished with minimal blood loss. When the operation is performed with optimal technique by a highly experienced surgeon, the need for blood transfusions is limited to very few cases. Likewise, in an expert's hands, it is rare that a myomectomy is converted during surgery to an unplanned hysterectomy because of uncontrollable bleeding. The gynecologic surgeon who has extensive experience with myomectomy is able to remove all fibroids regardless of their location. The successful myomectomy should result in resolution of all symptoms related to fibroids.

Myomectomy: The Operation.

Depending upon the location of the fibroid(s), myomectomy can be accomplished by either an abdominal or vaginal approach. When the fibroid causing symptoms is bulging into the uterine cavity (sub-mucous), it is usually possible to remove it by using a hysteroscopic technique. This technique involves using an operating "telescope": which is inserted into the uterus through the vagina. Hysteroscopic myomectomy is performed on an outpatient basis; the short recovery period at home is 2-3 days before resumption of full activity. In the presence of large fibroids in the uterine wall (mural) or bulging out of the uterus (sub-serosal), abdominal myomectomy through an abdominal incision is usually required. In most cases this can be accomplished through a low horizontal incision along the bikini line, resulting in a minimally visible scar. Following an uncomplicated abdominal myomectomy, discharge from the hospital is usually possible within 2-3 days. There is a variable recovery period at home of 2-6 weeks depending upon individual factors and life style.

A critical part of successful myomectomy is optimal reconstruction of the uterus after the fibroids have been removed. The irregular defects created in the uterine wall by the removal of the fibroids must be meticulously repaired so that

potential sites of bleeding and/ or infection are eliminated. A poorly reconstructed uterus may rupture during a subsequent pregnancy or delivery. In this regard, removing large fibroids through the laparoscope (telescope inserted through the navel) is not advisable in most cases because optimal reconstruction of the uterus is not accomplished in this manner.

There are numerous surgical techniques for performing myomectomy. However, the important goal common to all is minimizing blood loss and other complications. It is critical to prevent significant blood loss during and after surgery as this may result in postoperative complications such as anemia, fever, infection and the requirement for blood transfusion. Bleeding and/or infection may lead to pelvic adhesions, which, in turn, may cause pain or bowel obstruction in the short or long term. An expert in myomectomy should be able to assure the patient prior to surgery that the intended myomectomy will not turn into an unplanned hysterectomy because of uncontrollable blood loss.

What If Cancer is found?

About 1 in 200 women with fibroids is found at surgery to have a malignant tumor of the uterus (sarcoma). Therefore, the preoperative discussion between the woman and her surgeon should include consideration of this unlikely circumstance. The patient should be counseled regarding the importance of hysterectomy and removal of both ovaries as a life-saving procedure when cancer is found during the operation.

What is the Role of Hormone Treatment?

Some physicians advocate hormone treatment with GnRH agonists, such as Lupron, in preparation for myomectomy. This treatment postpones the operation for 2-4 months. During this time the fibroids decrease in size and the bleeding is markedly reduced. Although some surgeons feel that this makes the operation easier and diminishes blood loss, many other experienced surgeons find this very expensive treatment unnecessary with few exceptions. However, it is generally agreed that if a woman is very anemic, hormone treatment along with iron supplements promotes recovery from the anemia prior to surgery. Concern has been raised that GnRH treatment may shrink small fibroids, which could, therefore, be missed at surgery only to enlarge again and cause problems later.

What Kind of Imaging Tests May Be Helpful Prior to Surgery?

The role of imaging studies in women with fibroids includes: a) confirm the clinically suspected diagnosis of fibroids, b) exclude other causes of uterine enlargement or pelvic masses such as adenomyosis, uterine malignancy, and benign or malignant ovarian masses, c) to identify normal ovaries in the presence of an enlarged uterus, d) examine the kidneys and urinary tract for obstruction due to the pelvic mass, and e) precise determination of the number, size and location of the fibroids. The latter is particularly important for successful myomectomy because it helps the surgeon determine ahead of time what kind of operation is required. The type of imaging test depends on the individual findings in a given woman and the availability of certain equipment/techniques. The tests commonly used are pelvic ultrasound (both transabdominal and vaginal) and x-rays of the kidneys and urinary tract (IVP). Newer imaging modalities, which may be used in selected cases, include MRI and sonohysterography.

Questions to ask before choosing a surgeon for myomectomy:

1. How often do you perform myomectomy?
2. How many years have you performed myomectomy and how many myomectomies have you performed?
3. What was the outcome of these myomectomies: how often was the operation converted to a hysterectomy?
4. In what percent of cases were blood transfusions required?
5. How long do your patients stay in the hospital after surgery?

These questions are important because they help pinpoint the experience and "track record" of a doctor. An experienced confident surgeon will not find these questions threatening and should be readily forthcoming with these facts and figures. On the other hand, if a physician's surgical skill is limited primarily to hysterectomy, these questions will reveal inexperience or poor results with myomectomy. For further reassurance, consider speaking with women who have undergone myomectomy by the surgeon under consideration.

Conclusions:

As women become increasingly aware of the important issues related to fibroids and hysterectomy, there is growing interest in alternative treatments. Many of these issues are controversial among both professionals and laypersons. The ethical physician should inform the patient of the issues and options and, above all, respect her convictions and her right to make the ultimate decisions regarding her body. I hope that this presentation is helpful to the many women and their families who are facing this common problem.

Taken from <http://www.netreach.net/~hysterectomyedu/myomecto.htm>