Fibroids

Disclaimer

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Background – About Fibroids

70 to 80% of women will have developed one or more fibroids by age 50 years. They are usually asymptomatic.

The exact cause is unknown – likely multifactorial, with hormones contributing to growth.
- During pregnancy, fibroids may enlarge.
- At menopause, fibroids usually shrink.

They are usually benign. There is a rare risk of malignant leiomyosarcoma developing within fibroid (< 1 in 1000). Fibroids and endometriosis can co-exist.

Symptoms can be related to local pressure on pelvic organs, degeneration within the fibroid, or by increasing the bleeding surface area of the endometrium.

Fibroids are classified depending on location in wall of uterus:
- Submucosal – distorting uterine cavity affecting the endometrial surface.
- Intramural – within muscle wall.
- Subserosal – located on outside wall, sometimes on a pedicle.

Assessment

1. Take a history – ask patient about:
   - pelvic pain, including dyspareunia and dysmenorrhoea.
   - pelvic organ pressure or obstruction symptoms (bladder, bowel) – difficulty passing urine, urinary frequency, difficulty moving bowels, constipation.
   - heavy periods or abnormal uterine bleeding.
   - symptoms of anaemia.
   - subfertility.


3. Arrange investigations:
   - If heavy bleeding or symptoms of anaemia, consider FBE and iron studies.
   - Arrange pelvic ultrasound (transvaginal ultrasound preferred).
   - For rare complications of fibroids:
     - and urinary obstruction signs and symptoms, check urea and electrolytes and CT-KUB (kidneys, ureters, and bladder).
     - check for suspicious features of leiomyosarcoma on ultrasound.

Leiomyosarcoma
- Mixed echogenic and non-echogenic parts
- Central necrosis
- Doppler – irregular vessel distribution, low impedance, high peak systolic velocity
Management

1. Reassure the patient that fibroids are almost invariably benign.

2. If symptomatic:
   - arrange **immediate gynaecology referral or admission** if:
     - severe anaemia causing haemodynamic instability.
     - significant urinary obstruction.
     - symptomatic fibroid prolapse through cervix.
   - arrange **urgent or routine gynaecology referral** if:
     - heavy or irregular menstrual bleeding, with or without anaemia.
     - pelvic or abdominal pain.
     - pelvic organ pressure symptoms (bladder, bowel).
     - rapid growth of fibroid.
     - suspicion of malignancy.
     - urinary obstruction, renal impairment.
   - and need to manage heavy bleeding, see **Heavy Menstrual Bleeding**.

3. If asymptomatic:
   - with no identifiable risk factors, offer reassurance.
   - consider arranging **urgent or routine gynaecology referral** if:
     - single fibroids > 6 cm, or multiple fibroids > 5 cm.
     - asymptomatic fibroid prolapse through cervix.
   - consider second ultrasound in 6 to 12 months to check that the fibroids are not growing rapidly. If rapid growth of fibroid, arrange urgent or routine gynaecology referral.

4. Give special consideration to:
   - **Patient planning pregnancy**
     - **If patient**:
       - with single small fibroid (< 3 cm) in intramural or subserosal locations, reassure that there should be no effect on pregnancy.
       - with submucosal fibroids, discuss possible impact on fertility:
         - Fertility issues are likely related to fibroid size and position.
         - Myomectomy may improve obstetric outcomes in patients with a poor obstetric history, and subfertility.
     - **Arrange urgent or routine gynaecology referral** if:
       - large or multiple fibroids.
       - subfertility, particularly if fibroid is submucosal.
       - fibroid negatively impacted on previous pregnancy outcomes.
   - **Pregnant patient**
     - **If patient pregnant**:
       - Reassure the patient that most women with small fibroids have no complications, and there should be no effect on pregnancy.
       - Occasionally women may experience pain with fibroid growth in the pregnancy.
       - Rare complications of fibroids during pregnancy:
         - Antepartum haemorrhage, placental abruption
         - Intrauterine growth restriction
         - Malpresentations, labour dystocia
         - Miscarriage
         - Preterm labour
Arrange urgent or routine obstetric referral if:
- fibroids are associated with pain (after excluding other serious causes)
- fibroids > 5 cm or multiple fibroids.
- retroplacental or lower uterine segment location.
- distortion of uterine cavity.
- cervical fibroids.

Referral

- Arrange immediate gynaecology referral or admission if:
  - severe anaemia causing haemodynamic instability.
  - acute urinary obstruction.
  - symptomatic fibroid prolapse through cervix.
- Arrange urgent or routine gynaecology referral if:
  - suspicion of malignancy or leiomyosarcoma.
  - urinary obstruction, renal impairment.
  - heavy or irregular menstrual bleeding with or without anaemia.
  - rapid growth of fibroid.
  - pelvic organ pressure symptoms (bladder, bowel).
  - pelvic pain or abdominal discomfort.
  - patient is planning pregnancy and has:
    - large or multiple fibroids.
    - subfertility.
    - fibroids negatively impacted previous pregnancy outcomes.
- Consider arranging urgent or routine gynaecology referral if:
  - single fibroids > 6 cm, or multiple fibroids > 5 cm.
  - asymptomatic fibroid prolapse through cervix.
- Arrange urgent or routine obstetric referral if patient is pregnant with:
  - pain after other serious causes excluded.
  - fibroids > 5 cm or multiple fibroids.
  - retroplacental or lower uterine segment location.
  - distortion of uterine cavity.
  - cervical fibroids.

Information

For health professionals

Further information

- Australian Family Physician (AFP) – Uterine Fibroids: Investigation and Current Management
  Trends
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Fibroids in Infertility

For patients

Better Health Channel – Fibroids

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