FIBROIDS AND LAPAROSCOPIC MYOMECTOMY PATIENT INFORMATION

What is a fibroid?

A fibroid is a solid, benign (non-cancerous) tumour or growth of smooth muscle that can be found in any part of the body. One of the most common places for fibroids to grow is from the muscular wall of the uterus (womb). They can vary in size, number and position within the uterus. Fibroids can grow into the cavity of the womb, within the wall of the womb or grow outwards into the cavity of the abdomen. Different types of fibroids can be present in the same woman. The symptoms that a woman may experience with fibroids can be affected by where the fibroids are growing.

How common are fibroids?

It is estimated that up to 70% of women may develop uterine fibroids but the majority do not cause any symptoms and are insignificant in size. Some ethnic groups are more likely to develop fibroids and afro-Caribbean women are more susceptible to developing them at a younger age.

What causes fibroids?

It is not clear what causes fibroids and why some women are more susceptible to developing them. Fibroids are responsive to the female hormone oestrogen and are rarely seen before puberty and usually shrink after the menopause.

Are Fibroids cancer?

No, fibroids are not cancerous tumours.

Symptoms of fibroids

As explained above, many women will have no symptoms with fibroids. However, they can experience any of the following:

- Heavy and/or prolonged periods
- Pelvic pain associated with periods. Sudden or acute pain can occur with fibroids if they start to break down, called degeneration, or if are on a stalk and twist round on themselves.
- Large fibroids can also press onto the bladder causing urinary frequency, urgency and/or incontinence or prevent the bladder from emptying properly. Fibroids can also press onto the rectum causing constipation, pain or difficulty in opening the bowels
- Fibroids can interfere with the normal process of conception, particularly if they grow into the cavity of the womb.

What is a laparoscopic myomectomy?

A myomectomy is the removal of fibroids. This can be done laparoscopically, i.e. via keyhole surgery. The operation is done under general anaesthetic. Three or four small incisions are made on the skin of the abdomen to allow the surgeon to insert the instruments to do the operation. An 1cm incision is made in the belly button. This incision is normally made within the folds of the skin and is usually barely visible once healed. The surgeon will pass a telescope, a laparoscope, through this incision to allow them to see inside your tummy. During the operation, your tummy will be filled with gas to allow the surgeon to see more clearly, this gas will be let out at the end. Another 1.5 cm incision is made on the left lower hand side of the abdomen and a

0.5 cm incision on the lower right hand side. A further 0.5 cm incision may be needed in the bikini line, the decision of whether this will be needed is made during the surgery. The fibroids are removed from the wall of the womb and the wall of the womb is repaired with stitches that will not need removal. The fibroids are then cut into smaller pieces and removed through one of the incisions on the abdomen. All the incisions will be closed with a stitch that will dissolve on its own but which can be removed after 5 days. The operation can take several hours depending on the size, location and number of fibroids. As the incisions are small, patients usually have a much faster recovery than with an operation through a bigger cut.It is not always possible to remove all of the fibroids, particularly if they are small.

Will a laparoscopic myomectomy be suitable for me?

Laparoscopic myomectomies work best for women with a smaller number of fibroids. Your gynaecologist will advise you if a laparoscopic myomectomy will be suitable for you.

What are the risks?

Any operation carries risks. The following list includes general risks and those more specific to a laparoscopic myomectomy.

- Excessive bleeding. Occasionally, this can be heavy enough that a blood transfusion is required.
- Infection. Antibiotics through the vein are given during the operation to reduce the risk of infection.
- Injury to surrounding structures. The bowel, bladder, blood vessels and the ureters (the tubes between the kidneys and bladder) are most at risk. The chance of damage is 0.2 – 0.4 /1000 cases. If damage does occur then it will be repaired at the time. This can sometimes be done by key-hole surgery but an open cut may be needed. Sometimes, it is not possible to complete the operation by key-hole surgery and conversion to an open cut may be needed – the chance of this is about 1%.
- Adhesions. There is a risk of scar tissue developing inside the abdomen between the organs. This usually will not cause any problems but can sometimes impact on fertility if it involves the fallopian tubes and may make future surgery more difficult.
- Hysterectomy. If there is excessive bleeding, which cannot be controlled, at the time of the surgery then it may be necessary to remove the womb to stop the bleeding, the risk of this is about 1%.
- Caesarean section for future deliveries. As the fibroids are removed, there is a chance that the cut into the womb may extend into the cavity of the womb. If this happens, then it is not safe to labour in future pregnancies and you will advised to have a planned Caesarean section.
- Wound haematoma. You may develop a bruise under the skin where the incisions are made.
- Wound breakdown i.e. the wound does not heal well. This is temporary
- Wound hernia. You may develop a hernia the incision sites.
- Venous thrombo-embolism. Surgery increases the risk of developing a blood clot, usually in the lung or legs. You will be given compression stockings to wear and after your operation, during your stay in hospital and you will be given injections to thin the blood and reduce the risk of this happening.
- Undiagnosed cancer. Rarely, there may be undiagnosed cancer within the fibroid. The food and drug administration in the U.S.A. quote the risk as high as 1 in 380 patients, however, they included all cancers of the womb including endometrial cancer (cancer of the lining of the womb) including in women who were already

menopausal, in which this type of cancer is more common than cancer in a fibroid. European data suggest that the rate of cancer in a fibroid is closer to 1 in 1000 patients. Morecellating (cutting up the fibroid inside the abdomen) when there is an undiagnosed cancer may lead to a worse prognosis but this has not been established. Rarely, fibroid fragments, including benign ones, may implant and grow on the lining of the abdomen or on other organs in the abdomen. There has only been one previous case of this at this hospital.

The likelihood of complications increases in patients who are overweight or obese, heavy smokers and those with medical problems such as diabetes or those with poorly controlled chronic lung problems.

In less than 10% of cases following surgical treatment, there may be an increase in the size of the remaining fibroids and this may cause additional symptoms. There is also a chance that you will develop new fibroids in the future.

Alternatives to a laparoscopic myomectomy

You do not have to have treatment of your fibroids. It is sometimes possible to control heavy bleeding and pain with medications. Fibroids can also be treated with uterine artery embolisation, MRI guided focused ultrasound, radiofrequency ablation, trans-cervical resection of fibroid, open myomectomy and hysterectomy. Your gynaecologist will advise you on which of these may be suitable alternatives for you.

Treatment before surgery

It is not normal to have any treatment before surgery. You may require some iron supplements to treat anaemia before surgery.

Preparation for surgery

You will be sent written information about what time to attend the hospital and when to stop eating and drinking pre-operatively. On admission you will be assessed by the nursing staff and blood tests taken.

You will be seen following admission by the anaesthetist and Mr Miskry.

Medications: If you regularly take medicines in the morning, you should take them as usual with a small sip of water. If you are diabetic, you must not take your insulin or diabetic tablets on the morning of the operation. If you take blood thinning medications such as warfarin or aspirin, you will usually be advised to stop these before the operation but may be told to take alternatives. Do not stop these medications without medical advice.

Enhanced recovery: An enhanced recovery programme has been established at for patients undergoing surgery. It aims to reduce complications and the length of your hospital stay. An important part of this programme of care is your understanding of how you, and possible your friends and family, can play an active role in your recovery.

On the day of the operation

You will be asked to sign a consent form on the day of your operation. This will state the operation that you are having and the potential risks as outlined above. Everything will be fully explained to you by the doctor who is taking the consent.

Please bring with you all of the medications that you usually take.

To reduce the risk of infection, we advise everyone to have a shower or bath before going to the operating theatre. All make-up, nail varnish and jewellery (except wedding rings), body piercings and dentures must be removed. You will be accompanied to the operating theatre by a member of staff.

After the operation

You will initially go to a recovery area after your operation. Later, you will be transferred to the ward. Nursing staff will regularly monitor you including taking measurements of your pulse, blood pressure and temperature. You may have 1-2 drains coming out the incisions on the abdomen; these are usually removed about 24 hours after the operation.

You will be given regular painkillers by the nurses but can also ask for more if you have pain and it is appropriate. You may feel light-headed or sleepy after the operation. This is due to the anaesthetic and may continue until the next day. You may have a sore throat for a few days because of the tube that was in your throat to help your breathing during the operation You may also feel bloated and have pain in your shoulder. This is due to the gas that was used to inflate the abdomen and will settle over a few days as the gas is absorbed by the body. You should be able to eat and drink within a few hours of your operation but you may be attached to a drip to hydrate you until then. You may find it difficult to open your bowels in the few days after the operation and it may be necessary to prescribe you laxatives temporarily until this improves. You may have some vaginal bleeding which can last a few days to a couple of weeks – this is normal and is not a concern unless it becomes heavy or is increasing. You will also have a catheter, a flexible plastic tube that drains your urine. This will be removed the morning after the operation.

You will be encouraged to do gentle leg and breathing exercises on the ward after your operation to help prevent blood clots in the legs and chest infections. Recovery is aided by getting out of bed and being mobile as soon as possible after the operation.

You should expect to be discharged around 24 hours after your operation, some patients will be able to go home on the same day. The dressings on your wound should be removed the day after your operation. A follow up appointment will be made for you in clinic 6-8 weeks after your operation. If you feel unwell at home before then, you should see a healthcare professional at your GP or A&E. Symptoms that should prompt you to do this are if you develop high temperature or fever, worsening pain, vomiting or nausea or pain, inflammation or redness around the wound site.

Usually, it is safe to try to conceive 3 months after the operation.