Fibroids

Uterine fibroids are non-cancerous growths of the uterus that often appear during your childbearing years. Also called fibromyomas, leiomyomas or myomas, uterine fibroids aren't associated with an increased risk of uterine cancer and almost never develop into cancer.

As many as 3 out of 4 women have uterine fibroids sometime during their lives, but most are unaware of them because they often cause no symptoms. Your doctor may discover them incidentally during a pelvic exam or prenatal ultrasound.

In general, uterine fibroids cause no problems and seldom require treatment. Medical therapy and surgical procedures can shrink or remove fibroids if you have discomfort or troublesome symptoms. Rarely, fibroids can require emergency treatment if they cause sudden, sharp pelvic pain or profuse menstrual bleeding.

In women who have symptoms, the most common symptoms of uterine fibroids include:

- Heavy menstrual bleeding
- Prolonged menstrual periods — seven days or more of menstrual bleeding
- Pelvic pressure or pain
- Frequent urination
- Difficulty emptying your bladder
- Constipation
- Backache or leg pains

Rarely, a fibroid can cause acute pain when it outgrows its blood supply. Deprived of nutrients, the fibroid begins to die. By-products from a degenerating fibroid can seep into surrounding tissue, causing pain and fever. A fibroid that hangs by a stalk inside or outside the uterus (pedunculated fibroid) can trigger pain by twisting on its stalk and cutting off its blood supply.

Fibroid location influences your signs and symptoms:

- **Submucosal fibroids.** Fibroids that grow into the inner cavity of the uterus (submucosal fibroids) are thought to be primarily responsible for prolonged, heavy menstrual bleeding and are a problem for women attempting pregnancy.
- **Subserosal fibroids.** Fibroids that project to the outside of the uterus (subserosal fibroids) can sometimes press on your bladder, causing you to experience urinary symptoms. If

fibroids bulge from the back of your uterus, they occasionally can press either on your rectum, causing constipation, or on your spinal nerves, causing backache.

When to see a doctor

See your doctor if you have:

- Pelvic pain that doesn't go away
- Overly heavy or painful periods
- Spotting or bleeding between periods
- Pain with intercourse
- Difficulty emptying your bladder
- Difficulty moving your bowels

Seek prompt medical care if you have severe vaginal bleeding or sharp pelvic pain that comes on suddenly.

Uterine fibroids develop from the smooth muscular tissue of the uterus (myometrium). A single cell reproduces repeatedly, eventually creating a pale, firm, rubbery mass distinct from neighbouring tissue.

Fibroids range in size from seedlings, undetectable by the human eye, to bulky masses that can distort and enlarge the uterus. They can be single or multiple, in extreme cases expanding the uterus so much that it reaches the rib cage.

Doctors don't know the cause of uterine fibroids, but research and clinical experience point to several factors:

- **Genetic alterations.** Many fibroids contain alterations in genes that code for uterine muscle cells.
- **Hormones.** Oestrogen and progesterone, two hormones that stimulate development of the uterine lining in preparation for pregnancy, appear to promote the growth of fibroids. Fibroids contain more oestrogen receptors than do normal uterine muscle cells.
- **Other chemicals.** Substances that help the body maintain tissues, such as insulin-like growth factor, may affect fibroid growth.

There are few known risk factors for uterine fibroids, other than being a woman of reproductive age. Other factors include:

- **Heredity.** If your mother or sister had fibroids, you're at increased risk of also developing them.
- **Race.** Black women are more likely to have fibroids than are women of other racial groups. In addition, black women have

fibroids at younger ages, and they're also likely to have more or larger fibroids.

Areas of research

Research examining other potential risk factors continues in these areas:

- **Obesity.** Some studies have suggested that obese women are at higher risk of fibroids, but other studies have not shown a link.
- **Oral contraceptives.** So far, strong data exist showing that women who take oral contraceptives have a lower risk of fibroids.
- **Pregnancy and childbirth.** Researchers have also looked at whether pregnancy and giving birth may have a protective effect, and so far pregnancy and childbirth seem to have a protective effect.

Although uterine fibroids usually aren't dangerous, they can cause discomfort and may lead to complications such as anaemia from heavy blood loss. In rare instances, fibroid tumours can grow out of your uterus on a stalk-like projection. If the fibroid twists on this stalk, you may develop a sudden, sharp, severe pain in your lower abdomen. If so, seek medical care right away. You may need surgery.

Pregnancy and fibroids

Because uterine fibroids typically develop during the childbearing years, women with fibroids are often concerned about their chances of a successful pregnancy.
Fibroids usually don't interfere with conception and pregnancy. However, they can rarely distort or block your fallopian tubes, or interfere with the passage of sperm from your cervix to your fallopian tubes. Submucosal fibroids may prevent implantation and growth of an embryo.

Research indicates that pregnant women with fibroids are at slightly increased risk of miscarriage, premature labour and delivery, abnormal foetal position, and separation of the placenta from the uterine wall. But not all studies confirm these associations. Furthermore, complications vary based on the number, size and location of fibroids. Multiple fibroids and large submucosal fibroids that distort the uterine cavity are the type most likely to cause problems. A more common complication of fibroids in pregnancy is localized pain, typically between the first and second trimesters. This is usually easily treated with pain relievers.

In most cases, fibroids don't interfere with pregnancy, and treatment isn't necessary. It was once believed that fibroids grew faster during pregnancy, but multiple studies suggest otherwise. Most fibroids remain stable in size, although some may increase or decrease slightly, usually in the first trimester.

If you have fibroids and you've experienced repeated pregnancy losses, your doctor may recommend removing one or more fibroids to improve your chances of carrying a baby to term, especially if no other causes of miscarriage can be found and if your fibroids distort the shape of your uterine cavity.

Doctors usually don't remove fibroids in conjunction with a caesarean section because of the greater risk of excessive bleeding.

Investigations

Uterine fibroids are frequently found incidentally during a routine pelvic exam. Your doctor may feel irregularities in the shape of your uterus through your abdomen, suggesting the presence of fibroids.

Ultrasound

If confirmation is needed, your doctor may obtain an ultrasound — a painless exam that uses sound waves to obtain a picture of your uterus — to confirm the diagnosis and to map and measure fibroids. A doctor or technician moves the ultrasound device (transducer) over your abdomen (transabdominal) or places it inside your vagina (transvaginal) to obtain images of your uterus.
Transvaginal ultrasound provides more detail because the probe is closer to the uterus. Transabdominal ultrasound visualizes a larger anatomic area. Sometimes, fibroids are discovered during an ultrasound conducted for a different purpose, such as during a prenatal ultrasound.

Other imaging tests

If traditional ultrasound doesn't provide enough information, your doctor may order other imaging studies, such as:

- **Hysterosonography.** This ultrasound variation uses sterile saline to expand the uterine cavity, making it easier to obtain interior images of the uterus. This test may be useful if you have heavy menstrual bleeding despite normal results from traditional ultrasound.
- **Hysterosalpingography.** This technique uses a dye to highlight the uterine cavity and fallopian tubes on X-ray images. Your doctor may recommend it if infertility is a

concern. In addition to revealing fibroids, it can help your doctor determine if your fallopian tubes are open.

- **Hysteroscopy.** Your doctor inserts a small, lighted telescope called a hysteroscope through your cervix into your uterus. Your doctor injects (instills) saline into your uterus expanding the uterine cavity and allowing your doctor to examine the walls of your uterus and the openings of your fallopian tubes. A hysteroscopy can be performed in your doctor's office.

Imaging techniques that may occasionally be necessary include computerized tomography (CT) and magnetic resonance imaging (MRI).

Other Tests

If you are experiencing abnormal vaginal bleeding, your doctor may want to conduct other tests to investigate potential causes. He or she may order a complete blood count (FBC) to determine if you have iron deficiency anaemia because of chronic blood loss. Your doctor may also order blood tests to rule out bleeding disorders and to determine the levels of reproductive hormones produced by your ovaries.

There's no single best approach to uterine fibroid treatment. Many treatment options exist. In most cases, the best action to take after discovering fibroids is simply to be aware they are there.

Watchful Waiting

If you are like most women with uterine fibroids, you have no signs or symptoms. In your case, watchful waiting (expectant management) could be the best course. Fibroids aren't cancerous. They rarely interfere with pregnancy. They usually grow slowly and tend to shrink after menopause when levels of reproductive hormones drop. This is the best treatment option for a large majority of women with uterine fibroids.