2. CONSERVATIVE TREATMENT FOR FIBROMAS: PRACTICE GUIDELINES

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Practice guidelines: conservative treatment of fibroids.

Summary:
The conservative treatment of uterine fibroids is essentially based on symptomatology and the patient’s choice of treatment. The gynaecologist must develop a clear therapeutic protocol based on clinical examination, available test results and consideration of the patient's preference. The therapeutic options include close surveillance, hormonal treatments, conservative operative endoscopy and arterial embolization.

Goals: The main purpose of this document is to propose a common clinical approach for conservative treatment of fibroma for gynaecology-obstetrics practitioners working in Switzerland.

Subjects: This document was drawn up by the working group which met at Swissendos-Fribourg on 2 and 3 June 2005. It reports the proposals which were accepted unanimously. The subjects covered are essentially: epidemiology of fibromas, preoperative work-up, place of medical treatments, treatment for fibromas by hysteroscopy, laparoscopy and laparotomy including the indications, operating technique and complications for each type of operation. Radiological embolization for myomas is also discussed. Finally, the document also talks about the impact of fibromas with respect to infertility.

Results: The management of uterine fibromas must start with clinical assessment and imaging. All the various possibilities for diagnosis and treatment are covered by this report. It will provide the means for choosing the most appropriate treatment for each patient.

Evidence: The document was drawn up mainly taking the opinions of the experts present at Swissendos-Fribourg into account. A review of the medical literature was also made, using the international journals in the MEDLINE, Pubmed database. The level of evidence was defined according to the criteria given in the Canadian Task Force on the Periodic Health Examination.

Benefits and Risks: The benefit of conservative treatments for fibroids is that hysterectomy may be avoided while treating the symptoms presented.

The risks of conservative treatment must always be discussed with the patient, who must have been given full and appropriate information.

Assessment of the quality of the evidence (CTF) (1)

I : Evidence obtained from at least one properly randomized controlled trial

II-1 : Evidence from well-designed controlled trials without randomization

II-2 : Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3 : Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III : Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Classification of recommendations (CTF) (1)

A There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination.

B There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination.
There is poor evidence regarding the inclusion or exclusion of the condition in a periodic health examination, but recommendations may be made on other grounds.

There is fair evidence to support the recommendation that the condition not be considered in a periodic health examination.

There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

**Introduction: Epidemiology**

The pathology connected with uterine fibroids is a public health problem which must be addressed. Fibroids are the most frequent benign tumours affecting women. Indeed, about 20 to 40 % of women of child-bearing age have fibroids, and some of them need to receive treatment for the complications that they give rise to. The estimated rate of incidence is approximately 1 per 100 women-years. The peak of incidence occurs after the age of forty, but they sometimes appear as early as 25 years of age. They are more frequent if the patient is black, obese and nulliparous. There may also be a genetic factor since a family tendency to develop uterine fibroids is observed. In some countries like the USA, about 40 % of women over 60 have had a hysterectomy. The annual incidence of hysterectomy for fibroids is 1.9 % in the USA, and 2.8 % in Great Britain (3) (13) (22) (23).

**Preoperative work-up**

The investigation of reference in the preoperative work-up for symptomatic fibroids or those discovered by clinical palpation remains pelvic ultrasound with colour Doppler, which should take place by the transabdominal and the transvaginal route. It provides precise information on the number of fibroids, their size, location (anterior, posterior, fundal, isthmic, cervical, broad ligament). In addition, it is essential in certain cases to know the exact relationship between the fibroid and other structures: distance between the fibroid and the serosa, distance between the fibroid and the endometrium, position relative to the uterine cavity. It is also important to determine whether there is associated adenomyosis or not because this can invalidate the indication for myomectomy (24) (25).

Ultrasound must be coupled with colour Doppler in order to map out the position of the uterine vessels (vascularisation by one or two uterine arteries), predict how quickly the situation is evolving and examine the response to certain treatments. In addition, in the case of adenomyoma the use of Doppler increases the pertinence of the diagnosis.

However, in certain situations, pelvic ultrasonography has limits: large uterus, large number of fibroids, fibroids smaller than 3 cm, posterior areas that are invisible, adenomyosis, differential diagnosis with an extra-uterine mass, etc. In these situations when ultrasonography is not able to provide an answer to all the questions posed for management, pelvic MRI should be used in addition. MRI provides the means for mapping the fibroids. In the work-up for fibroids, and is the means of investigation which performs best with respect to inter-observer variability (26) (27) (28).

Other means available for the work-up for fibroids include hysteroscopy or hysterosonography, which can be used to study the uterine cavity (submucosal fibroid). Hysterosalpingography is indicated in case of infertility, in order to investigate the tubes. Abdomino-pelvic scanning has no indication in the preoperative work-up for fibroids.

**Place of medical treatments**

Concerning medical treatment of uterine fibroids, the GnRH agonists have been the subject of the most thorough investigations. The hypo-oestrogenic conditions obtained thanks to these drugs brings about a quick reduction of about 35 to 65 % in volume. The maximum drop in volume is obtained after 3 months of treatment, but the fibroids return to their initial volume within a few month after treatment ends. This is why use of the GnRH agonists is restricted to the preoperative period. Various randomised studies have stated that the GnRH agonists are useful in the preoperative period, but a systematic review of the literature reveals that only a small number of patients were included in these studies, with inconsistent advantages with respect to preoperative treatment of myomas (30) (35). A recent randomised study including an adequate number of patients treated preoperatively with GnRH analogs showed a 22 % reduction in tumour volume, but was unable to show any advantage with respect to peroperative blood loss, operating time, postoperative morbidity or the length of the hospital stay (36). No disadvantage was noted concerning the cleavage plane. So to put it briefly, it would seem that preoperative use of
GnRH agonists is justified in cases of anaemia due to menorrhagia in order to restore normal haemoglobin levels. However, it seems that there is a higher rate of recurrence after GnRH agonists have been used preoperatively (37).

More recently other medical treatments have been proposed. For example, the volume of fibroids also drops with treatment by Danazol, which is an androgenic, multiple steroid synthesis inhibitor (38). However its secondary effects are unpleasant and greater than those observed when GnRH agonists are used.

Various studies have also demonstrated that administration of 12.5 to 50 mg mifepristone, an antiprogestative agent, reduces the volume of myomas by 40 to 50 % (39) (40). When 60 mg raloxifene, a selective oestrogen receptor modulator, is taken daily, fibroids also become smaller, but only in premenopausal women (41) (42).

Medical treatment using progestational hormones has no effect on tumour volume, and only suspends the symptoms for a short while. They can be prescribed in case of endometrial hyperplasia, or if the patient's main complaint concerns symptoms of hypermenorrhoea.

Although much work is currently being carried out to clarify our understanding of medical treatments for fibroids, the only one that can be recommended is the use of GnRH agonists preoperatively in certain cases.

**Indications, techniques and complications of hysteroscopic myomectomy**

This technique can be used only when the fibroids are submucosal and small or medium-sized (less than 4 cm), and few in number (less than 3) (3)(11). Hysteroscopic resection of intra-cavity fibroids is a typical example of "minimally invasive surgery". Ablation of the fibroid is carried out via an endo-uterine approach with direct vision, and a hysteroscope fitted with an operating channel and irrigation using Somanol + Ethanol 1%. The fibroid is excised in small fragments using a monopolar electrocautery loop. This technique can also be used by experienced surgeons for certain interstitial fibroids with submucosal development. Two phases are sometimes used for resection of this kind of fibroid when there is a large interstitial component. With this technique, given that the myomas are in an immediate submucosal location, the myomectomy site is never sutured because it practically always heals over without any defect. The operative difficulties are connected with the size and degree to which the fibroid has developed interstitially.

Hysteroscopic resection of intracavity fibroids can be carried out using a bipolar loop. The advantage of bipolar current is that normal saline is used for irrigation, thus reducing the potential for a serious metabolic accident which is always possible with Somanol + Ethanol 1 %.

The risk of haemorrhage associated with this technique depends on the size and number of fibroids, which is why this risk is low for hysteroscopic myomectomy. Consequently any haemorrhage that does occur is often secondary to perforation of the uterus by the electrocautery loop. Uterine synchia happens in about 10 % of cases. Certain preventives measures can applied, such as peroperative installation of a contraceptive coil or postoperative prescription of a combination of oestrogen and progesterone. In case of infertility, a second-look hysteroscopy on an outpatient basis may be indicated two months after the operation. If there is any synchia this can then be corrected. The risk of the symptoms recurring postoperatively is around 20-30 % after 3 years. It seems to be distinctly higher than after laparotomy. However, if solely the sub-group of women with a uterus of normal size and less than 3 fibroids is examined, this risk appears comparable to that observed with myomectomy by laparotomy, at 10 % after 5 years. This suggests that the risk after hysteroscopic myomectomy is connected with the existence of interstitial or submucosal myomas left in place (11) (12)

**Indications for laparoscopic myomectomy**

The indications are cases when the fibroids give rise to symptoms: menorrhagia, metrorrhagia, pelvic pain or dragging feelings, pressure on neighbouring organs (bladder, rectum, ureter). Another indication that Doppler ultrasound has brought to the fore is the subject of more debate, i.e. hypervascularisation of the fibroid, which explains its growth and which will result in complications requiring treatment.

The limiting factors for operative laparoscopy are the number and volume of the fibroids. The accepted indication is a single, subserous or interstitial fibroid, which is mobile and measures 8 cm or less. The counter indications concern large, multiple fibroids (more than 3-4 fibroids, bigger than 3-4 cm). It must be borne in mind that each case also needs to be analysed according to other parameters (age, BMI, haemoglobin level, how mobile or not the uterus is, association with submucosal fibroids) and, of course, the surgeon's experience (2) (3) (4) (15).
Uterine surgery

**Technique and complications of laparoscopic myomectomy**

The technique for laparoscopic myomectomy associates the following steps: hysterotomy (most often vertical), enucleation, uterine suture often in two planes using Vicryl® (Ethicon), particularly in women desiring pregnancy. There are specific indications for occluding the one or two arteries vascularising the fibroid using a clip. This is the case, for example, when Doppler ultrasound has shown a fibroid measuring at least 7 cm and which is well-vascularised. The uterine artery can be occluded using two different techniques. The best-known method consists of opening the broad ligament between the round ligament and the infundibulopelvic ligament. The umbilical artery is located then followed closely until the origin of the uterine artery is reached. The ureter remains clearly visible, at the midline. One or two endosurgical clips are then installed. The same technique is repeated on the other side if the fibroid is vascularised by both uterine arteries. The second technique consists of a posterior approach to the uterine artery. After anteverting the uterus, the uterine artery is identified beneath the lower part of the posterior layer of the broad ligament, just above the ureter. The serosa is incised, the artery separated off and a clip installed. Its pulsatility makes the artery is easy to see, except when there are adhesions or endometriosis at this location. These two techniques can only be used when it is possible to work in the space between the uterine artery and the myomatous uterus. Preventive occlusion of the artery results in immediate and quasi elective devascularisation of the fibroid. The ischaemia affects solely the fibroid when a single artery is occluded. Ischaemia of the uterus follows when both arteries are occluded. This ischaemia only lasts a few hours, thanks to revascularisation by the cervico-vaginal arteries, those in the round ligament and the infundibulopelvic arteries. It lasts just long enough to be able to carry out a myomectomy under excellent conditions with no bleeding, and to achieve a good quality suture with no risk of haematoma. However, this uterine artery ligature technique may be tricky for surgeons without much experience. As no randomised and controlled studies have yet proved it to be innocuous, especially in fertile women desiring further pregnancies, a number of experts agree that this technique should be reserved for certain very specific cases of myomectomy (2) (4).

Conversion to laparotomy during laparoscopic myomectomy is possible in case of difficulty. Selection of patients for laparoscopic myomectomy must be meticulous, therefore, in order to avoid conversion to laparotomy (6). It is estimated that the rate of conversion to laparotomy should not exceed 2-3 % (4).

Haemorrhage may complicate laparoscopic myomectomy. The rate of heterologous transfusion is 1.4 %, and that of hysterectomy around 0.2 % (2) (6).

Postoperative adhesions may occur on the hysterotomy scar (30 % of cases). It would appear that use of the laparoscopic route reduces the rate of postoperative adhesions compared with laparotomy: 35.6%/patient and 16.7 %/myomectomy (5). Postoperative adhesions may involve the adnexa. This type of adhesion has very detrimental effects on fertility. The use of protective barriers appears to limit the formation of adhesions. A second-look laparoscopy may be considered two months after the myomectomy in order to remove adhesions in the event of infertility, or if pregnancy is desired.

Fibroids recur in about 20 % of cases. This frequency can be explained by the fact that it is impossible to palpate the myometrium correctly via laparoscopy, meaning that small myomatous elements may be left that are liable to be the origin of recurrence. This is why it is recommended to establish a precise "map" of the myometrium (preoperative ultrasound or MRI).

**Ergonomics of laparoscopic myomectomy**

The information concerning the number of fibroids, their size, location and position relative to the uterus obtained by the preoperative ultrasound examination allows the surgeon to establish a plan for work before commencing the operative laparoscopy procedure. There is no standard pattern for inserting the trocars, and they should be installed according to the location of the fibroids and above all such as to provide the surgeon with the most ergonomic approach possible for the uterine suture, which is generally along two planes.

Various power sources (cold knife, monopolar, bipolar knife, ultracision, ligasure) can be used during the myomectomy, but it is important that the way they are used should result in minimal necrosis of the uterine tissue, and especially avoiding necrosis of the edges of the hysterotomy.
Extraction of tissues during hysteroscopy and laparoscopy

During hysteroscopy the fibroids are mostly extracted via the cervix. The diathermy loop with its semi-circular shape is ideally suited to slicing the fibroid into small pieces and removing them. They can also be removed by curettage.

During laparoscopy, the tissues can be extracted using an electric endoscopic morcellator. If this instrument is used, it is advisable to ensure that morcellation takes place under direct visual control, with the instrument directed towards the Pouch of Douglas, well away from the lateral pelvic walls in order to keep the risk of vascular accidents to a minimum. The morcellator must also be kept at a distance from the bowel and bladder. Tissues excised during laparoscopic myomectomy can also be extracted via a posterior colpotomy, cutting the fibroids up using the cold laparoscopic knife or by making a low transversal minilaparotomy.

Myomectomy by laparotomy

Myomectomy by laparotomy consists of excising the fibroids via one or more hysterotomies. In case of large fibroids, meticulous suture of the hysterotomies along two or more planes is necessary to ensure good quality healing. All fibroids, whatever their size or number, can be dealt with using this technique. Peroperative opening of the uterine cavity allows submucosal fibroids and any associated polyps to be treated. The procedure most often takes place using a low horizontal incision (Pfannenstiel) for cosmetic reasons, or more rarely by a subumbilical midline incision. If there is a single fibroid in an anterior location or at the fundus, a mini-laparotomy can be used (incision measuring about 5 centimetres) for extraction of the fibroid. Conversely, the subumbilical midline incision may be required when the uterus is very large.

The complication which is feared the most during poly myomectomy via laparotomy is haemorrhage. The risk of heterologous transfusion is estimated to be 6 %, and the hysterectomy rate to be 1 % of cases.

In almost every case myomectomy via laparotomy results in the formation of postoperative peritoneal pelvic adhesions. Their frequency may be reduced by the use of adhesion barriers.

The cumulative risk of symptomatic recurrence after myomectomy via laparotomy is about 10 % at 5 years.

Fibroids and infertility

Classically, submucosal fibroids and those that deform the uterine cavity can affect fertility. So it is appropriate to remove them if the patient is infertile. More recently, a study of the literature (6) has revealed that even interstitial fibroids that do not deform the uterine cavity can have an adverse effect on in vitro fertilization. Similarly myomectomy of fibroids responsible for menometrorrhagia improves fertility.

It has now been established that the desire for pregnancy is not a counter indication for laparoscopic myomectomy. The postoperative pregnancy rate depends mainly on the patient's age (better before 35 years old), the duration of infertility prior to myomectomy (better when less than 3 years) and the existence of other associated factors (7) (9). Nevertheless caution is essential when indicating laparoscopic myomectomy.

Cases of uterine rupture during pregnancy or childbirth have been reported after myomectomy whether carried out by laparotomy, laparoscopy and even hysteroscopy (9). However the frequency of this type of accident is not very well established. In our experience, the risk of rupture after laparoscopy is between 1 and 2 % (8-10). Although certain authors make this claim, (15), it appears difficult to say whether or not the risk is greater when the myomectomy takes place via laparoscopy than another approach. Concerning hysteroscopy, the risk has not been really satisfactorily assessed, but it is probably very low apart from those cases where there has been peroperative uterine perforation. Concerning myomectomy via laparotomy, the "good obstetric reputation" of scars after hysterotomy for myomectomy is based on several old, large, retrospective series in which no case of rupture was reported (9). These results nevertheless do not agree with those of a retrospective study carried out at the Trinidad maternity hospital in which the rate of rupture after myomectomy via laparotomy was 4 % (16).

Radiological embolisation of myomas

Based on techniques established in the context of gynaecological or posttraumatic pelvic haemorrhage, embolisation of fibroids was described for the first time in 1995 (17). Over 10,000 procedures were carried out in the year 2000 (18). Since then thousands more embolisations have taken place and there are increasing numbers of publications concerning this technique. The goal of embolisation is to introduce polyvinyl alcohol particles or micro
spheres into the two uterine arteries in order to stop or considerably reduce the arterial flow to the fibroids resulting in irreversible ischaemic alterations, while avoiding any permanent damage to the uterus. The arteries are accessed via one or both of the femoral arteries. Depending on the anatomy, it may be necessary to use micro catheters. After the procedure haemostasis is obtained by manual inguinal pressure. Antalgic and anti-inflammatory medication is administered intravenously. The patient generally spends the night in hospital, but many cases treated on a purely out-patient basis have been described.

Technical success is defined as occlusion or a very considerable reduction in the arterial flow in the two uterine arteries. Clinical success is defined as the disappearance of symptoms such as menorrhagia, and those due to the effect of the weight of the fibroids (19).

Embolisation is indicated in patients with fibroids giving rise to symptoms which have a clear detrimental effect on the quality of life, notably due to chronic pain, bowel or urinary malfunction, or anaemia due to dysmenorrhoea. Patient selection depends on the symptoms, imaging results (ultrasound and/or MRI) and the patient's preferences.

The following are considered to be absolute counter indications for fibroid embolisation: on-going pregnancy, current or recent infection of the uterus or an absolute refusal of hysterectomy which might prove necessary in case of complications. Relative counter indications are allergy to the contrast products, kidney failure, pedunculated subserous fibroids and very large fibroids.

The literature reports a reduction of about 50-60 % in the size of the fibroids, and a reduction of about 40-50 % in the size of the uterus. Clinically this results in disappearance of abnormal bleeding in over 90 % of cases, disappearance of the effects due to the weight of the fibroids in 88-92 % of cases, and elimination of all symptoms in over 85 % of cases.

Complications of the procedure include temporary amenorrhoea in 5-10 % of cases, and permanent amenorrhoea for 0-3 % of patients under 45 and 7-14 % of those aged over 45. Transcervical expulsion of the fibroids is described as a complication in 0-3 % of cases, however the question remains as to whether this is a complication or a physiological bodily reaction. Non-infectious endometritis has been described in 1-2 % and infectious endometritis in 1-2 % of cases. The other complications are exceedingly rare (19).

The rate of recurrence is low after technically successful embolisation (<10 %). In spite of adequate treatment by embolisation the uterus is capable of generating new fibroids (20).

A large number of patients have been able to go full term with a normal pregnancy after embolisation. Nevertheless, it is not yet possible according to the literature to state whether embolisation should be encouraged or prohibited in patients desiring pregnancy after treatment. After embolisation, a few problems with the placenta have been described (21). These are individual cases with no significant value, which need to be taken in perspective with the complications such as uterine rupture which may appear after other methods of treatment for fibroids.

At this point in time, embolisation can be proposed for a large number of cases as a real alternative to the surgical techniques, being both reliable and accompanied by a low rate of complications.

**Recommendations in practice**

1. All patients presenting one or more fibroids at clinical examination should be given a full work-up to establish their extent. This always includes abdominal and transvaginal pelvic ultrasound examination. Hysterosonography, hysteroscopy or MRI may be prescribed when the ultrasound results are difficult to interpret, when there is infertility or when a doubt persists as to the nature of the tumour. (III-A)

2. Medical treatment for the fibroids may be useful preoperatively. It relies essentially on the use of GnRH agonists. These provide the means of reducing the volume of the myomas prior to surgery. The recommended duration of treatment is 3 months without any "add-back therapy". (I-A)

3. Small numbers (less than 3) of small or medium-sized (less than 4 cm) submucosal fibroids that give rise to symptoms (menorrhagia, metrorrhagia) can be treated by hysteroscopic myomectomy. This is usually carried out using a monopolar resection loop with irrigation with Somanol + Ethanol 1 %. Hysteroscopic resection can also be carried out using a bipolar loop. The advantage is that it allows normal saline to be used, which keeps the risk of serious metabolic accident to a minimum. (III-A)
4. The risk of haemorrhage with hysteroscopic myomectomy depends on the size and number of fibroids requiring resection. Haemorrhage is most often secondary to uterine perforation. Uterine synechia happens in about 10% of cases. The risk of the symptoms recurring postoperatively is around 20-30% after 3 years. This risk of recurrence is mainly connected with the presence of interstitial or subserous myomas left in place. (III-B)

5. Myomectomy carried out by laparoscopy is still reserved today for experienced laparoscopic surgeons who have undergone appropriate and extensive postgraduate training (III-A)

6. The indications for laparoscopic myomectomy can be discussed when there are fibroids with symptoms and those which present hypervascularisation that is the reason for their rapid growth. The indications are mainly a single subserous or interstitial fibroid which is mobile and measures 8 cm or less. (III-A)

7. The counter indications for laparoscopic myomectomy are: large multiple fibroids (more than 3-4 myomas over 4 cm), a uterus of size equivalent to more than 16 weeks of amenorrhoea, fibroids measuring 10-15 cm, on-going pregnancy, the presence of associated endometrial cancer or uterine sarcoma. The main general counter indications for laparoscopic myomectomy are medical pathologies that are liable to be worsened by the pneumoperitoneum, a prolonged Trendelenburg position or hypercapnia. (III-A)

8. The complications of laparoscopic myomectomy are conversion to laparotomy (2-3%), peroperative haemorrhage, postoperative adhesions (30%) and recurrence of the fibroids (20%). (III-A)

9. Laparotomy is the only approach for myomectomy that allows all the fibroids to be removed whatever their size, number and location in the uterus. The complication which is feared the most is haemorrhage (6%), especially during polymymectomy. The risks of adhesions and recurrence (10% at 5 years) are not negligible. (III-A)

10. Submucosal and interstitial fibroids together with those that deform the uterine cavity can have an adverse effect on fertility and the results of In Vitro Fertilization. A desire for pregnancy is not a counter indication for myomectomy by the hysteroscopic or laparoscopic approach. However, the risk of uterine rupture during a subsequent pregnancy after laparoscopic myomectomy is assessed at between 0 and 2%. The patients must be informed of this risk before any laparoscopic surgery for myomas. (III-C)

11. Radiological embolisation of fibroids is an effective alternative to surgical treatment. It allows the fibroids to be reduced by about 50-60% in volume, and disappearance of abnormal bleeding in over 90% of cases. Selection of candidates for this technique depends on the symptoms, the imaging results and the patients' preferences. (III-B)

12. The gynaecologist and patient must be aware of the counter indications for embolisation: on-going pregnancy, active or recent infection of the uterus, patient's refusal to undergo hysterectomy in the event of complications, allergy to the contrast products, kidney failure, pedunculated subserous fibroids and very large fibroids. (III-D)

13. The consequences of embolisation consist of temporary amenorrhoea (5-10%), permanent amenorrhoea (0-14%), transcervical expulsion of the fibroids (0-3%), endometritis (1-2%) and recurrence (less than 10%). (III-A)

14. At present the data available in the literature is not such as to allow embolisation to be recommended in patients who wish to remain fertile after treatment. (III-D)
Bibliography


**Multiple choice question:**
Laparoscopic myomectomy is possible in one of the following circumstances:

A – a single submucosal fibroid measuring 3.5 cm

B – four 3.5 cm fibroids

C – one 7 cm subserous sessile fibroid

Answer: C