Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Information for Patients Undergoing Uterine Artery Embolisation for Fibroids (UAE)

Department of Radiology

Introduction

This leaflet is intended to provide answers to common questions that you may have regarding fibroid embolisation

It is almost certain that you are having the fibroid embolisation done as a pre-planned procedure, in which case you should have plenty of time to discuss the situation with your consultant and the radiologist who will be doing the fibroid embolisation, and perhaps even your own GP.
If you need the fibroid embolisation as an emergency, then there may be less time for discussion, but none the less **you should have had sufficient explanation before you sign the consent form**.

What is fibroid embolisation?

Fibroid embolisation is a new way of treating fibroids by blocking off the arteries that feed the fibroids, the uterine arteries, and making the fibroids shrink. It is performed by a radiologist, rather than a surgeon, and is an alternative to an operation. Fibroid embolisation was first performed in 1995, and since then over 100,000 women have had the procedure performed, worldwide.

Why do I need fibroid embolisation?

Other tests that you have had done will have shown that you are suffering from fibroids, and that these are causing you considerable symptoms. Your gynaecologist and your GP should have told you all about the problems with fibroids, and discussed with you ways of dealing with them. Previously, most fibroids have been treated by an operation, generally a hysterectomy, where the womb is removed altogether. In your case, it has been decided that embolisation is the best treatment.

Who has made the decision?

The doctors in charge of your case, and the radiologist doing the fibroid embolisation, will have discussed the situation, and feel that this may be the most suitable treatment. However, it is very important that you have had the opportunity for your opinion to be taken into account, and that you feel quite certain that you want the procedure doing. If, after full discussion with your doctors, you do not want the fibroid embolisation carried out, then you must decide against it.

Who will be doing the fibroid embolisation?

A specially trained doctor called a Radiologist. Radiologists have special expertise in using x-ray equipment, and also in interpreting the images produced. They need to look at these images while carrying out the procedure. Consequently, Radiologists are the best-trained people to insert needles and fine catheters into blood vessels, through the skin, and place them correctly.

Where will the procedure take place?

Generally in the x-ray department, in a special "screening" room, which is adapted for specialised procedures.

How do I prepare for fibroid embolisation?

You need to be an in-patient in the hospital. You will probably be asked not to eat for 4 to 6 hours beforehand, though you may be told that it is all right to drink some water.

You need to have a needle put into a vein in your arm (venflon), so that painkillers can be given. The specialist pain team nurse will set up a pump containing pain relief and connect this to the venflon. You will hold the control device for the pump. Once in place, this will not cause any pain. You may also receive a sedative to relieve anxiety.

You will be asked to put on a hospital gown. As the procedure is generally carried out either using an artery in the wrist or alternatively using the big artery in the groin, you may be asked to shave the skin around the groin area.

If you have any allergies, you must let your doctor know. If you have previously reacted to intravenous contrast medium, the dye used for kidney x-rays and CT scanning, then you must also tell your doctor about this.

What actually happens during fibroid embolisation?

The exact technique may vary slightly but the general outline of the procedure is as follows.

You will lie on the x-ray table, generally flat on your back. You will have a monitoring device attached to your chest and finger, and may be given oxygen through small tubes in your nose. The radiologist will keep everything as sterile as possible, and may wear a theatre gown and operating gloves. The skin near the point of insertion, either the wrist or the groin, will be swabbed with antiseptic, and then most of the rest of your body covered with a theatre towel.

The skin and deeper tissues over the artery in the groin will be anaesthetised with local anaesthetic, and then a needle will be inserted into the artery. Once the radiologist is satisfied that this is correctly positioned, a guide wire is placed through the needle, and into this artery. Then the needle is withdrawn allowing a fine, plastic tube, called a catheter, to be placed over the wire and advanced into the artery.

The radiologist will use the x-ray equipment to make sure that the catheter and the wire are then moved into the correct position, into the other arteries which are feeding the fibroid. These arteries are called the right and left uterine arteries. A special x-ray dye, called contrast medium, is injected down the catheter into these uterine arteries, and this may give you a hot feeling in the pelvis. Once the fibroid blood supply has been identified, fluid containing thousands of tiny particles is injected through the catheter into these small arteries which nourish the fibroid. This silts up these small blood vessels and blocks them so that the fibroid is starved of its blood supply.

Both the right and the left uterine arteries need to be blocked in this way. It can often all be done from just one access point (Wrist or the right groin), but sometimes it may be difficult to block the branches of the right uterine artery from the right groin, and so a needle and catheter needs to be inserted into the left groin as well. At the end of the procedure, the catheter is withdrawn and the radiologist then presses firmly on the skin entry point for several minutes, to prevent any bleeding. In case of access from wrist, a wristband like device will be placed to prevent bleeding. This can be removed after 4 hours.

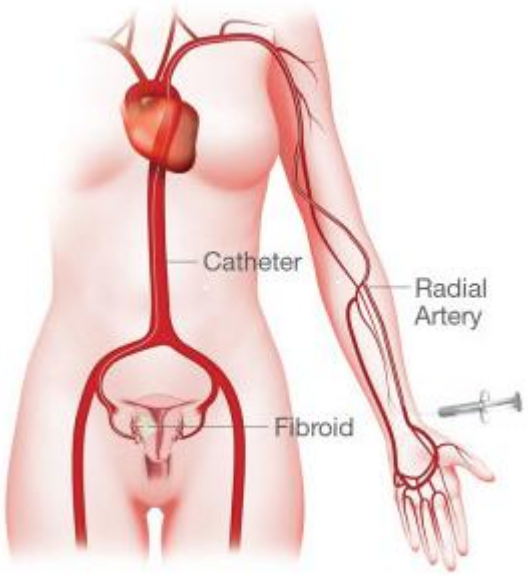

Figure: Fibroid embolization through access from the wrist

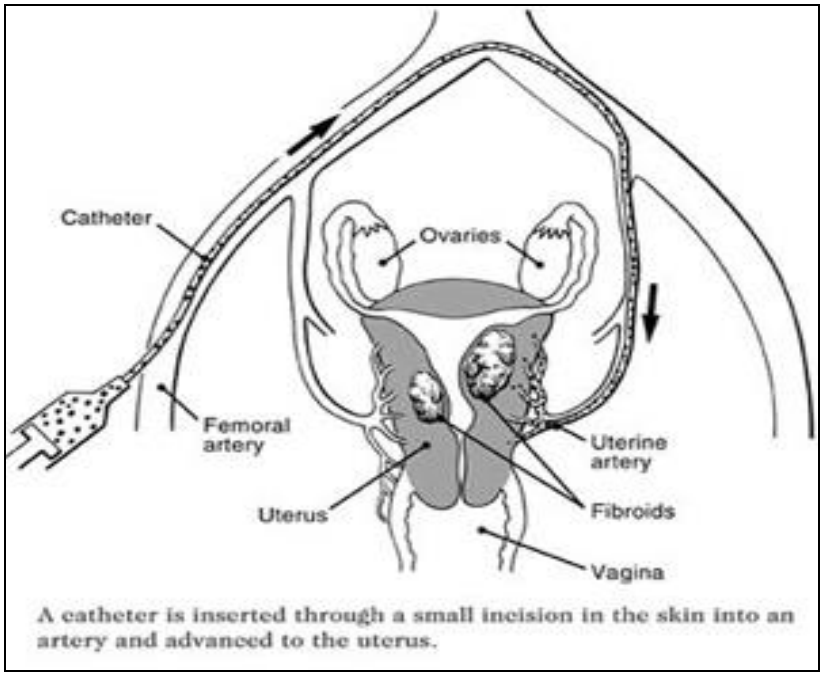

Figure: Fibroid embolization through access from the groin

Will it hurt?

When the local anaesthetic is injected, it will sting to start with, but this soon passes off, and the skin and deeper tissues should then feel numb. The procedure itself is not normally painful. You will have control of your pain relief and the Radiologist will advise you when to administer this as the procedure progresses so that your pain is minimised. There will be a nurse, or another member of staff, standing next to you and looking after you. As the dye, or contrast medium, passes around your body, you may get a warm feeling, which some people can find a little unpleasant. However, this soon passes off and should not concern you.

How long will it take?

Every patient's situation is different, and it is not always easy to predict how complex or how straightforward the procedure will be. Some fibroid embolisations do not take very long, perhaps an hour. Other embolisations may be more involved, and take rather longer, perhaps over two hours. As a guide, expect to be in the x-ray department for about two hours.

What happens afterwards?

You will be taken back to your ward on a trolley. Nurses on the ward will carry out routine observations, such as taking your pulse and blood pressure, to make sure that there are no untoward effects. They will also look at the skin entry point to make sure there is no bleeding from it. You will generally stay in bed for a few hours, until you have recovered. You will generally be kept in hospital over night or for a day or two. Once you are home, you should rest for three or four days.

What are the risks or complications?

Fibroid embolisation is a safe procedure, but there are some risks and complications that can arise, as with any medical treatment.

There may occasionally be a small bruise, called a haematoma, around the site where the needle has been inserted, and this is quite normal. If this becomes a large bruise, then there is the risk of it getting infected, and this would then require treatment with antibiotics.

Most patients feel some pain afterwards. This ranges from very mild pain to severe crampy, period-like pain. It is generally worst in the first 12 hours, but will probably still be present when you go home. While you are in hospital this can be controlled by powerful painkillers. You will be given further tablets to take home with you.

Most patients get a slight fever after the procedure. This is a good sign as it means that the fibroid is breaking down. The painkillers you will be given will help control this fever.

A few patients get a vaginal discharge afterwards, which may be bloody. This is usually due to the fibroid breaking down. Usually, the discharge persists for approximately two weeks from when it starts, although occasionally it can persist intermittently for several months. This is not in itself a medical problem, although you may need to wear sanitary protection. If the discharge becomes offensive and if it is associated with a high fever and feeling unwell, there is the possibility of infection and you should ask to **see your gynaecologist urgently.**

The emergency gynaecological assessment unit telephone number is 01633 – 234052, or 01633-234579

The most serious complication of fibroid embolisation is infection. This happens to perhaps two in every hundred women having the procedure. The signs that the uterus is infected after embolisation include great pain, pelvic tenderness and a high temperature. Lesser degrees of infection can be treated with antibiotics, and perhaps a small operation on the womb, a "D and C" (Dilatation and Curettage). Once severe infection has developed, it is generally necessary to have an operation to remove the womb, a hysterectomy. There is a 1 in 200 chance of needing a hysterectomy as a result of complication (usually infection).

Ovarian failure is another important complication occurring in 1% of patients under 45 years of age.

There is a very low risk of death.

Five patients worldwide have been reported to have died and over 100,000 procedures have been performed. Two of the deaths were from pulmonary embolus and three from infection.

The complication rate of UAE is much lower than hysterectomy for fibroids which has a serious complication rate of 5% and a death rate of 1 in 1,500.

If you feel that you would not want a hysterectomy under any circumstances, then it is probably best not to have fibroid embolisation performed.

What else may happen after this procedure?

Some patients may feel very tired for up to two weeks following the procedure, though some people feel fit enough to return to work three days later. However, patients are advised to take at least two weeks off work following embolisation. Approximately 8% of women have spontaneously expelled a fibroid, or part of one, usually six weeks to three months afterwards. If this happens, you are likely to feel period like pain and have some bleeding.

A very few women have undergone an early menopause, the change of life, after this procedure. This has probably happened because they were at this time of life to start with.

You will have a follow up scan arranged after 5 months and you should have a gynaecological outpatient review at approximately 6 months post procedure.

What are the results of fibroid embolisation?

Success rate of UAE is over 85%. UAE kills all fibroids in one go with a very low recurrence rate long term. Satisfaction rates for the procedure are over 90%.

Some women, who could not become pregnant before the procedure because of their fibroids, have become pregnant afterwards. However, if having a baby in the future is very important to you, you need to discuss this with your doctor as it may be that an operation is still the better choice.

NICE guidance on UAE

It has been decided that the procedure is safe enough and that most patients have improved symptoms. All patients should be given full information about the treatment and any uncertainties e.g. in regard to future pregnancy. The decision on treatment should be made by both a gynaecologist and an interventional radiologist.

Some of your questions should have been answered by this leaflet but remember that this is only a starting point for discussion about your treatment with the doctors looking after you. Do satisfy yourself that you have received enough information about the procedure before you sign the consent form.

Further information can be gained from the British Society of Interventional Radiologists Website www.bsir.org.uk

For further information contact:-

Radiology Nurses on:- 01633 - 234327
Radiology Department, Royal Gwent Hospital

"This document is available in Welsh /
Mae'r ddogfen hon ar gael yn Gymraeg".