Is myoma uteri needs a hysterctomy ?

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Dear Doctor: I am 37 years old, married. Six months ago, I was told to have a 6 cm. and 3.5 cm. tumors (myoma uteri) in my uterus after vaginal examination and ultrasonography. My doctor told me to have a hysterectomy (removal of the uterus and the tumors). This upsets and troubles me so much since I still want to have a baby. Are there any other alternative ways that can cure these tumors and I can still have a baby?

The above example question is a very common question among most middle–aged women who are suffering from having myoma uteri. They also need the précised answer for their decision making.

Myoma uteri or fibroids are the most common benign tumors of the uterus in the middle aged women. It is the uterine muscle wall tumor which is not a cancer and causes no harm when it is still small. It is hormonal (estrogen) dependent and a number of tumors can decrease in size at menopause. If it becomes larger and causes symptoms such as, vaginal bleeding, infertility, repetitive pregnancy loss or urinary problems, this tumor needs to be removed. Generally, hysterectomy or total removal of the uterus along with the tumor is the procedure of choice.

According to a brief review by Associate Professor, Dr. Charnchai Vantanasiri, Vice Chairman of Department of Obstetrics and Gynecology, **hysterectomy** is a very common operation. In 2005, there were 1055 cases of hysterectomies done at Siriraj Hospital. Eighty three percents (883 cases) were due to myoma uteri.

However, if you are still young and need to have a further pregnancy, **myomectomy** or removal only of the tumor (if technically feasible) will be your alternative

option and should be discussed with your gynecologist for its possibility. In general, about 16% of patients with myomas are candidates for.

This operation is not simpler than hysterectomy and sometimes more difficult to perform. Furthermore, 25-40% of the tumors may recur in the future when treated with this technique and may require another operation. The risk of recurrence is increased in those who had multiple tumors in the first presentation.

With nowadays technology, both procedures can be done through the conventional abdominal incision (laparotomy) or laparoscopy. Laparoscopic surgery is relatively less invasive, less scar, less hospital stay and less postoperative pain, but needs highly trained surgeons and costs more.

The American College of Obstetrician and Gynecologists' criteria for myomectomy include secondary infertility with a history of second trimester loss and preservation of fertility in women with either hypermenorrhea leading to anemia or a large lower abdominal mass. Extensive myomectomies are not justified in patients who no longer want to have children because the associated morbidity and mortality are comparable to those of hysterectomy. Laparoscopic myomectomy should reserve for patients with less than 4 myomas with diameters of < 7 cm. The fertility rate after surgery was about 65%.

Uterine artery embolization (UAE) is the newest treatment of myoma uteri with collaboration between gynecologists and interventional radiologists. This procedure involves placing a small catheter into an artery in the groin and directing it to the blood supply of the myomas. Little plugs are injected through the catheter to block these arteries and cause the myomas to shrink spontaneously.

At present, UAE technique is feasible in just a few university hospitals and the percentage of shrinkage of the tumor is still under investigation. There is also no

sufficient information to predict the percentage of women who will be able to become pregnant after UAE. Some studies reported of 33% pregnancy rate so far.

Since each procedure as mentioned has its advantages and disadvantages. You should extensively discuss with your gynecologist for the feasibility of each procedure before carefully deciding on treatment. The extent of your tumor is also one of the most important factors for considering which procedure is best fit.