SUMMARY OF RECOMMENDATIONS

Assessment

- Asymptomatic women with fibroids where the uterine size is less than 16 weeks in size (and where other causes of pelvic mass have been excluded) do not need further investigations but should be advised to seek medical advice if symptoms occur (D).

- Asymptomatic women with fibroids >16/40 should have specialist referral to discuss options including observation (D).

- Women who have fibroids detected during pregnancy should be referred to a specialist for a consult but do not require additional surveillance unless symptoms arise during the pregnancy (D).

- Although there is no evidence that asymptomatic women with a fibroid uterus greater than 20 weeks will have future health problems, hysterectomy or myomectomy is an option (D).

- Transvaginal sonohysterography (TVSH) should be considered prior to hysteroscopy in women where intrauterine pathology such as submucous fibroids and polyps are suspected as diagnostic hysteroscopy can be avoided in up to 40% of women (A).
• Transvaginal ultrasound of the endometrium is accurate in excluding endometrial hyperplasia but is often unable to distinguish submucosal fibroids and polyps (A).

• Transabdominal ultrasound may be required for uteri greater than 12 weeks' size as these will be beyond the reach of the transvaginal ultrasound (D).

• Transvaginal ultrasound and transvaginal sonohysterogram are both more accurate in diagnosing the location of fibroids than hysteroscopy (A).

• When recommending hysteroscopy the following should be considered:
  - Normal saline should be used as it offers advantages (shorter and less discomfort) over carbon dioxide instillation (A).
  - Local anaesthetic should be offered as either a paracervical block, uterosacral block or uterine instillation (A).

• There is insufficient evidence to recommend magnetic resonance imaging (MRI) scanning as an initial diagnostic test for uterine pathology (D).

• MRI should be considered for women in whom the location or nature of the fibroids remains uncertain after transvaginal ultrasound and transvaginal sonohysterography or who wish to avoid the possible discomforts of a TVSH (D).

• There is insufficient evidence to recommend CT scanning in the assessment of fibroids (D).
Medical Treatments

- Progestogens should not be recommended in the treatment of uterine fibroids as there is insufficient evidence of benefit (D).

- Oral contraceptives are not effective in shrinking uterine size but may reduce menstrual blood loss with a resultant improvement in haematocrit (C).

- Hormone replacement therapy (HRT) should not be used to treat fibroids as it is not effective in reducing uterine fibroid size (A).

- Women who bleed while on continuous combined HRT and who are known to have fibroids should have adjustments made to their HRT by either decreasing the oestrogen dose or increasing the progesterone dose (D).

- Transdermal oestrogen formulations should not be given to women with fibroids (A).

- RU486 is effective in reducing uterine fibroid size without causing a reduction in bone mineral density (D).

- Danazol should not be recommended as initial treatment for fibroids as it is not as effective as gonadotrophin-releasing hormone analogues and has androgenic side effects which limit its use (C).

- Gestrinone is effective in reducing uterine and fibroid size but androgenic side effects may limit its use (A).

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are not effective as a treatment for women with fibroids in reducing heavy menstrual bleeding (B).
• Gonadotrophin-releasing hormone analogue (GnRHa) treatment effectively reduces uterine and fibroid size but unpleasant side effects and a reduction in bone mineral density limit its sole use to 6 months (A).

• Gonadotrophin-releasing hormone (GnRH) analogue treatment for 3 months followed by combined ‘addback’ therapy (oestrogen plus progestin) result in fibroid shrinkage and are an alternative for women who have contraindications to surgery or who do not wish to undergo. Once therapy stops then the fibroids will return to pretherapy size. (B)

• There is insufficient evidence to recommend progestogen-releasing intrauterine systems to reduce uterine fibroid size (C)

Surgical Management

• Administration of GnRH analogues for 2 to 4 months prior to surgery for uterine fibroids is recommended for women with a large uterus (> 18 weeks size) or pre-operative anaemia (B).

• Women who are diagnosed with submucous uterine fibroids and heavy or abnormal menstrual bleeding should be offered hysteroscopic ablation or resection as an alternative to hysterectomy (C).

• Women with subserous and intramural fibroids associated with symptoms such as heavy menstrual bleeding and pressure symptoms should be offered a myomectomy as an alternative to hysterectomy (D).
• Laparoscopic myomectomy should not be undertaken in women who wish to conceive because of case reports suggesting increased risk of uterine rupture (D).

• There is insufficient evidence to recommend the routine use of adhesion barriers (B).

• There is insufficient evidence to recommend the routine use of vasopressin in reducing operative blood loss (C).

• There is insufficient evidence to support the introduction of laser induced interstitial thermotherapy, myolysis or cryomyolysis technique (D).

• Embolisation of uterine fibroids may be an effective alternative to myomectomy or hysterectomy but RCTs are awaited (D).

• The low incidence of leiomyosarcoma discovered incidentally in asymptomatic women with uterine fibroids does not support operative management of fibroids as prevention of leiomyosarcoma (D).

• The decision whether a hysterectomy or myomectomy is undertaken is dependent on: the woman’s preference, the age of the woman, the desire to retain reproductive potential and the position and number of the fibroids (D).

• Women with fibroids associated with symptoms such as heavy menstrual bleeding and pressure symptoms should be offered a myomectomy as an alternative to hysterectomy (D).
- Women who have fibroids detected during pregnancy should be referred to a specialist for a consult but do not require additional surveillance unless symptoms arise during the pregnancy (D).