City and Hackney Fibroids Pathway

Homerton University Hospital NHS Foundation Trust

NHS North East London Clinical Commissioning Group

PATIENT PRESENTS WITH 1

- Unscheduled / heavy bleeding
- Dysmenorrhoea
- Pelvic / back pain
- Urinary symptoms (if present, arrange a mid-stream urine test to exclude UTI)
- Gastrointestinal symptoms — e.g. bloating, or constipation

HISTORY 2

- Menstrual history (see Heavy Menstrual Bleeding pathway)
- Obstetric and family history
- History of infertility
- History of known fibroids
- Rate of distention and growth of fibroids
- Cervical screening

EXAMINATION 3

- Check for bulky uterus on pelvic examination and/or renal angle tenderness
- Typical fibroid mass arises out of the pelvis, has an irregular knobbly shape, a firm or hard consistency, and can be moved slightly from side to side
- Perform Ultrasound to confirm. If imaging shows presence of uterine fibroids, see below.

MANAGEMENT 4

Appropriate treatment based on size & location of fibroids and symptoms

Asymptomatic fibroids

- Manage if symptoms change, reassure no treatment required
- Click here for NICE guidelines

Symptomatic fibroids

Diameter < 3cm / No intracavity fibroids / Causing heavy periods

- Initial management in primary care
- For further treatment information please click here

Symptomatic fibroids

Diameter > 3cm / Intracavity fibroids / Red flag symptoms present / Failed initial treatment

- Refer to secondary care
- For further treatment information please click here

⚠ RED FLAG

Refer urgently if:

- Postmenopausal bleeding
- Persistant post-coital bleeding (>4 weeks) once infection ruled out and had up to date smears
- Acute pelvic pain

PATIENT INFO

PIL **NHS Choices - Fibroids**

Authors: Anita Coutinho (GP Clinical Lead for Gynaecology)
Sandra Watson (Consultant Gynaecologist)

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SYMPTOMATIC FIBROIDS

Diameter < 3cm / No Intracavity Fibroids / Causing Heavy Periods

Initial management in Primary Care:

1. **Levonorgestrel-releasing intrauterine system** (LNG-IUS) e.g. Mirena® or Levosert®
   - Provided long-term (>12 months) use is anticipated.
   - Change to Mirena if copper coil in situ, either at your practice or refer to community gynaecology service.

DO NOT USE copper intrauterine devices and the LNG-IUS in patients with distortion of the uterine cavity if they cannot be easily fitted. All other methods of contraception can be used without restriction

2. **Tranexamic acid** (dose is 1g TDS for maximum 4 days) and/or non-steroidal anti-inflammatory drugs (NSAIDs)
   - Stop if symptoms do not improve in three menstrual cycles.
   - **For NSAIDS:** Assess any contraindications, counsel for GI side effects and consider prescription for protective proton pump inhibitor
3. **Combined oral contraceptives** – review symptoms after 3 months
4. **Norethisterone**
   - 5mg TDS from days 5 to 26 of menstrual cycle. Use as temporary measure whilst awaiting review by a gynaecologist. Issue acute prescription and review after 1 month.
5. **Long-acting progestogen-only injectable -** review symptoms after 3 months

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SYMPTOMATIC FIBROIDS TO BE MANAGED BY SECONDARY CARE

Diameter > 3cm / Intracavity Fibroids / Red Flag Symptoms Present / Failed Initial Treatment

Refer to Secondary Care:

- Symptoms (e.g. heavy menstrual bleeding – click here for pathway) that have not improved despite initial treatments
- Fibroids and menorrhagia: consider referring to secondary care for hysteroscopy and endometrial ablation
- Large fibroids causing menorrhagia despite symptomatic treatment, or pressure symptoms (dyspareunia, pelvic/ abdominal pain, constipation, urinary symptoms): Myomectomy, hysterectomy, uterine artery embolisation (*performed at Royal London – not Homerton*) should be considered
- Intracavity (submucosal) fibroids: Transcervical Resection of a fibroid (TCRF) should be considered
- Women with fertility or obstetric problems associated with fibroids: consider myomectomy
  - **Submucous fibroids**: should be removed
  - **Intramural fibroids** causing distortion of endometrial cavity: consider removal
  - **Subserosal fibroids**: consider removal if obstructing ovary/fallopian tube

Although fibroids likely to grow in pregnancy - impossible to predict whether they will and by how much.

Doing a myomectomy (with risks of surgery including possible formation of adhesions potentially affecting future fertility) has to be weighed up against the chance of the fibroids adversely affecting the pregnancy.

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