Mersey and West Lancashire Teaching Hospitals
NHS Trust

Having a Uterine embolisation

Patient leaflet

If you need this leaflet in a different language or accessible format please speak to a member of staff who can arrange it for you.

اگر به این بروشور به زبان دیگر یا در قالب دسترس‌پذیر نیاز دارید،
لطفاً با یکی از کارکنان صحبت کنید تا آن را برای شما تهیه کند.

Jeśli niniejsza ulotka ma być dostępna w innym języku lub formacie,
proszę skontaktować się z członkiem personelu, który ją dla Państwa przygotuje.

Dacă aveți nevoie de această broșură într-o altă limbă sau într-un format accesibil,
vă rog să discutați cu un membru al personalului să se ocupe
de acest lucru pentru dumneavoastră

如果您需要本传单的其他语言版本或无障碍格式，请联系工作人员为您安排。

إذا احتجت إلى هذه النشرة بلغة أُخرى، أو بتنسيق
يسهل الوصول إليه، يرجى التحدث إلى أحد الموظفين لترتيب ذلك لك.

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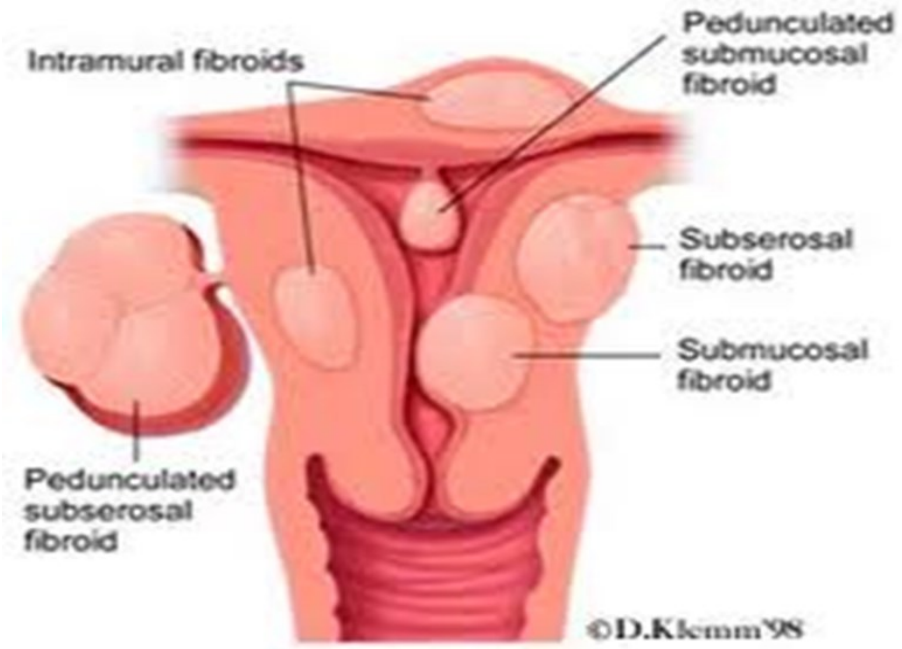
Introduction

This leaflet tells you about having Uterine Artery Embolisation. It explains what is involved and what the possible risks are. It is not meant to replace informed discussion between you and your doctor, but can act as a starting point for such discussions. If you have any questions about the procedure please ask the doctor who has referred you or the department which is going to perform it.

What are fibroids?

Fibroids are abnormal growths of the muscle wall of the womb or uterus. Uterine fibroids are the most common growth in the female genital tract. You might hear them referred as “fibroids” or by several other names, including leiomyoma, leiomyomata, myoma and fibromyoma.

Fibroids are non-cancerous (benign) growths. While fibroids do not always cause symptoms, their size and location can lead to problems for some women including painful or heavy periods and pressure symptoms affecting the urinary bladder, bowel or lower back. Fibroids may occur in a number of locations. They most commonly lie in the wall of the uterus (intramural fibroids) but may protrude either outside the uterus or into the cavity of the uterus.



Introduction

How common are fibroids?

Fibroids are very common. The number of women who have fibroids increases with age until menopause: about 20 percent of women in their 20s have fibroids, 30 percent in their 30s and 40 percent in their 40s. About a ⅓ of women aged 35 and older have uterine fibroids of a significant size. Fibroids are more common in certain ethnic groups.

Do fibroids need treatment?

Fibroids are very common and do not necessarily require any treatment at all. The most common indications for treatment are pain, heavy menstrual bleeding or pressure on adjacent organs such as the bladder.

What is Embolisation?

Embolisation is the process of causing an organ or tumour to reduce in size by blocking its blood supply. This can be achieved by using a number of different materials such as small foam particles, metal coils or as in the case of uterine artery embolisation, embosphere particles specially designed for the purpose. The interventional radiologists performing the procedure have years of experience of embolisation in other parts of the body for problems such as cancerous growths or to stop bleeding following a trauma. Uterine artery embolisation simply applies these skills and techniques in the uterus.

Where will the procedure take place?

The procedure will take place in the Radiology Department in a special “screening room” design specially for this type of procedure. This is similar to an operating theatre into which specialised X-ray equipment has been installed.

Who will you see?

A specially trained team of radiographers and nurses led by an interventional radiologist within the radiology department. Interventional radiologists have special expertise in reading the images and using imaging to guide catheters and wires to aid diagnosis and treatment.

As the procedure takes place in a sterile setting all staff members will be wearing scrubs. All members of the team will introduce themselves.

The day of the procedure

You can eat a light breakfast on the morning of the procedure. You will be admitted to a hospital ward where you will be clerked in by the nursing staff. Some blood tests and a pregnancy test are performed prior to the procedure. It is also routine to insert a bladder catheter. This is for your own comfort as you will need to lie flat for several hours after the procedure.

Most importantly, however, the catheter keeps the bladder empty during the procedure as the contrast (dye) injected to show the arteries is excreted by the kidneys ends up in the bladder. Without a catheter the views the radiologist gets of the uterine arteries would be obscured. A blood sample is also taken as a baseline of ovarian function. It does not matter if you are due a period around the time of the embolisation.

The embolisation procedure itself is usually painless but pain can occur afterwards when the arteries have been blocked and spasm occurs. We routinely set up a PCA (patient controlled analgesia) pump which runs through a small drip in the back of your hand and allows you to give yourself a dose of morphine as required. This can be used during the procedure and for 12 hours or so afterwards. The amount of discomfort felt by patients varies enormously and the advantage of a PCA pump is that you are in complete control of the painkillers and can use as much or as little as you need to control any pain you might have.

At the start of the procedure you will be given antibiotic injections and suppositories which prevent the introduction of any infection at the time of the procedure and help with pain control.

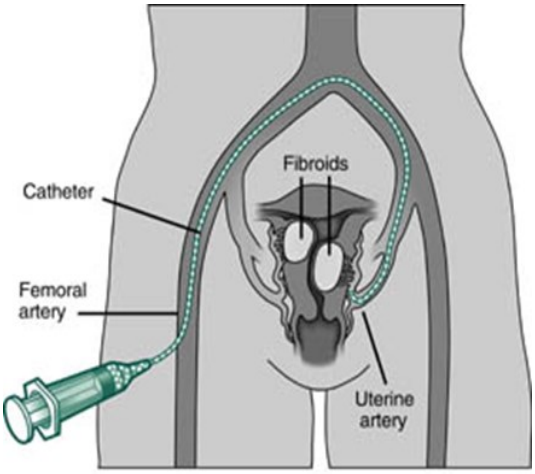
What happens during Embolisation?

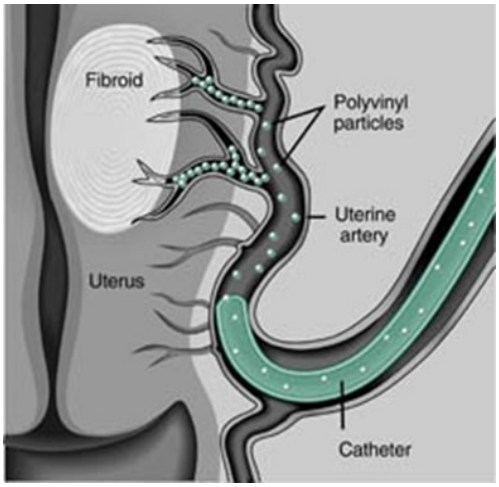
The Interventional radiologist will explain the procedure and ask you to sign a consent form. Please feel free to ask any questions that you may have and, remember that even at this stage, you can decide against going ahead with the procedure if you so wish.

You will be asked to get undressed and put on a hospital gown. A small cannula (thin tube) may be placed into a vein in your arm, so that a sedative or painkillers can be given if required. You will lie on the X-ray table, generally flat on your back. You will have monitoring devices attached to your chest and finger and may be given oxygen.

The procedure is performed under sterile conditions and the Interventional Radiologist and radiology nurse will wear sterile gowns and gloves. The skin near the point of insertion, usually the groin will be swabbed with antiseptic and you will be covered with sterile drapes.
A small incision of only a few millimetres is made at the crease at the top of the leg to access the femoral artery and a tiny tube (catheter) is inserted into the artery. The interventional radiologist guides the catheter through the arteries to the uterus using X-ray imaging to guide the catheter's progress. The catheter is advanced into the uterine artery to a point beyond any branches going to the cervix.

The interventional radiologist slowly injects the embosphere particles. These particles are precisely calibrated in size to wedge the arteries supplying the fibroids. Over several minutes, the arteries are slowly blocked.





It is necessary to embolise the arteries feeding both sides of the uterus even if the fibroids are confined to one side. It has been shown that if just one side is blocked the artery on the opposite side will grow and take over and feed the fibroid.

This may mean having to make small punctures in both groins. The X-ray dose is small but as the ovaries are very sensitive to radiation all possible measures are taken to minimise the dose. The procedure normally takes 60 minutes. You will be awake or may have some sedation.

After uterine artery embolisation

Following the embolisation procedure you will be looked after by nursing staff initially in a recovery bay and then taken back to the ward. You will need to lie flat for a few hours to reduce the risk of bleeding from the puncture sites in the groins. You will have the morphine pump to control any pain and the nursing staff can give medication to relive any nausea caused by the morphine. The urinary catheter is removed overnight and the patient controlled analgesia taken down the following morning.

A one night hospital stay is the norm. You should be ready to go home by lunchtime the day after the procedure. You can return to normal activities almost immediately but may experience some fatigue and crampy pain (like severe period pain) for a few weeks. You should not drive for 48 hours and it is advisable to book about 10 days off work.

What are possible complications?

Infection

Infection is a rare but potentially serious complication and may occur in the degenerating fibroids anything up to several months following the procedure itself. Antibiotics are routinely given at the time of the embolisation but if you develop a high temperature or bad smelling discharge at any time in the months post procedure you should see your GP or gynaecologist immediately for further advice. A course of antibiotics may be necessary.

Post Embolisation Syndrome

This is an effect of the fibroids dying away. This results in mild flu like symptoms and sometimes a minor temperature. It is helped by the painkilling tablets which you will be given to take home with you. It should not last more than a week.

Periods

It is not uncommon for your first period to be either missed or heavier than usual after the procedure, it is rather unpredictable. Following that your periods should return to normal. Due to the risk of infection and the possible passage of fibroid material you should use pads rather than tampons for at least 6 months following embolisation.

Vaginal discharge

You may have a vaginal discharge for some weeks after the procedure. If you feel otherwise well, this is not a cause for alarm. It represents dead fibroid tissue being expelled from the womb and should eventually clear up. Although occasionally solid lumps of fibroid tissue may be mixed with blood clot, it commonly appears as whitish stringy material that may be mixed with blood clot at the time of your period. Again this is not a cause for concern.

Ovarian failure

If particles enter the ovarian artery during the procedure it is possible that ovarian failure and early menopause may result. This is a very small risk as all measures are taken during embolisation to prevent particles ending up where they shouldn't). A blood test taken before the embolisation (FSH or follicle stimulating hormone) provides a baseline measure of ovarian function.

Pregnancy

The official UK guidelines from the Royal College of Radiologists and Royal College of Obstetricians and Gynaecologists Joint Working Party (November 2000) recommended that women undergoing uterine artery embolisation should be advised not to try and conceive due to theoretical adverse effects on the embryo. These early recommendations were perhaps over cautious and it is recognised that many women choose embolisation as an alternative to hysterectomy in order to preserve fertility and keep their options open. It is not, however, advisable to become pregnant within 12 months of the procedure as the fibroids are still breaking down.

Further Information

If you have access to the internet there is a wealth of information available.

The following is a selection:

British Society of Interventional Radiologists (see 'Patients' section)
www.bsir.org

Society of Interventional Radiologists (USA – see 'Patients section)
www.sirweb.org

UCLA website
www.fibroids.com

UK based website with discussion groups etc
www.fibroidnetwork.com

UK patient support group
www.femisa.org.uk

NICE patient information on UAE
www.nice.org.uk/PG094publicinfo

Radiation

Having a uterine embolisation involves the use of radiation. Any examination using radiation is only performed when strictly necessary and it is felt the benefits of the examination outweigh any potential risks. All imaging is performed using the minimum amount of radiation necessary, and is individualised for each patient depending on the size of the patient and the condition being investigated.

For more information on radiation please see the link below:
https://www.ukhsa-protectionservices.org.uk/radiationandyou/

Pregnancy

You are asked to contact the Radiology department if you suspect that you may be pregnant or if the appointment is more than 10 days after the start of your last period.

If you are, or think you could be, pregnant then you must tell us prior to, or on arrival for, your appointment.

Extravasation

Occasionally when you are having a contrast (dye) enhanced procedure there is a small risk that the injection of contrast can leak out of the artery and under the skin. This is called an extravasation. We find this occurs in 1 out of 200 injections. If this does happen then further advice will be given to by the Radiographer and Radiologist at the time of the procedure.

Injection of X-ray contrast (dye)

If you have had an allergic reaction to iodine or the X-ray contrast (dye) in the past, then you must tell us prior to, or on arrival for, your appointment. The contrast (dye) used during the procedure contains iodine.

There are risk factors associated with injections of X-ray contrast (dye), which can be increased by certain conditions. We will complete a safety questionnaire to check your suitability to have the X-ray contrast (dye). The risk of serious allergic reaction to contrast materials that contain iodine is extremely rare, and radiology departments are well equipped to deal with them.

The injection usually causes nothing more than a warm feeling passing around your body, a metallic taste in your mouth and a sensation of passing water. These effects will pass within a few minutes.

Table 1: Types of allergic reaction to Contrast (X-ray Dye)

Category	Type
Mild	Minor rash, redness, Swelling of the skin, Mild nasal congestion, sneezing, runny nose. Mild high blood pressure, nausea, Mild vomiting.
Moderate	Generalised redness Marked rash, Itching, and swelling of the skin, Hoarseness or throat tightness, Fainting Swelling of face and throat.
Severe	Respiratory arrest Cardiac arrest Fluid on the lung Seizures Cardiogenic shock The risk of death is extremely rare.

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Notes

Finally

The pictures taken during the examination are studied carefully and a detailed report is produced. The results will be sent to the person who referred you for the test. They will discuss the results with you and any treatment you may need.

You may already have an appointment with the team who referred you. If not, please contact them to arrange one to discuss the results of this test.

If you have any further questions, please do not hesitate to call the Radiology department via the number given on your appointment letter.

As this is a teaching hospital there may be students and observers present during your examination as part of their ongoing training. Please let the staff know if you do not wish any students to be present during your attendance.

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