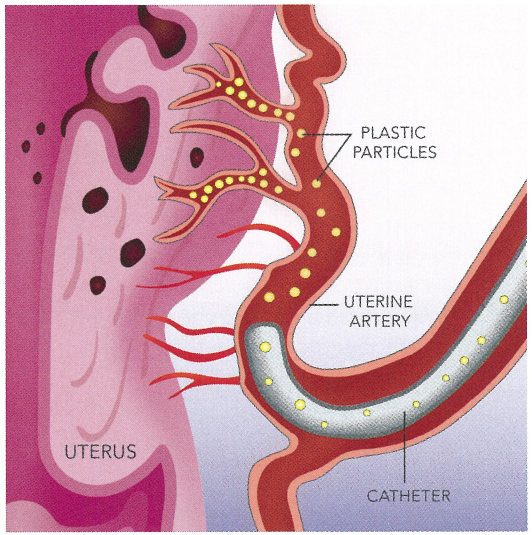
What are the advantages of UAE over hysterectomy?

UAE is less invasive. The symptoms are effectively treated without surgically removing the uterus. The risk of blood transfusion, wound infection/ breakdown and other surgical risks are eliminated and there is no need for general anaesthetics. The hospital stay is much shorter (1-2 days vs. 5-7 days). Time to return to normal activities is much faster (1 week vs. 4-6 weeks).



May I lose my period after UAE?

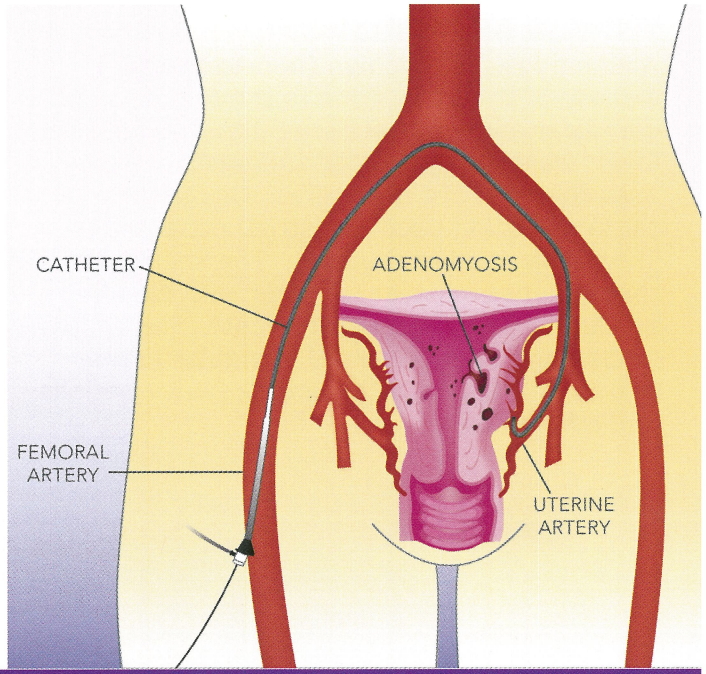
Yes, but this is probably age related natural menopause rather than caused by UAE. If you were younger than 40, the chance of natural menopause is less than 3%; if you were older than 50, the chance is more than 40%. Some particles might find their way to the ovaries via shared blood supply. However, studies have shown that UAE does not affect ovarian function in treated women.

Can I still conceive after UFE?

Yes, successful pregnancy outcome is possible after UAE. If the uterus were not normal to start with, the rates of miscarriage, preterm delivery, caesarean section and postpartum haemorrhage could be higher.

What are the recovery issues and complications after UAE?

Some patients experience significant pain in the first 8-12 hours. Pain control can be achieved with our pain management protocol including Patient Controlled Analgesia (PCA). Procedural related complications such as injury to artery are extremely rare (<1%). Delayed complications, such as shedding of tissue fragments and infection of the uterus, occur in less than 1- 3%. If you developed pain, fever and smelly vaginal discharge, you will need to be assessed and treated in a hospital emergency department. Most fragments can pass by themselves; rarely they need to be removed by a gynaecologist via vagina. The need for hysterectomy is highly unlikely.



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Adenomyosis

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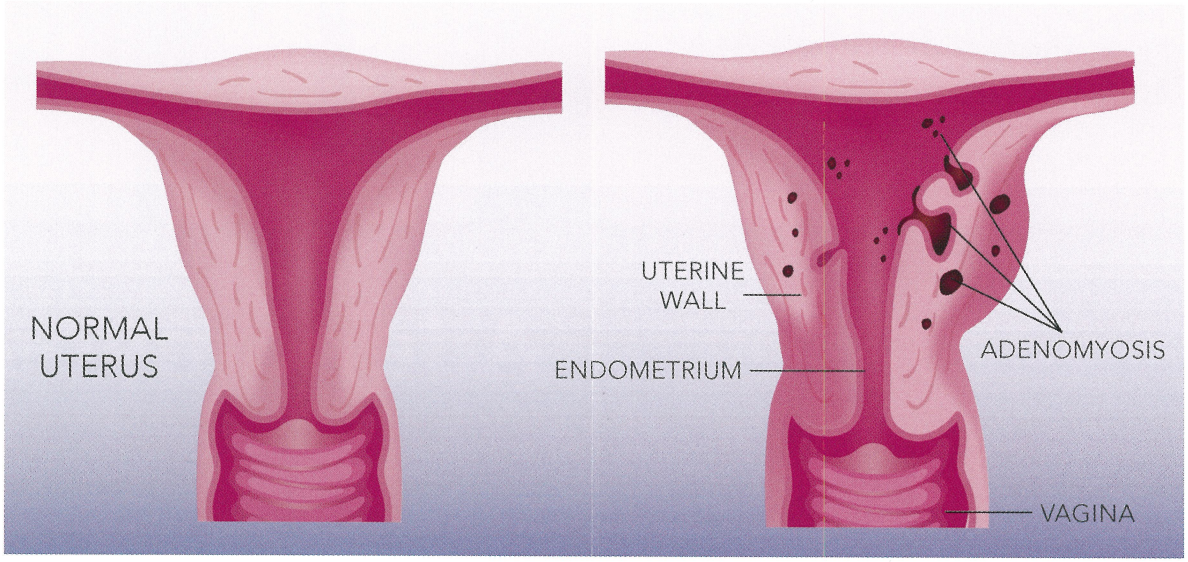
Patient information

By Dr Eisen Liang

What is adenomyosis?

Adenomyosis is a benign (non-cancerous) disease of the uterus due to the migration of glandular endometrial tissue into the muscle layer. Normally glandular endometrial tissue lines the cavity of the uterus. This layer thickens during each menstrual cycle and is shed at the end of the cycle. The shedding of the endometrial layer together with bleeding produces the menses each month. The embedding of endometrial glandular tissue into the muscle layer can cause heavy periods and inflammation.



How is adenomyosis diagnosed?

The symptoms of adenomyosis are heavy and painful menstrual periods. The uterus maybe enlarged and tender on internal examination. These clinical features however are rather non-specific and therefore diagnosis maybe difficult. Ultrasound findings are usually quite subtle and might be missed. Focal adenomyosis (adenomyoma) can be mistaken as fibroid. MRI is more definitive than ultrasound, especially when fibroids are also present. There is no specific blood test for adenomyosis. CA125 may be raised but this is neither sensitive nor specific.

What are the medical treatment options?

Non-steriodal anti-inflammatory drugs (NSAIDs) are useful for pain control. Tranexamic acid (Cyklokapron) can be used to treat heavy periods but should not be used in patients with increased risk of venous thrombosis. Oral progestrogen can be used to control menstrual bleeding. The side effects are headache, nausea, bloating sensation and mood changes. Low-dose, continuous combined oral contraceptives with withdrawal bleeds every 4–6 months may also be used for symptom control.

Progestrogen-releasing IUD (Mirena) has a satisfaction rate of 56% at 1 year. It may not be immediately effective and the side effects are irregular spotting or continuous bleeding in the first few months, acne, weight gain, bloating sensation and mood changes. Gonadotropin-releasing hormone (GnRH) agonist can be used only in the short term, due to its side effects of low oestrogen such as hot flushes, mood changes and osteoporosis.

What are the procedural options to treat adenomyosis?

Diffuse adenomyosis cannot be removed surgically without hysterectomy. Unlike fibroids, focal adenomyosis or adenomyoma are not easily separated out from the normal adjacent tissue and therefore surgical removal is not appropriate.
Endometrial ablation heats only a depth of few millimeters of tissue and is not useful except for the very superficial type of adenomyosis. It can seal off the embedding endometrial tissue potentially worsening period pain. In the setting of painful heavy periods and an apparently normal ultrasound, it is prudent to exclude adenomyosis by MRI before endometrial ablation.
In the past, hysterectomy is the only definitive treatment for adenomyosis.

What is uterine artery embolisation UAE?

Tiny particles are injected inside the arteries to restrict the blood flow to the uterus. The adenomyosis tissue will shrink, as it is less tolerant to the lack of blood supply than the normal uterine muscle. Under local anaesthetic, a tiny nick allows the insertion of a small catheter (a tube 1- 2 mm in diameter) to be advanced into the uterine artery under X-ray guidance.

How effective is UAE for adenomyosis?

For pure adenomyosis, relief was achieved in 83% short-term and 65% long term. For combined adenomyosis and fibroids, relief was achieved in 93% short-term and 82% long term. The hysterectomy rate is around 13%, suggesting that 87% of women can be spared of hysterectomy. Our own patient satisfaction rate is 90%.