Women Need FEMME

A Commentary Article - A review of current evidence from a patient perspective on in-patient fibroid treatments; finding evidence inadequate for women seeking fibroid treatment (and their clinicians) to make informed treatment choices and therefore urging clinical teams to participate in the FEMME Trial (*A Randomised Trial of Treating **F**ibroids with Either **E**mbolisation or **M**yomectomy to **M**easure the **E**ffect on the Quality of Life Among Women Wishing to Avoid Hysterectomy*)

Most British people expect their medical treatment to be evidence based, backed by clinical research and trials performed to the highest standards. They believe they will be fully informed about the treatment options available and that the treatment and outcomes they receive from the NHS will be on a par with the best.

While newer surgical and hospital treatments have been reviewed by clinical guidance and regulatory bodies and evaluated for safety and efficacy, older treatments have not been assessed in the same way. They may never have been through any review process whatsoever, to establish safety or efficacy. Case studies and experience alone represent the data base. Yet these treatments are still available in the NHS and often accepted as the 'gold standard' against which new treatments are compared. Although NICE has recommended approximately 800 'do not do's for treatments and interventions that are not clinically effective and/or cost effective, many of these treatments are still commissioned, used and paid for by the NHS, including D&C [1, 2]. Other treatments, even though they have been widely available in the NHS for many years arguably, do not have sufficient evidence to be classified by NICE as safe and efficacious enough for routine use in the NHS. This would surely concern many patients if they knew.

Far too few of the very many women needing treatment each year for their symptomatic uterine fibroids are fully and objectively informed about all their treatment options [3]. This is contrary to Government policy, and GMC [4] and NICE guidelines [5]. In part this is because historically abdominal hysterectomy was the only treatment available (this is still the case in some hospitals) and seen as a 'gold standard' by some gynaecologists (although many

women disagree [3]). Too much of the basic evidence about safety, efficacy, morbidity, mortality, fibroid re-growth, the need for additional/re-intervention, fertility and pregnancy rates is not available and has not been fully compared and formally reviewed. Long term costs have not been examined.
Many women wish to avoid hysterectomy for very valid reasons –

- it is not safe enough - the mortality and morbidity is considered too high
- they wish to –
    - retain their fertility and femininity
    - maintain full sexual function
    - have a successful pregnancy
- it is too invasive for a condition which is not life threatening
- recovery time is too long – women cannot afford to take 3 months off work
- the social and economic costs to the woman, her family and employer are too high.

"***I've been diagnosed with large fibroids and was advised to have a complete hysterectomy. I don't want one, as I want to keep my fertility and financially it's just not a viable option! I'm self employed and cannot take three or more months off work without pay!!!"***

"I am unwilling to have such an invasive treatment as a hysterectomy when there is a real and less invasive alternative."

Myomectomy has until recently been the only surgical treatment available for women with symptomatic fibroids wishing to avoid hysterectomy and/or retain fertility. It has rarely been offered to older women wishing to avoid hysterectomy, while women are increasingly delaying pregnancy. There is some evidence of successful pregnancy outcomes after myomectomy, but very little clinical evidence on morbidity, mortality and re-intervention rates from fibroid re-growth, adhesions etc. Some clinicians believe almost all women will eventually go on to have hysterectomy.

The newer interventional radiology treatment uterine artery/fibroid embolisation [UAE] has extensive clinical evidence on safety and efficacy and is currently the only hospital [i.e. non-pharmaceutical] treatment for fibroids >3cm that has been reviewed by NICE Interventional Procedures Guidance [IPG]] and given "normal arrangements" from a safety and efficacy perspective [6]. While a number of papers have been published citing many successful pregnancies following UAE there is now an important question of which treatment is most effective in which women, with which types of fibroids.

Many women ask FEmISA, The Fibroid Network and other fibroid support groups which treatment would be better for them, myomectomy or fibroid embolisation/UAE? There is currently insufficient evidence for them [or their clinicians] to make an informed decision on all the important issues they need to consider – fertility and pregnancy success rates, morbidity both short and long term, mortality, re-intervention rates, fibroid re-growth rates,

adhesions, social costs, and recovery time. These women will have to live with the consequences of their treatment choice, if they are offered one. Currently there is no well supported comparable data based on high quality evidence. Nor are the costs well compared.

After NICE published the Clinical Guidelines on Heavy Menstrual Bleeding [5] one of their research recommendations was - ***What are the long-term recurrence rates of fibroids after uterine artery embolisation or myomectomy***? Women also ask what are the re-intervention rates for each procedure, short and long-term? NICE's research recommendations from IPG on UAE [6] are **– "NICE** ***encourages further research into the effects of uterine artery embolisation (UAE) compared with other procedures to treat fibroids, particularly for women wishing to maintain or improve their fertility*****".**
Evidence published recently gives conflicting results. Comparative studies between myomectomy and UAE are often not followed up for long enough and have small patient numbers and in some cases mismatched patient groups [7]. The conclusion from the recent Cochrane review, a meta-analysis of five RCTs comparing UAE with other surgical interventions for fibroids concluded –

> ***"UAE appears to have an overall patient satisfaction rate similar to hysterectomy and myomectomy and offers an advantage with regards to a shorter hospital stay and a quicker return to routine activities. However, UAE is associated with a higher rate of minor complications and an increased likelihood of requiring surgical intervention within two to five years of the initial procedure. There is very low level evidence suggesting that myomectomy may be associated with better fertility outcomes than UAE, but more research is needed."***

It was also mentioned that the major complication rate for myomectomy*"* ***is less well defined"*** [8.]

The latest published meta-analysis of fertility and pregnancy outcomes after UAE for fibroids and postpartum haemorrhage [PPH] [9] gave a cumulative live birth rate for fibroid patients of 65.2% and cumulative pregnancy rate for PPH of 87.2%. In discussion it was stated –

> "***The cumulative pregnancy rate from the pooled analysis was 58.6%, and the mean age was 35.9 years. This rate is comparable to the age-adjusted pregnancy rates in the general population. Also considering that there is some degree of subfertility associated with fibroid tumors, these findings contradict the current recommendations from SIR and ACOG***". The authors concluded "***there is low-level evidence to suggest that pregnancy rates following UAE are comparable to the age- adjusted rates in the general population"***

There are also further issues when considering morbidity. Fibroid re-growth is an issue for both myomectomy and UAE, as NICE research recommendations suggest. More evidence on comparative re-growth and re-interventions rates is important.

Adhesions are a serious complication of abdominal surgery, including myomectomy, but many studies do not consider this. How often is this risk discussed with patients?
According to the recent paper - Prevention of adhesions in gynaecological surgery: the 2012 European field guideline [10].

- *"93 % of patients undergoing any abdominal/pelvic surgery are affected*
- *Over one third of patients who undergo extensive open surgery seem to be readmitted with adhesion-related complications within 10 years*
- *Adhesions are involved in 56 % of reintervention complications*
- *Adhesions are responsible for 20–40 % of secondary infertility cases in women"*

Adhesions may well diminish fertility, as might UAE by inadvertently affecting blood supply to the ovaries, but in neither case, is the magnitude of any effect properly understood. It is time they were.

HES has recently published mortality statistics by diagnosis and procedure and the total death rate for '*abdominal excision of the uterus'* within 90 days of the procedure is 0.6%, which is worryingly high. While these treatments are used for a wide range of conditions including cancers, it is important to know the mortality rate for all surgical fibroid treatments and the risk to patients.

The independent patient groups supporting women with fibroids therefore very much welcomed and support the FEMME trial - ***A randomised trial of treating Fibroids with Embolisation or Myomectomy to Measure the Effect on quality of life, among women wishing to avoid hysterectomy,*** which is being funded by NIHR [11]. This study will measure the changes in the quality of life a total of 650 women [under review] experience after their fibroids are treated with either uterine artery embolisation (UAE) or myomectomy; the number of adverse events: menstrual blood loss; reintervention rates and determine the cost-effectiveness of each procedure with follow up over 4 years

Although many centres have agreed to participate in this study and 88 patients have been recruited to date (July 13) there is a significant reluctance from some clinical teams and units to take part. Their comments would suggest that they are very confident about the superiority of one of the treatments, myomectomy.
The short and incomplete review of recent comparative evidence shown above about the most effective treatments, and the questions about safety and outcomes data for myomectomy emphasise the great need for the FEMME study.
Women with fibroids need to know which treatment is best for them, as do the teams treating them and the NHS. Currently this evidence is not available and FEMME can address this.
The FEMME study will give us the important missing evidence to help women and their clinical teams make treatment choices to give optimum outcomes for women with symptomatic fibroids. We urge all the clinical teams in the trial centres to recruit patients and participate with enthusiasm.
It is the women with fibroids and their partners and families who have to live with the consequences of their treatment choice and their choice must be evidence based. We urge the clinical teams in the FEMME trial centres to support FEMME and recruit patients.

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References

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11. FEMME trial details – **Full title of study**: ***A randomised trial of treating Fibroids with Embolisation or Myomectomy to Measure the Effect on quality of life, among women wishing to avoid hysterectomy***
REC reference number: 11/WM/0149
Protocol number: 11/WM/0149