

Myomectomy

Uterine fibroids, also known as leiomyomas or myomas, are the most common benign (non-cancerous) tumors of the female reproductive tract. They are present in up to 80% of women and cause significant gynecologic problems in about 30% of women. They are more common in African American women.

Uterine fibroids are composed of smooth muscle cells, like the cells that make up the walls of the uterus. They can vary in size from a small pea to a large melon. Fibroids can be present and not cause any problems. Most women who do have symptoms experience pelvic pressure, pelvic pain, or heavy, frequent periods.

Uterine fibroids cause symptoms based on their location within the uterus. Uterine fibroids located along the inner lining of the uterus are known as submucosal fibroids, and those beneath the outer lining of the uterus are known as sub-serosal. Fibroids located in the intervening muscle are known as intramural. The location of uterine fibroids is important because it may determine what treatment options your doctor offers to you.

Many women with uterine fibroids that have symptoms that cannot be controlled with medical therapy will have a hysterectomy to control their symptoms. However, women who would like to preserve their fertility have the option of having a myomectomy. Myomectomy is a surgical procedure that involves removing the fibroids from the uterus while keeping the uterus intact.

A myomectomy can be performed hysteroscopically (submucosal), laparoscopically (intramural and sub-serosal), or abdominally. The choice of surgical route will depend on the location and number of uterine fibroids, as well as your personal medical and surgical history.

Unfortunately, up to 25% of women will have new fibroids develop and cause symptoms within five years of a myomectomy. Because of the high rate of recurrence, myomectomy is generally not recommended for women who have completed childbearing and continue to suffer from excessive heavy menstrual periods, pelvic pressure, and pain due to fibroids.

Types of Myomectomy

Hysteroscopic Myomectomy

A hysteroscope is a 5-8mm telescope used to examine the interior of the uterus. It is attached to a fiber optic light source and video camera. Your doctor can see the inside of your uterus using this device.

In women who suffer from submucosal fibroids (over 50% of the fibroid is within the uterine cavity), the hysteroscope can be used to remove the fibroid. Using advanced hysteroscopic equipment, your doctor can shave the fibroid away and leave a normal uterine cavity. When performed to control heavy vaginal bleeding due to a single submucosal fibroid, hysteroscopic myomectomy is successful in about 75% of women. The success rate declines as the number of fibroids increases.

The most common complications from this procedure are related to the fluid used to distend the uterus. Your surgeon will observe the intake and output of this fluid and will stop the procedure if an imbalance occurs – even if the procedure isn't finished.

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Abdominal Myomectomy

Some patients will require a traditional abdominal myomectomy. In this procedure, the surgeon makes either a Pfannenstiel (bikini) incision or a midline incision and removes the uterine fibroids. The technique offers greater access to the uterus and makes it easier to repair the uterus. However, it requires a longer postoperative recovery period and may result in more scar tissue.

Patients with an exceptionally large uterus or multiple uterine fibroids often require an abdominal myomectomy. All of our surgeons attempt to perform procedures in a minimally invasive fashion, but for your safety, an abdominal incision may be required in some cases to remove the uterine fibroids.

Laparoscopic Myomectomy

Traditionally, a large abdominal incision is required to perform a myomectomy. However, as laparoscopic surgery and technology have been refined over the past 15 years, laparoscopic myomectomy has become an option for experienced laparoscopic surgeons.

In this procedure, the surgeon inserts 3-4 trocars measuring 5-12mm each into your abdomen, guided with help from a tiny video camera. This technique is primarily used for removing intramural and sub-serosal uterine fibroids. The fibroids are removed from the uterus, and the defect is sewn closed using sutures.

Because laparoscopic incisions are small, recovery usually only causes minimal discomfort. Since the abdominal cavity is not opened, the risk of contamination and bacterial infection is low. The intestines are not exposed to the drying effect of air or the irritating effects of the sterile gauze pads used to hold the bowel out of the way during the abdominal surgery.

As a result, the normal function of the bowels returns almost immediately after surgery. This method also spares the patient postoperative gas pain and avoids the multiple-day delay before patients are able to eat again. After laparoscopic myomectomy, women usually return to normal activity, work, and exercise within 7-10 days.

Robotic Myomectomy

In some cases, your surgeon may choose to perform your surgery utilizing the DaVinci robotic system. This robotic device is entirely controlled by your surgeon and increases accuracy, resulting in outcomes similar to with laparoscopic myomectomy. Most surgeons use the DaVinci system to assist with technical factors related to your case or to assist with extensive suturing that may be necessary.

Conclusion

Myomectomy is an excellent procedure for women who suffer from gynecologic symptoms related to uterine fibroids. It allows the woman to retain her uterus and the potential for future fertility. Most patients who get pregnant after a myomectomy will require a Cesarean delivery. In most cases, myomectomy is not recommended for women who do not desire future fertility, since the uterine fibroids tend to recur in many patients after a myomectomy.

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