Primary Care Fibroid Referral Pathway

Aim of referral pathway:

- To provide primary care and specialities within secondary care with clear guidance on the referral criteria to the secondary care specialist fibroid clinic.
- To ensure appropriate referral and utilisation of secondary care services.

Assess risk of fibroids

- Ethnicity: around 60% of black women will have fibroids by 35yrs which increases to 80% by age 50, whereas Caucasian women have an incidence of 40% by 35yrs and 70% by age 50.
- Age: fibroids become increasingly common through reproductive life and regress after menopause
- Presenting symptoms e.g. menorrhagia, pressure symptoms, pain, infertility.

Examination

- Abdominal, pelvic bimanual and speculum examination should be performed to assess for fibroids but also to rule out other pathology.

Investigations

- FBC if heavy menstrual bleeding to assess haematological impact
- Swabs if risk of sexually transmitted infections
- Cervical cytology if screening overdue
- USS Pelvis to assess for structural changes
- *Ca125 can be raised in women with fibroids and normal ovaries. No further investigation required if no suspicion of ovarian malignancy on USS.

USS Pelvis

- **Transabdominal USS:** better for pedunculated subserosal fibroids or very large fibroids
- **Transvaginal USS** better resolution for smaller fibroids and their relation to the endometrial cavity
- If any previous imaging – compare fibroid size to assess for rapid enlargement and risk of sarcoma.
- Understand the relevance of USS findings to minimise referrals.
    - If incidental finding of fibroid and asymptomatic repeat USS in 12 months and if no change, conservative management is appropriate.
    - Fibroids <5cm referred will be seen in core gynaecology clinic.
    - Fibroids >5cm referred will be seen in the fibroid specialist clinic.

MRI is not recommended as first line imaging from primary care.

Important points from an USS report:

- Dimensions of uterus- May be reported as bulky or evidence of adenomyosis.
- Location and size of fibroids.
- Relation of fibroids to endometrial cavity including any distortion.
- Appearance of endometrium e.g. normal, cystic, polyp, thickness if postmenopausal.
- Size and appearance of ovaries.

Management

- Initiate medical management in low risk patients.
- If heavy menstrual bleeding is the presenting symptom then medical management should be offered while the patient has further investigation.
- Manage heavy bleeding regardless of referral.
- Medical options should be discussed as per NICE CG44 guidance with the risks and benefits of each option (including the option of no action) for the patient to make an informed decision. (appendix 2)
- Offer a review and option to change treatment after 3 months to assess if satisfactory improvement in symptoms.

For women with fibroids that are found incidentally and are asymptomatic

- Asymptomatic fibroids do not require treatment.
- Most need no further investigation unless rapid growth or suspicion of malignancy.
- Annual follow up to assess size and growth in primary care.

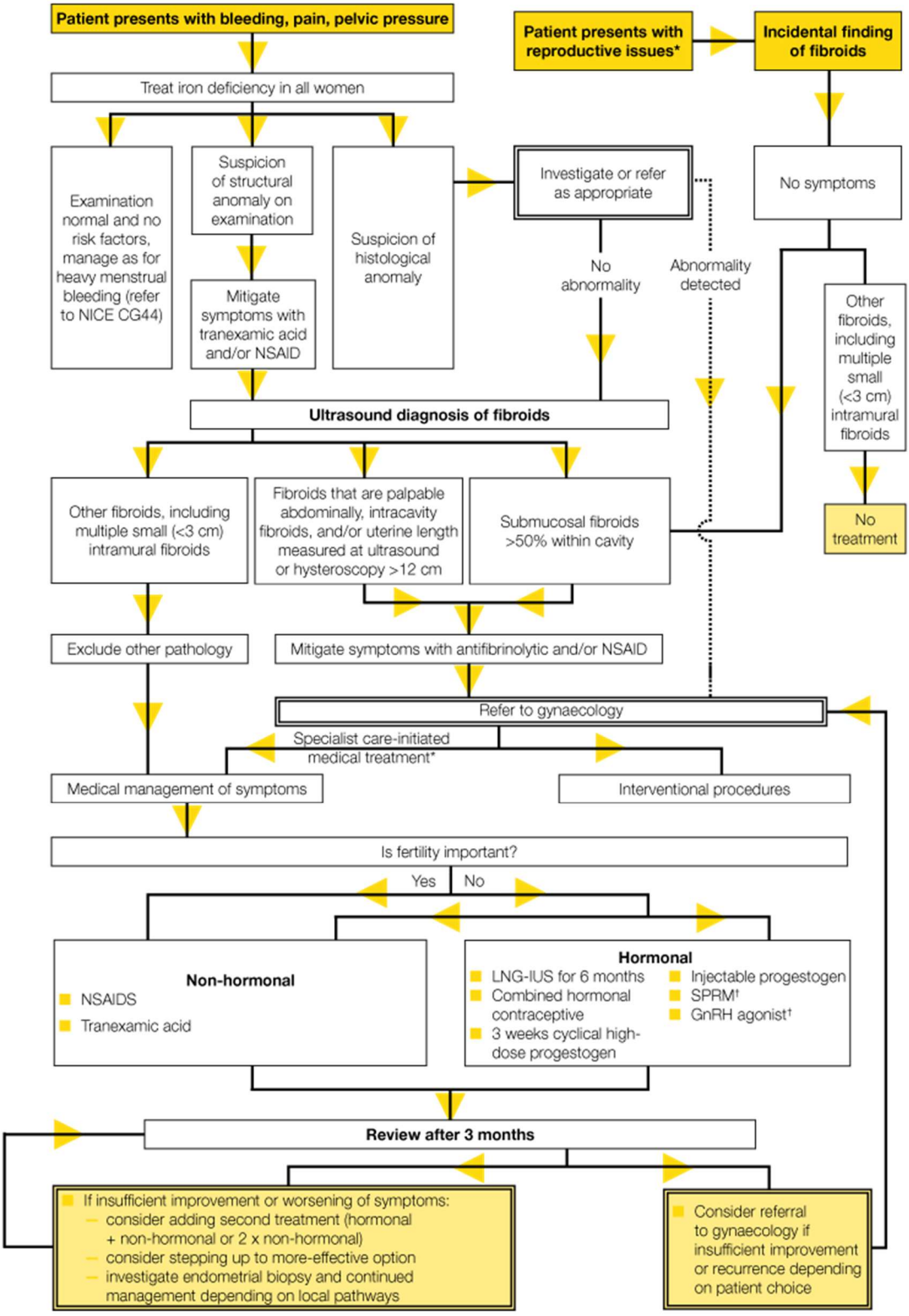
Referral criteria to secondary care

- Not all fibroids need secondary care opinion.
- Most medical treatment can be provided in primary care without a specialist opinion.
- Patients must have been fully assessed with history, examination, ultrasound scan requested and medical treatment initiated before being referred.
- Referral letters must include all relevant information as above.

Patients meeting referral criteria:

- Heavy menstrual bleeding secondary to fibroids not improved with medical treatment.
- Clinical or radiographically suspicion of malignancy e.g. rapidly enlarging fibroid.
- Primary or secondary infertility with USS evidence of fibroid >3cm or submucosal fibroid >50% within the cavity.
- Patient has compressive symptoms e.g. bladder or bowel with USS evidence of fibroid.

- Fibroids palpable abdominally, or intracavity fibroids +/- uterine length is greater than 12cm on USS or at hysteroscopy.
- Atypical fibroid location e.g. parasitic fibroid.
- Patient is requesting surgical intervention.
- ***Women with a pelvic mass associated with other symptoms of cancer (e.g. unexplained bleeding, weight loss) should be referred as USC i.e for an appointment within 2 weeks.***



Appendix 1: Gray S, Connolly A, Ma R et al. The assessment and management of uterine fibroids in primary care. *Guidelines* Oct 2014; **54**: 259–264. www.guidelines.co.uk/wpg/uterine-fibroids

Treatment	Contraceptive effect	Effect on pain	Effect on bleeding	Fibroid volume	Special consideration
NSAID	No. Fertility preserved	Helpful	Reduction shown in HMB	Not evaluated	Gastric irritation Patients with asthma Start at onset of bleeding Mefenamic acid is the only NSAID with a licence for HMB but other NSAIDs may have a class effect
Tranexamic acid	No. Fertility preserved	No effect	Reduction shown in HMB	Not evaluated	Max. daily dose of 4 g best given as a 1 g four times daily Start at onset of bleeding and use for up to 4 days Available over the counter Thromboembolic events are rare
LNG-IUS	Yes, reversed on removal	Usually helpful	Significant reduction but may take 6 months	No conclusive evidence	Not contraindicated in nulliparous women Clinicians who fit intrauterine devices should be appropriately trained and attend regular updates to maintain their competence Progestogenic side-effects tend to be minimal and usually settle after 6 months
CHC	Yes, reversed on stopping	Usually helpful	Reduction shown in HMB	Not evaluated	Commonly used in clinical practice, although

			Helped by extended use (tricycling or continuous)		oestradiol valerate/dienogest combination is only product licensed in women with HMB, with evidence of 88% reduction in menstrual blood loss Assess risk of ATE and VTE Refer to UKMEC
High-dose oral progestogen	No, but not recommended if trying to conceive	Usually helpful	Reduction shown in HMB if used on days 5-26 of each cycle (15 mg norethisterone or 20-30 mg/day medroxyprogesterone acetate	Not evaluated	Progestogenic side-effects significant and limit long-term continuation May be helpful at menopause Avoid norethisterone if BMI >30 kg/m^2 due to risk of VTE Use in luteal phase only (i.e. day 19-26) is not effective
High-dose injected progestogen	Yes, and will take up to a year before fertility returns after last injection	Usually helpful	Reduction, with high incidence of amenorrhoea with continuous use	Not evaluated	Variable weight gain Caution in women with high risk of osteoporosis or cardiovascular disease due to hypoestogenic effects

GnRH analogues	No. Additional non-hormonal contraception required in all women at risk of pregnancy	Yes, gradual reduction	Gradual reduction up to 30 days to achieve amenorrhoea	Significant volume reduction of 53% by 3 months	Specialist initiated; for shared care, see local guidelines. Menopausal symptoms usual Consider add-back HRT (continuous combined or tibolone) if young (<45 years), high osteoporotic risk, or intractable menopausal symptoms develop Limited use because of osteoporosis risk

Appendix 2: Medical treatment available to primary care for the treatment of fibroids.

References:

Gray S, Connolly A, Ma R et al. The assessment and management of uterine fibroids in primary care. *Guidelines* Oct 2014; **54**: 259–264. www.guidelines.co.uk/wpg/uterine-fibroids

NICE guideline Heavy Menstrual Bleeding: assessment and management 2018.

Fibroids: diagnosis and management Lumsden 2015