Ultrasound Relieves Fibroid Symptoms for 2 Years

BY TIMOTHY F. KIRN
Sacramento Bureau

Los Angeles — Patients treated with magnetic resonance–guided focused ultrasound for uterine fibroids who experience improvement maintain that improvement for 2 years, Dr. Bobbie S. Gostout said at the Obstetrical and Gynecological Assembly of Southern California.

"When you see a 48-year-old woman who wants to think about a hysterectomy, this is a great option to offer her as a bridge to menopause," said Dr. Gostout of the department of obstetrics and gynecology at the Mayo Clinic, Rochester, Minn.

At the meeting, Dr. Gostout described the Mayo experience with 42 patients treated by the new modality who have now been followed out to 2 years.

Those 42 patients had a total of 55 treatments, though as time went on and the practitioners refined their technique there was less and less need for repeat procedures, Dr. Gostout said.

The procedures took an average of 3 hours, and only one patient had a length of stay longer than 5 hours.

None of the patients Dr. Gostout was involved with needed any pain medication stronger than an over-the-counter drug, she said.

Afterward, compared with matched total abdominal hysterectomy patients, the ultrasound patients had 83% fewer provider encounters, 66% fewer additional procedures, and 66% fewer additional diagnostic tests.

"It's not hard to care for these patients in your practice because they do so well," Dr. Gostout said.

The patients' average score on a symptom severity scale was 61, where the average fibroid patient scores 50 on that particular scale. At 3 months, the average score had dropped to 38, and by 6 months, it had dropped to 34. "That's still true," she said. "If patients are happy at 6 months they tend to remain happy at 24 months."

At 24 months, the duration of bleeding experienced by the patients had dropped an average of 1 full day compared with baseline, when the mean was 6.1 days. Excess bleeding, which was defined as menstruation lasting longer than 7 days, declined by one half.

Moreover, 49% of patients who had pressure and urinary frequency as a symptom (37 patients) had complete resolution, and only 1 patient was not helped at all. Of 25 patients who had nocturia, 17 had complete resolution and only 2 had no improvement.

The one symptom that was not improved in any patients was menstrual spotting between periods.

Complications from the procedure included deep vein thrombosis in one patient, sciatic nerve pain in two patients, and diarrhea lasting 24-48 hours after the procedure in "occasional" patients, probably resulting from heating of the rectum during the procedure.

"This is by far the safest treatment I offer to my patients with uterine fibroids," Dr. Gostout said.

She also noted that there have been eight pregnancies reported in women who have had the procedure; however, she still considers the treatment to be experimental for patients who want to have children.

Some patients who have the procedure get up off the table and describe having relief from their symptoms immediately, Dr. Gostout said. But more commonly, patients describe feeling ever-increasing relief with time, and the amount of time is highly variable.

"Most patients said they had gradual improvement over 3 months, and some had continued improvement for up to a year," she said. ■

Pluses, Minuses of Menorrhagia Treatments

San Francisco — Abnormal uterine bleeding is among the most common of gynecologic complaints, Dr. Lee P. Shulman said at a conference on contraceptive technology sponsored by Contemporary Forums.

Such bleeding poses measurable health risks, is associated with a lower health status, and can cause discomfort, anxiety, and a poorer quality of life.

While formal definitions of "abnormal uterine bleeding" exist, the bottom line is that menstrual bleeding is excessive when the woman believes it is excessive, said Dr. Shulman of Northwestern University, Chicago.

After conducting a menorrhagia work-up that might include both transvaginal ultrasound and an endometrial sample, the clinician must choose among a variety of therapeutic options. Each has its advantages and disadvantages.

—Robert Finn

Treatment	Advantages	Disadvantages
NSAIDs	Readily available Inexpensive Well tolerated	Only 20%-25% reduction in bleeding Gastritis
Estrogen plus progestin hormonal contraceptives	More than 50% reduction in bleeding Menstrual cycle more predictable Extended regimen reduces withdrawal bleeding Contraceptive effect	Daily use essential Systemic side effects
Cyclic oral progestin	Requires only 12 days of therapy per cycle (beginning on day 14)	Intermittent oral therapy might affect successful use Progestin-related side effects Less effective than oral contraceptives
Depot medroxyprogesterone acetate	Requires only one injection every 90 days About 60% of women amenorrheic at 1 year Highly effective contraception	Irregular bleeding Progestin-related side effects Intramuscular injection Patient concerns about weight gain and bone loss (but evidence is reassuring)
Gonadotropin-releasing hormone agonist	Once monthly or once every 3 months injection More than 90% reduction in bleeding	Hypoestrogenic state (vasomotor symptoms and bone loss) Intramuscular injection Expensive Inappropriate for long-term use
Levonorgestrel intrauterine system	Long-term efficacy About 20% of patients amenorrheic at 1 year Highly effective contraception Delivery of progestin locally to endometrium 70%-90% reduction in blood loss at 1 year	Requires insertion Up-front initial cost
Endometrial ablation	Office procedure or outpatient surgery Less time consuming and costly than hysterectomy	5%-10% of patients require second ablation Requires specific equipment and expertise Usually prevents future fertility but not effective contraception
Uterine artery embolization	Effective for fibroid-associated menorrhagia in 90% of patients Usually preserves ovarian function Less invasive than hysterectomy	Serious adverse events possible Might require hospital stay for pain control Skill of radiologist is critical
Hysterectomy	Definitive	Surgical risks Expense Eliminates future childbearing

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Cervical Cancer Rates Higher in Rural Residents

Houston — Rates of cervical cancer are higher for women living in rural areas than for those living in cities, Vicki Benard, Ph.D., reported at the annual meeting of the American Society of Preventive Oncology.

Dr. Benard of the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention reported cervical cancer rates among women in the United States, using the CDC's National Program of Cancer Registries, the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program, and the 2000 U.S. census.

Census county codes were used to categorize residents as rural, suburban, or metropolitan. A total of 39,946 cervical cancer cases were reported. Among metropolitan dwellers, the case rate was 11.8 per 100,000 residents; for those in the suburbs, the rate was 13.2 per 100,000; and for rural residents, the rate was 13.8 per 100,000, Dr. Benard reported.

When broken down demographically, black women had the highest rate of cervical cancer at 17.1 per 100,000 residents, followed by 11.4 per 100,000 for white women, 9.9 per 100,000 for Asian/Pacific Islanders, and 7.2 per 100,000 for American Indian/Alaska Natives. Age also factored into cervical cancer rates: Women aged 45 years or younger living in metro areas had a rate of 14.5 per 100,000, compared with 17.2 per 100,000 for rural women.

Dr. Benard and her colleagues speculated that the disparities are due to income, access to care, or quality of health care, but the study did not measure these factors. The study findings are especially timely, as screening and vaccinations against human papillomavirus become available. "Rural areas may need special education and outreach," Dr. Benard said.

—Carole Bullock