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Uterine Artery Embolisation (Fibroid Embolisation) Interventional Imaging Department



This leaflet tells you about having fibroid embolisation. It explains what is involved and what the possible risks are. It is not meant to replace informed discussion between you and your doctor but can act as a starting point for such discussions. If you have any questions about the procedure, please ask the doctor who has referred you or the department which is going to perform it.

What is fibroid embolisation?

Fibroid embolisation is a relatively new way of treating fibroids by blocking the arteries that feed the fibroids (uterine arteries), making the fibroids shrink. It is an effective alternative to an operation.

Why do you need fibroid embolisation?

Your gynaecologist will have told you about fibroids and discussed treatment options with you. Previously, most fibroids have been treated by an operation to remove the fibroids individually (myomectomy) or by removing the womb (hysterectomy). In your case, it has been decided that embolisation is a suitable treatment option.

Are there any risks?

Fibroid embolisation is a safe procedure, but as with any medical procedure there are some risks and complications that can arise. Occasionally a small bruise may develop in your groin at the needle entry site. Most patients feel some pain afterwards, which ranges

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Further Information

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty.

If they cannot resolve your concern, please contact our Patient Experience Team on 01932 723553 or email asp-tr.patient.advice@nhs.net. If you remain concerned, the team can also advise upon how to make a formal complaint.

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hours. You will be kept in hospital overnight and discharged the next day. Once at home, you should refrain from strenuous exercise for about a week. One to two weeks off work is advised.

What are the results of embolisation?

The vast majority of women are pleased with the results, reporting a significant improvement in their quality of life. By one year, most fibroids shrink to about half their size resulting in significant improvement in both heavy prolonged periods and symptoms relating to pressure. Once fibroids have been treated like this, they do not generally grow back again. Some women, who could not become pregnant before the procedure because of their fibroids, have become pregnant afterwards. However, if having a baby in the future is very important to you, you need to discuss this with your doctor as it may be that an operation is still the better choice.

Finally

Some of your questions should have been answered by this leaflet but remember that this is only a starting point for discussion about your treatment with the doctors looking after you. Make sure you are satisfied that you have received enough information about the procedure.

from very mild to severe crampy, period-like pain. It is generally worst in the first 12 hours and is controlled by painkillers. You will be given painkiller tablets to take. Most patients get a slight fever after the procedure. This is a good sign as it means that the fibroid is breaking down. The painkillers help control this fever. Vaginal discharge can occur afterwards and may be bloody, due to the fibroid breaking down. This can persist for up to two weeks or can be intermittent for several months. If the discharge becomes offensive, and if associated with a fever, there is the possibility of infection, and you should ask to see your gynaecologist urgently. The most serious complication of fibroid embolisation is infection. This happens to perhaps one in every two hundred women. Severe pain, pelvic tenderness and a high temperature can occur. Lesser degrees of infection can be treated with antibiotics, or a dilatation and curettage (D&C). In severe cases an operation to remove the womb may be necessary but this is extremely rare. There is a 2–4% chance that the procedure will lead to premature menopause. This occurs usually in women who are 45 years or older. Most women find it takes about six to nine months to resume a regular menstrual cycle.

Are you required to make any special preparations?

You will need to be an inpatient. You will be asked not to eat for six hours before the procedure. A urinary catheter may be placed into your bladder by a nurse. You need to have a small needle put into a vein in your arm for a sedative and painkillers to be given. An anti-inflammatory suppository may be given. A special painkiller injection device will be attached so that you can administer safe

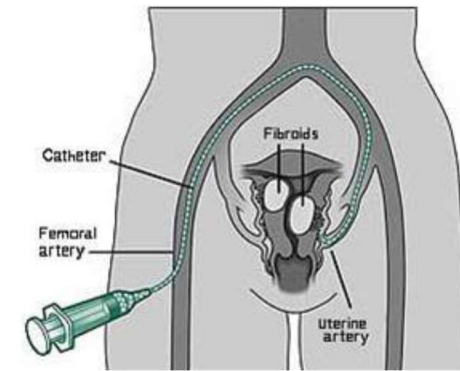
doses of painkillers after the procedure by pressing a button (patient-controlled analgesia; PCA).

Who will you see?

A specially trained team led by an interventional radiologist within the radiology department. Interventional radiologists have special expertise in reading the images and using imaging to guide catheters and wires to aid diagnosis and treatment.

What happens during fibroid embolisation?

The procedure will take place in the X-ray department, and you will lie flat on your back. You may have monitoring devices attached to your chest and finger and may be given oxygen. Your groin will be swabbed with antiseptic, and you will be covered with sterile drapes. Local anaesthetic will be injected in the skin in your groin and a needle will be inserted into the artery. Sometimes both groins are used. A fine plastic tube called a catheter is placed into the artery. The radiologist uses X-ray equipment to guide the catheter into the arteries, which are feeding the fibroids. A special dye, called a contrast agent, is injected down the catheter into these uterine arteries, and this may give you a hot feeling in the pelvis. Fluid containing thousands of tiny particles is injected through the catheter into these arteries to block them. The catheter is removed, and pressure applied to the groin to stop bleeding.



Will it hurt?

When the local anaesthetic is injected, it will sting for a short while, but this soon wears off. You may develop cramp-like pelvic pain toward the end of the procedure, but this is treated with intravenous painkillers.

How long will it take?

Every patient is different, and it is not always easy to predict; however, expect to be in the radiology department for about two hours.

What happens afterwards?

You will be taken back to your ward. Nursing staff will carry out routine observations including pulse and blood pressure and will also check the treatment site. You will stay in bed for at least six