

You Can Influence Uterine Fibroid Care

Uterine Fibroids (UF), also known as uterine leiomyomas, are highly prevalent in premenopausal women, affecting up to 80% of Black women and nearly 70% of White women by age 50.¹ While UF can be asymptomatic, 25-50% of affected individuals will experience symptoms possibly associated with significant morbidity.² This disease underscores the need for early diagnosis and effective management. As Physician Associates (PAs) are at the frontline of care,³ there are significant opportunities for PAs to make a difference in this area.

PAs play an important role in healthcare delivery in the United States and address needs in multiple specialties including women's health.³ As primary care providers, PAs offering routine care to women of reproductive age are often the first line of contact for those with concerns and symptoms associated with UF.⁴ A patient-centered approach can empower you to recognize the most common UF-associated symptoms.

For many patients with UF, their journey is complicated by long diagnostic delays averaging 3.6 years and visits with multiple providers before receiving a diagnosis for UF.⁵ A delay in diagnosis can partly be attributed to normalization and lack of symptom recognition.⁶ Individuals with symptomatic UF may experience significant impact on daily life activities, productivity, personal relationships, sexual life, and even choosing types and colors of clothing for fear of soiling clothes or bedding.⁵⁻⁸ Patients report profound burden on their mental and emotional well-being, struggling with feelings of helplessness, negative body image and sexuality, and severe distress.⁹

Heavy menstrual bleeding (HMB) is the most frequently reported symptom and can potentially result in development of iron-deficiency anemia.^{2,10} The clinical picture may include pelvic pressure, dysmenorrhea, dyspareunia and bulk symptoms such as abdominal distension or distortion, urinary frequency and/or urgency, and constipation due to uterine enlargement.^{2,7,10} UF is also associated with infertility, and increased risk of obstetric complications such as recurrent miscarriage, preterm labor, premature rupture of membranes, obstruction of labor, among others.^{2,11}

When reviewing UF, it is crucial to understand that Black women are disproportionately affected by UF with a higher prevalence compared to White women, have a three times higher risk of developing UF, and experience earlier onset, increased disease severity, and a higher amount of larger-sized UFs.¹²⁻¹⁵ Additionally, Black women are three times more likely to develop anemia, and 3.5 times more likely to be hospitalized due to UF.^{2,16,17} Disparity also extends to therapy as Black women are 2.4 times and 6.8 times more likely to undergo hysterectomy and myomectomy than White women, respectively.¹⁷

Research has demonstrated the heterogeneity of UFs in relation to their size, location, clinical picture, and underlying pathophysiology.² Two systems were developed by the International Federation of Gynecology and Obstetrics (FIGO) for abnormal uterine bleeding (AUB) in women of reproductive age, in which FIGO AUB System I provides nomenclature of symptoms of normal uterine bleeding and AUB, and System II classifies the etiologies of AUB.^{2,18,19} Moreover, FIGO established a leiomyomata subclassification system that describes the location of the UF in relation to the endometrium and serosal surface.^{2,18,19} These systems standardize nomenclature and terminology in an effort to facilitate education, clinical care, and research.¹⁹

The clinical picture of UF varies and is diverse in its characteristics such as size, quantity, and location of fibroids with regards to patients and symptoms.² Some symptoms of UF including but not limited to

HMB, dysmenorrhea, and dyspareunia are common to other gynecologic diseases and are an additional factor to consider during patient assessment.^{2,10,20,21}

Bear in mind that the histories of the following individuals is indicative of UF: a 38-year-old teacher with HMB with a cycle of 28-30 days, and 6 days of heavy bleeding, during which she soaks a pad or tampon every 1-2 hours, has anemia, and fears soaking through her clothes, and 47-year-old nurse with HMB, pelvic pressure, frequent urination with a 26-28 day cycle, and 8 days of bleeding which impacts her work and daily life activities.

Workup for the above two patients includes a thorough medical history, abdominal and pelvic examination, and imaging.¹⁸ Potential pelvic exam findings in patients with UF can include a firm, multilobular, enlarged uterus.^{2,18} Regarding the imaging component, transvaginal ultrasonography is considered the standard confirmatory tool for UF identification,^{2,10,18} and may also exclude other diagnoses such as pregnancy and adnexal mass.¹⁰ Further identification of smaller submucosal fibroids will likely warrant sonohysterography.^{2,10,18} Magnetic resonance imaging is preferred for UFs extending beyond the pelvis² and to further detail UF characteristics.^{2,18}

HMB evaluation should also include ruling out other etiologies of AUB and pelvic masses, with consideration that a mass could be a leiomyosarcoma.^{2,18} Pregnancy should be excluded, and patients should also be tested for anemia.¹⁹

As patient-centered care is paramount, listening to patients and understanding their disease can empower both patients and providers in shared decision-making.²² With a potentially underrecognized disease, there are opportunities to increase education about UFs and normal vs abnormal female physiology.^{6,23} Moreover, enhancing your disease awareness and education can empower you to play a greater role in diagnosing HMB associated with UF.

To learn more and explore disease state videos and resources for uterine fibroids and endometriosis, please visit our [educational website](#).

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