



OBSTETRICS – GYNECOLOGY – INFERTILITY

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Hysteroscopic Myomectomy

A normal menstrual flow usually lasts 4 to 7 days and averages 4 to 6 pads per day. Some women have extremely heavy or prolonged menses that may last longer than one week or necessitate using more than one pad or tampon per hour. If an intracavitary uterine fibroid exists, heavy bleeding can often occur. Oral contraceptive pills can sometimes control the cycles. If this does not control the bleeding, a Hysteroscopic myomectomy is often the only alternative. This is an outpatient procedure through the vagina and cervix which can remove fibroids in the cavity of the uterus. It does not remove fibroids located on the outside of the uterus or in the muscular wall of the uterus.

Small fibroids can be removed using a heated wire loop with a resectoscope. This is called a hysteroscopic myomectomy. The myomectomy can be performed without the ablation to remove only the fibroids to maintain fertility.

Preoperatively, your surgeon may recommend a laminaria or misoprostel tablets to prepare your cervix for the procedure. A laminaria is a dehydrated seaweed stick about 2 inches in length that is placed into the cervix to cause a gradual and non-traumatic dilation of the cervix as the seaweed rehydrates and expands. Misoprostel tablets are placed by the patient into the vagina as deep as possible at least 4 hours prior to the procedure. The tablets cause the cervix to dilate atraumatically. Both procedures for cervical dilation may cause uterine cramping similar to menstrual cramps. Ibuprofen can help relieve the cramps.

Following the surgery, patients may notice a brownish to whitish discharge that may last up to one month. Bleeding like a light period may also occur just after the procedure. If a myomectomy was performed small white “chips” of the fibroid may also be expelled vaginally after the procedure.

Complications with this procedure are rare. The risks associated with any surgery include but are not limited to the risk of an anesthetic, infection, or bleeding. Most patients are healthy and with modern anesthesia equipment and monitoring, complications of anesthesia are rare. The risks of post-operative hemorrhage are less than 5% but may require additional surgery. Infection rates are less than 5%. Since there is a large volume of fluid instilled into the uterus during the procedure, there is the possibility that excess fluid absorption can cause an alteration in blood electrolytes or trouble breathing. If this occurs, it usually corrects itself fairly rapidly. Finally, although rare, there is a risk of puncturing the uterus with the hysteroscope. If the uterine perforation is not recognized at the time of surgery and the surgery is continues, injury to the bowels or other intraabdominal organs may cause complications which may require additional surgery.

After your surgery, you may be groggy or weak from the anesthetic. These effects wear off at different times for different people. You should be able to drive and do most activities within a day or two. If there was a problem during your surgery, you may be hospitalized.

To prevent infection after the procedure, you should not have intercourse, use tampons, or douche for at least a week. You can shower, bathe, or swim as soon as you feel like it. Fever, pain in the abdomen,

heavy bleeding or a foul-smelling discharge should be reported to your doctor. A follow-up appointment should be scheduled one to two weeks after your surgery.