UTERINE FIBROMA
ANATOMIC – CLINIC FORMS. RADICAL SURGERY VERSUS CONSERVATIVE THERAPEUTIC STRATEGY

– ABSTRACT –

SCIENTIFIC COORDINATOR:
PhD MIHAI B. BRAILA

PHD STUDENT
DIANA VANIOVA KLIMENTOVA

CRAIOVA
– 2011 –
Objectives.
The importance of my PhD. Thesis

Keywords: fibromyoma, abnormal bleeding, miomectomy, miometrectomy, anexectomy, surgery

Through the research conducted in Clinic II Obstetrics and Gynecology Emergency County Hospital Craiova I wanted to update my doctoral thesis in a series of clinical – paraclinical and therapeutical current aspects in fibromyoma.

We found high frequency of this pathology in the woman's life, direct socio – medical implications, economic and family available all over the world, not only in Romania or the Emergency Hospital Craiova.

For fibromyoma, is practiced in the U.S. alone a total of more than 700,000 hysterectomies every year, its price depending on the technique applied, between 10,000 to 15,000 dollars.

In many cases, on young women is practical for the fibromyoma radical surgery, this solution is often unfair, taking into account that fibromyoma is still a benign tumor of the myometrium that malignises rarely (0.001% of cases).

In this paper we had as objective the approach of fibromyoma as a very common pathology of the female genital sphere, clinical – paraclinical analysis of cases over a period of 11 years (2000-2010), taking in the study 10 parameters which I considered most important in the special personal part of my PhD thesis.

I assumed a great responsibility when I accepted this research topic taking into account the high incidence, of the pathology “banality”, the fibromyoma being currently considered as the “Cinderella” of female genital pathology, in which may no longer raise nothing scientific spectacular.

Through the research that I’ve done, I realized that in addition to high – frequency fibromyoma has, it also is the objective of study for more than obstetric specialties (surgery, endocrinology, diabetes and nutrition, interventional radiology imaging, oncology, pathology, clinical laboratory, plastic and reconstructive surgery).

From the objectives addressed the most difficult part of my research was the issue of medical therapy and especially classical and modern surgery.

Hormonal treatment, classical surgical interventions, radical or conservative, hysteroscopy or laparoscopic interventions, embolization with embosfere, are analyzed in my doctoral thesis in which I stated that “nothing is new under the sun, any old being an inexhaustible source of new” (Acad. PhD. Eugen Aburel, Acad. PhD. Traian Rebedea, PhD. Mihai Braila).

Fibromyoma treatment depends outside the case law, of the school of gynecologic or obstetric surgery.

Undeniably, conservative surgery has lost ground to the radical, mutilated, much easier and more efficient.

Whatever the cost, benefits or disadvantages are found later on, perhaps too late to fix anything that is useful especially for to the patient.

When it is a disease with high malignant potential is good for the surgical therapy applied to be radical or ultra-radical.

When the pathology is essentially benign, it is useful that the classical or modern surgery to be as conservative as it can be, especially for young women.

The key in solving uterine fibromyoma is knowledge, clinical experience, practical training and especially surgical, indication and choosing the most appropriate timing of intervention, ability to cope with unforeseen intraoperative lesions, before deciding the surgical intervention.
The study done by me started in 2006. A retrospective component of this study aimed at “Fibromyoma - anatomical – clinical forms. Radical surgery versus conservative treatment strategy”, therefore, I approached the cases on a period of 11 years (2000-2010).

In my research I examined the cases of fibromyoma admitted in Clinic II Obstetrics – Gynaecology of the Clinic Emergency County Hospital Craiova, Chief of Clinic Univ. Dr. Mihai B. Braila, the scientific leader of my PhD thesis.

In the mentioned period have been hospitalized a total number of 3859 patients as seen in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Total patients</th>
<th>Total patients operated</th>
<th>Total hysterectomy with bilateral anexectomy</th>
<th>Total hysterectomy without bilateral anexectomy</th>
<th>Myomectomy</th>
<th>Myometrectomy</th>
<th>Supraistmic Hysterectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>300</td>
<td>93</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2001</td>
<td>298</td>
<td>59</td>
<td>6</td>
<td>43</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2002</td>
<td>388</td>
<td>73</td>
<td>6</td>
<td>51</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2003</td>
<td>422</td>
<td>92</td>
<td>11</td>
<td>59</td>
<td>10</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2004</td>
<td>341</td>
<td>90</td>
<td>7</td>
<td>53</td>
<td>16</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>2005</td>
<td>396</td>
<td>96</td>
<td>8</td>
<td>63</td>
<td>12</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2006</td>
<td>329</td>
<td>86</td>
<td>9</td>
<td>58</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>2007</td>
<td>403</td>
<td>112</td>
<td>11</td>
<td>70</td>
<td>23</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2008</td>
<td>332</td>
<td>92</td>
<td>9</td>
<td>54</td>
<td>17</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2009</td>
<td>346</td>
<td>73</td>
<td>5</td>
<td>38</td>
<td>17</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2010</td>
<td>304</td>
<td>93</td>
<td>7</td>
<td>59</td>
<td>16</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 1. - Report of interventions conducted in the Obstetrics Clinic II Ginecolgogie

Of these a total of 959 surgeries were performed for fibromyoma, 24.8%.

1. Age of patients.

According to Table 2, we studied patients aged 20 and over 60 years dividing them into 5 groups as shown in the table.
<table>
<thead>
<tr>
<th>Year</th>
<th>20 – 30 years</th>
<th>31 – 40 years</th>
<th>41 – 50 years</th>
<th>51 – 61 years</th>
<th>&gt;60 years</th>
<th>TOTAL/years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1</td>
<td>12</td>
<td>63</td>
<td>17</td>
<td>0</td>
<td>93</td>
</tr>
<tr>
<td>2001</td>
<td>0</td>
<td>10</td>
<td>37</td>
<td>12</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>2002</td>
<td>0</td>
<td>6</td>
<td>55</td>
<td>12</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>2003</td>
<td>2</td>
<td>14</td>
<td>59</td>
<td>17</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>2004</td>
<td>0</td>
<td>20</td>
<td>57</td>
<td>13</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>2005</td>
<td>1</td>
<td>9</td>
<td>59</td>
<td>26</td>
<td>1</td>
<td>96</td>
</tr>
<tr>
<td>2006</td>
<td>3</td>
<td>23</td>
<td>49</td>
<td>11</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>2007</td>
<td>1</td>
<td>25</td>
<td>59</td>
<td>23</td>
<td>4</td>
<td>112</td>
</tr>
<tr>
<td>2008</td>
<td>0</td>
<td>18</td>
<td>56</td>
<td>18</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>2009</td>
<td>2</td>
<td>16</td>
<td>40</td>
<td>15</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>2010</td>
<td>2</td>
<td>12</td>
<td>60</td>
<td>17</td>
<td>2</td>
<td>93</td>
</tr>
<tr>
<td>TOTAL/</td>
<td>12</td>
<td>165</td>
<td>594</td>
<td>181</td>
<td>7</td>
<td>959</td>
</tr>
<tr>
<td>groups of age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 - the age distribution of the studied group

2. Their living environment.
   Of the 959 patients operated for uterine fibromyoma 685 (71.4%) are from urban areas, the remaining 274 (28.5%) come from rural areas.

3. Profession.
   Patients come from all professions and found in my study 511 cases working in various areas (53.28%), intellectual 235 (24.50%) and 213 farmers (22.21%).

4. History.
   From history I was interested in the general personal (cardiac, renal, hematologic, collagen diseases, endocrine disease, pulmonary disease, etc.) where we noted significant influences in the incidence and anatomical- clinical fibromyoma forms. I was particularly interested in obstetrical and gynecological personal history (number of births, abortions, ectopic pregnancies, sterility/infertility).
   In most cases I found women with a history of few deliveries (569 patients had 1 or 2, 59.6% respectively). In the spontaneous abortion or on demand I could not extract significant conclusive data observation sheets.
   From history I have noted without systematizing, however the specification in the direct filiation with uterine fibroids, the presence of ectopic pregnancies, pelvic inflammatory disease, the cysts of the ovary, the sterility/infertility, fibrocystic mastosys.
   Without minimizing their importance in the incidence of uterine fibroids can mean that at least ethiopathogenical, between some fibromyoma and fibroids could be a link or some mutual influence.
   It is known the implication of uterine fibroids in abortion, the occurrence of sterility and its importance in the normal development of a pregnancy. Also the fibroma implication in birth and post – partum. Jeffcoat said decades ago that “while the pregnancy should constitute fruit of sin, uterine fibroids would represent the price of virtue” to reveal precisely the aspect that the uterine fibroids are an attribute of sterility/infertility and to the women who haven’t had any pregnancies, topographic especially in tumoral form circumscribed by fibromyoma and not diffuse, also through the tumor volume, thier number (single or multiple/multiple forms of fibroma).

5. Admission grounds.
   In the vast majority of cases of uterine fibroids operated in the clinic, dominant symptom for addressing the specialist’s consult was vaginal bleeding (bleeding more than 7 days) in tumor forms and/or uterine polifibromatose in 746 cases (78.9%).

Clinical exam with valves combined with vaginal and rectal touch may reveal: clean cervix with or without lesions, more or less obvious macroscopic, with dehiscence external orifice by which blood loss quantity amount is variable; enlarged uterus volume (variable size) or very irregular hard, with single or multiple fibroid nodules whose topography has implications both in terms of subjective complaints and possible neighborhood compression (bladder, parameters, urethras, rectum, sigmoid, bowel loops). This clinical examination has value also through the possible stop of uterine bleeding by having a biopsial curettage, hemostatic and explorer tip of the uterine cavity, by the scoop or by hysteroscopy in the event of an immediate surgery strategy, following or delayed.

7. Paraclinical diagnosis.

Investigations that followed the clinical examination were necessary and were made both to clarify the diagnosis of uterine fibromyoma, anatomo–clinical form, and to exclude any other eventual concomitant pathologic entities which could have imposed in the context of an alternative therapeutic strategy by the following: continuous hormonal progesterone medication and haemostatic, radical surgical treatment of classic or modern laparoscopy, conservative surgery treatment, interventional radiology (embolization).

The most important paraclinical explorations in the diagnosing the uterine fibroids were:

A. Ultrasonography
B. Divided uterine curettage, hemostatic and biopsy
C. Hysteroscopy
D. Colposcopy and cervical biopsy
E. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

8. Preoperative indication and the preparation of the patient for intervention

After stabilizing the clinical and paraclinical positive and differential diagnosis, depending on the contextual therapeutic strategy, was established by the team in all cases. This was done by the head doctor of the clinic, the doctor on call, the section and the ATI doctor. Therapeutic strategy aimed at:

A. Usual preoperative blood and urine laboratory investigations
B. In certain situations, where appropriate, were required interdisciplinary checkups: cardiology, internal diseases, diabetes and nutritional diseases, nephrology, urology, interventional radiology.
C. Type of anesthesia practiced: general oral-tracheal intubation (IOT) or spinal

9. Type of surgery

a. Crippling radical surgery
   o Total Extracapsular hysterectomy (Wiart) with bilateral anexectomy
   o Total intracapsular hysterectomy (Aldrige - Richardson) with bilateral anexectomy
   o Total interanexială hysterectomy (with conservation of the annexes) 
     Practiced usually classic and not laparoscopicaly.

b. Classical conservative surgery and rarely laparoscopic.
   o Single or multiple miomectomy
   o Miometrectomy, an Aburel process, especially in women under 40 who wanted motherhood
   o Supraistmic hysterectomy with uterine cavity reconstruction the Rebedea process, especially in women under 40 who wanted to maintain menstrual function, genital static, urinary function, sexual function, assigning often to the proper intervention, partial resection of the ovary and posterior colpoperineorafy with miorafy anal linkage. This type of intervention has been practiced even in large fibroids, single or multiple
the only condition was a clean cervix, as in the miometrectomy Aburel practice.
c. Interventional radiology, through embolization of the uterine fibroids permanent and temporary of uterine artery in the service of the Emergency Hospital Craiova, in the last year and a half, but most often in 2005 in radiology interventional department of the University Emergency Hospital Bucharest.

Regarding the surgery itself mention the following:
- By type of anesthesia, in the 959 cases of uterine fibroids practical operation:
  - IOT general anesthesia in 728 cases (75.9%),
  - In 231 cases (24.1%) practicing the spinal loco-regional anesthesia (spinal anesthesia)

There is a total of 706 radical operations from 959 cases (73.6%), total hysterectomy with bilateral anexectomy. Of these a total of 617 cases (87.4%) were extracapsular hysterectomies total or simple (Wiart process) and 89 cases (12.6%) intracapsular hysterectomies (Aldrige – Richardson process).
- Total interanexial hysterectomies (with annexes conservation) were performed in 138 cases, respectively14.3%.

Overall total hysterectomies with or without bilateral anexectomies were practiced in 844 cases out of 959, 88.1% respectively.
- Conservative operations.
  - They represented a total of 115 of a 959 operated uterine fibroids, respectively 11.9% as follows:
    - Myomectomy 45 cases (4.6%)
    - Miometrectomy Aburel 39 cases (4.1%)

10. Supraistmic hysterectomy with uterine cavity reconstruction, 31 cases (3.2%)

Postoperative evolution. Incidents, accidents, complications.

On the examined group were not reported anesthetic incidents or accidents, except in certain cases in which anesthesia had no effect, requiring general anesthesia with IOT. We didn’t record any serious intraoperative incidents, such as the sliding of vascular ligation, severe intraperitoneal hemorrhage or retroperitoneal hematoma.
Mortality was 0.

Postoperative morbidity records:
- Abdominal infected wounds in 98 cases of uterine fibroids operated 959 (10.2%)
- intestinal obstruction by adhesive straps which imposed surgical reinterventions in 3 cases (0.3%)
- Leg thrombophlebitis in 31 cases (3.2%), especially in the period 2004 – 2005 when the prophylaxis through heparinisation with low molecular weight preparations was not systematic, as at present.
- Vaginal bleeding after total hysterectomy in the first 24 hours postoperatively, resolved by strengthening low vaginal tranche hemostatic and message threads endovaginal for 24 – 48 hours in 5 cases (0.5%).
- Bladder-vaginal fistulae subsequently resolved in the urology service in 3 cases (0.3%)

11. The cost

Retrieving data from the direction of the County Hospital emergency Craiova (accounting), record the following:
- A day of hospitalization costs 245.15 RON
- Classical hysterectomy costs 1459.12 RON, requiring an average of 8 days of hospitalization.
- Total laparoscopic hysterectomy costs 2076.64 RON, requiring an average of 3 days of hospitalization.
- Embolization by embosfere pole - vinyl - alcohol costs 2076.64 RON and 2 days of hospitalization.

Because of the conditions, especially technical, the embolization by embospheres was approachable only of last year. It began to be practiced frequently in 2005 in Bucharest Emergency University Hospital. Unfortunately you cannot practice it in large fibroids or large women after age 40.

Small fibroids, unique and rarely multiple in women under 40 years may benefit from embolization when they want motherhood.

Interventional radiology service in the Emergency County Hospital Craiova started to work for uterine fibroid treatment a year and a half ago, through Mr. Dr. Dan Hertzog, taking the technique from the University Emergency Hospital Bucharest, has embolized about 30 unique uterus fibroids in women under 40 years with good results.

I didn’t consider these cases because they were not admitted to Obstetrics Gynecology Clinic II, but in the Department of Endocrinology.

   A. Uterine fibroids with prolonged menstrual flow
   B. Bulky uterine fibroids that produces compression

Of the patients operated in Obstetrics and Gynecology Clinic II County Emergency Hospital Craiova, respectively 959, a total of 785 had anatomical – clinical bulky uterine fibroid that produces compression, percentage 81.85%.

   A. Uterine fibroids with aseptic necrobiosis
   B. Muscular fibroid with septic necrobiosis
   C. Uterine malignant fibroids
   D. Uterine fibroids with sterility / infertility

Out of 165 operated patients aged 31-40 years, a number of 98, respectively 59%, showed sterility/infertility secondary to muscular fibroid found and operated. The group studied by me during 2000-2010 in Obstetrics and Gynecology Clinic II Clinical Emergency County Hospital Craiova, the number of 959 patients I found and recorded 112 cases, respectively 11.67%, sterility/infertility associated with uterine muscular fibroid.

The following are the two Romanian conservative techniques when treating uterine muscular fibroid:

   The technique principle is primarily linked to the protection of the tubal ostium of the uterine horns. For this reason is practiced uterine incision on the anterior wall; removal of myometrium fibroid nodules; tactile control of myometrium fibroid nodules after removal.

2. Supraistmic hysterectomy with uterine cavity reconstruction, (HISRCU) process Acad. Rebedea Traian.

This is a conservative surgical procedure, indicated in women under 45 who have diffuse uterine fibromatosis and polifibromatosis, with or without associated adenomyosis, without other injuries cervico-uterano-anexial and want, under signature, maintaining the menstrual function and genital-pelvic statics. The current performance level of diagnosis, intensive care and surgery makes difficult to understand “fear of failure by plastic” in the polifibromatosis treatment, when a young woman wants the menstrual function and a normal psychological – sexual life. In the absence of concomitant cervical – utero – anexial lesions with potential risk of malignancy is difficult to bear by the under 45 years patients the stigma of climax of early surgery (post – total hysterectomy with or without bilateral anexectomy).
The conditions of the intervention practice are:

- Cervical, endometrial, normal appendices;
- The desire of women to preserve menstrual function and static genital – pelvic;
- Knowledge of technique.

The indications were:

- Diffuse fibromatosis with extended rebel menstrual flow at repeated hemostatic curettage and biopsy, as well as in various medical treatments.

Contraindications result from the absence of conditions and indications.

All the patients were thoroughly investigated both in the genital area before surgery, and general biology, anesthesia consultation, indication for conservative surgery.

HISRCU is an exceptional technical and we recommend it to all gynecologists surgeons when certain conditions are met, the indications and contraindications, attributed that the technical process resembles with Cirio. Wrong, simply because a bulky uterus, by HISRCU, obtains a “miniature uterus” which cavity restored at a rate of 2/3 to a normal one (50 – 70 ml capacity), is neither too high to determine the subsequent bleeding or too small to produce in time final oligohipomenorea/amenorrhea.

I was able to control, hysteroscopy, histerografic and biopsy some of the cases operated many years ago. Good clinical results were confirmed by practical exploration, arguing once again the undeniable value of the technique.

Embolization

Materials and methods

Selection of cases eligible for endovascular treatment by uterine artery embolization is made by the following criteria:

1. Diagnosis established by:
   a) history and clinical examination;
   b) endovaginal or transabdominal ultrasound examination supplemented with Doppler ultrasound;
   c) excluding a normal or ectopic pregnancy;
   d) classic biopsy curettage or hysteroscopy with histopathology examination.

2. Inclusion criteria, indications.

By the UAE can benefit women of childbearing age, with the desire for later procreation, with the condition that the muscular fibroma is unique and not bulky. Collaboration between gynecologists and interventional radiology doctor is essential for the success of the method.

3. Exclusion criteria:

- General angiography contraindications: allergy to dye, renal insufficiency and/or hepatic, bleeding coagulation disorders;
- Intrauterine pregnancy;
- Tubal pregnancy complicated by tubal rupture or tubal abortion – the absolute exclusion criterion;
- Severe anemia, decompensated heart failure, uncontrolled ventricular arrhythmia, uncontrolled or malignant hypertension;
- Gynecological malignancies (ovarian cancer, uterine, endometrial, cervical);
- Important pelvic irradiation;
- Connective tissue disease;
- Acute vasculitis;
- Acute pelvic infections;
- Contraindications associated with medication, digitalis toxicity and anticoagulant treatment;
Chapter V
Results and discussion

Research made by me, in my doctoral thesis focused on the complex theoretical and practical study of uterine fibroids, circumscribed form, tumor on the incidence, clinical and paraclinical diagnosis but particularly on alternative therapeutic strategy applied to medical, surgical conservative and radical, interventional radiology.

- I conducted the study over a 11-year casuistry present and retrospective (2000-2010) admitted and settled in Clinic II Obstetrics Gynecology of the Emergency County Hospital Craiova under the guidance of Head Clinic, PhD Mihai B. Braila, scientific leader of my doctoral thesis.
- I studied the patients, case report forms, operator protocols, have participated in interventions, we sought the histopathological papers, immediate postoperative evolution and in some cases delayed.
- The number of uterine fibroids operated in 11 years was 959 cases from a total of 3859 patients operated in the clinic for various genital – urinary disorders, 24.8%.
- This incidence isn’t very high compared to some statistics in the country and abroad, especially considering the fact that of uterine fibroids are concerned the general surgery physicians, surgeons oncologists, endocrinologists, specialists in interventional radiology.
- If to the group analyzed were added uterine fibroids resolved elsewhere outside Obstetrics Gynecology Clinic II might come to think that about one third of women consult specialists for muscular fibroids, which fact corresponds to reality.
- Clinical – paraclinical parameters and operators that I researched in my study were represented (as follows):
  1. Age of patients
  2. Living environment
  3. Profession
  4. Antecedents
  5. Reasons for admission
  6. Clinical diagnosis
  7. Laboratory diagnosis
  8. Surgical indication.

Chapter VI
Conclusions

1. I took in study present and retrospective anatomical – clinical uterine fibroids forms operated and submitted in Clinic II Obstetrics Gynecology of the County Emergency Hospital Craiova over 11 years (2000-2010).
2. During this period were operated 3859 patients of which 959 cases of women for uterine muscular fibromyoma (24.8%).
3. On the cases I studied results that at least one woman in five after the age of 35 years has uterine muscular fibromyoma and at about 35% of the patients are found circumscribed myometrium tumors. In this statistic could be included uterine muscular fibroids hospitalized and operated on the other Clinic of Obstetrics and Gynecology, Clinics of Surgery in the hospital, in interventional radiology and Clinical Endocrinology.
4. Analyzed parameters of my research work were extracted from case report forms, the operating protocols, from intervention rooms in which I participated, at the patients bed, pre – and post – operatory. These parameters are:

5. By age, the largest incidence of uterine fibroids operated was the group between 41-50 years (62.4%), followed by the group between 51-60 years (181 cases, 18.8%) and group 31-40 years (165 cases, 16.9%). The total of these three groups of 5 is 941 cases (98.1%). At extreme ages, the incidence of uterine fibroid was extremely low (between 20 to 30 years 1.2%, over 60 years 0.7%). Under the age of 20 and over the age of 70 years have not found any cases. On the personal research, I found that over 90% of uterine fibroids were encumbered predominantly in women aged over 30 years, the tumor was not seen in under 20 years and even in late postmenopausal.

6. By area of origin, of the 959 patients with uterine fibromiom operated in Clinic II Obstetrics Gynecology, 685 (71.4%) are urban, the remaining 274 (28.6%) are rural. Here I mention that the most severe forms anatomical – clinical uterine fibroids that have imposed radical surgery, mutilating (total hysterectomy + bilateral anexectomy) were particularly in rural areas.

7. After the occupation, 511 cases were workers in various fields (54.3%), 235 cases intellectual (24.6%) and 213 cases of farmers (21.1%). I noticed that the intellectual anatomical – clinical forms of uterine fibroids were less complex, less severe compared with groups of workers and farmers. The latter two categories were actually practiced all mutilating radical surgery. Compared to class intellectuals on which where practiced also conservative surgery.

8. I have been interested in history especially in terms of obstetrical and gynecological. 569 patients (59.6%) had one or two births, miscarriages or terminated pregnancies in progress, others, sterility/infertility, ovarian cysts, pelvic inflammatory diseases, endometrial hyperplasias. From these studies it is confirmed that uterine fibroma is the prerogative of sterility/infertility.

9. Reasons for hospitalization were dominated by extended menstrual flow (746 cases, 78.9%). Other symptoms were added over the related with the increase in volume of the abdomen, compression, heavy feeling in the pelvis, dysuria, pelvichipogastric pain. Several cases were presented for lesions of the cervix, ovarian cysts, infertility, menstrual irregularities, uterine fibroid detection is for most a surprise at the admission in a hospital or specialized consult.

10. Clinical diagnosis absolutely essential was the one who in more than 72% of cases established the diagnostic of presumptive uterine fibroids or uterine polifibromatosis, anatomical – clinical form, eventual coexisting lesion or associated pelvic – genital.

11. Laboratory diagnosis in all cases of uterine muscular fibromyoma admitted assumed a logic lineage, the ultrasound, uterine hemostatic curettage and biopsy, colposcopy and eventual cervical biopsy, sometimes hysteroscopy, rarely computed tomography and magnetic resonance imaging.

12. The surgical indication was established in team (chief clinical physician, physician responsible for the sector, ATI doctor) with the approval and signature of the patient. Surgical therapeutic attitude, radical versus conservative was determined according to the pathology context, technological possibilities, the maternity desire of the women or the conservation of the menstrual and psychosexual function.

13. In 728 cases operated of uterine muscular fibromyoma 959 (75.9%) was performed general anesthesia with the IOT, in the rest, 231 cases (24.1%) was practiced spinal anesthesia.

14. Classical radical surgery (total hysterectomy + bilateral anexectomy) was performed in 706 cases (73.6%). A number of 617 (81.7%) were total extracapsular hysterectomies or simple (Wiart process), in 89 cases (18.3%) practicing the total intracapsular hysterectomy (Aldridge - Richardson procedure). In my study shows that total simple hysterectomy or extracapsular is 7 times more common than total intracapsular hysterectomy. This is faster by about 15-20
minutes, being preferred by most practitioners in the clinic. In chronic cases such as uterine fibroids and not obstetrical and gynecological emergencies could be practiced intracapsular hysterectomy, even if more laborious. This intervention provides safety to the operator on the ureters and bladder, after providing a genital - urinary static much more anatomical to the hysterectomised women by keeping the capsule, compared with those that have cut their supporting ligaments, namely the uterus, another genital - pelvic comfort, urinary and psychosexual with great importance in family and society.

15. Total hysterectomy with preservation of the annexes or interanexial was performed in 138 cases (14.3%). There are some practitioners who prior to surgery require investigations for tumoral markers specific to ovarian cancer (CA - 125 CA - 19.9, CA - 15.3, ACE, ESR), others run intraoperative partial bilateral resection of the ovary with imediat histopathology exam to actually exclude potential malignant with subsequently serious repercussions for women, family and society.

16. Classical conservative surgery is unfortunately a poor representation on the group studied by me (115 cases in a total of 959 fibroids operated). Only one tenth of women with uterine muscular fibromyoma operated benefited from classic conservative surgery (myomectomy single or multiple 45 cases, 4.6%; miometrectomy sagittal anterior - posterior, Aburel process, 39 cases, 4.1%; supraistmic uterine hysterectomy with cavity reconstruction, process Rebedea – Mihai Georgescu Braila, 31 cases, 3.2%). This low incidence of conservative uterus interventions, compared with high incidence of radical mutilating operations in uterine muscular fibroma was actually also the main research objective of my thesis. The clinical material (patients with very large uterine muscular fibroma fibromyoma, almost giant, after the age of 40 years, with severe cervical dysplastic lesions, associated ovarian tumors, endometrial hyperplasias) shows ignorance, lack of regular gynecological control, poor addressability to specialist consultation, absence of concrete psycho – sexual and genital forms of education of young woman especially through family planning clinics, giving up deliberately on contraception, on the annual cervical - vaginal Babes – Papanicolaou cytology.

17. Very few currently practicing gynecologists or surgeons actually have the knowledge and experience in the conservative surgery of uterine muscular fibroma (mostly limited to myomectomy, not knowing the types of miometrectomies, and especially the Aburel process, the only that preserves the reproductive function, hysterectomy with supraistmic uterine cavity reconstruction). Current gynecologists and surgeons limit themselves at practicing the mutilating radical interventions such as total hysterectomy, regardless of the process of intra – or extra – capsular, most practicing simple total hysterectomy.

18. Laparoscopy may be performed for a total hysterectomy or a mimectomy. But can not solve the miometrectomy and neither the supraistmic hysterectomy with uterine cavity reconstruction.

19. Hormonal treatments administered in a series of operated cases of uterine muscular fibroma, no matter how sophisticated (progesterone, especially analogues of LRH), are expensive and do not solve the problem while having the problem of circumscribed tumor and simultaneously unwanted side effects by installing a “chemical menopause” at a young age.

20. Embolization with embosfere of polyvinyl – alcohol as a solution for the future, but not for large or multiple uterine fibroids and at women where coexist with ovarian tumors, pelvic inflammatory disease, cervical dysplasia, at which even if the uterine bleeding stops they require anyway the surgical intervention, often radical, mutilating and not conservative.

21. In the group studied by me, the mortality in uterine muscular fibroma operations was "0". Morbidity is not significant and consisted of abdominal wound infection, bowel obstruction with subsequent surgical reintervention, leg thrombophlebitis, bleeding of the vaginal slice, bladder – vaginal fistulas, situations actually exposed in the “Results and Discussion” chapter.
22. Anatomical – clinical uterine muscular fibroma shapes found by me otherwise mentioned in the previous chapter, the results being a conjunction between the clinical aspects found by me, the macroscopic, intraoperative and microscopic, histopathology:
- Uterine fibroids with extended menstrual flow, I found in 746 cases (78.9%);
- Uterine bulky fibroids that produces compression with or without extended menstrual flow, I met in 711 cases (74.1%);
- Uterine fibroids with aseptic necrobiosis, was noted in 117 cases (12.2%);
- Uterine malignant fibroid, in “0” cases;
- Uterine fibroids with septic necrobiosis, was evacuated vaginally and was not considered in my study in the classical radical or conservative surgery.

23. Uterine fibroids are a benign tumor with extremely low rate of malignancy (0.001%) can be solved conservatory in useful time, and not radical mutilating especially when it comes to young women who want maternity or at least the menstrual and genital – sexual normal functions. This is the clinical – biological reality worldwide and the efforts that were made and are still being made, have as a purpose the benefits of the individual, family and society, with maximum efficiency at as low prices.

Selected bibliography

5. CRİŞAN N., NANU D. Terapeutica hormonală ginecologică, Societatea Știință și Tehnică SA, București, 1998