During the past 20 years, the efforts made to critically evaluate uterine artery embolization (UAE) have resulted in the almost universal acceptance of this procedure as an effective treatment option for patients with symptomatic leiomyomata. In time, questions have been raised regarding the applicability of UAE to defined subsets of patients, including those with adenomyosis, pedunculated fibroids, or a desire for future fertility. These questions are the result of dated reports in the medical literature that, unfortunately, even today, have caused these patients to be denied access to UAE or to not even have UAE included in a discussion on potential treatment options with their physician. The revised Quality Improvement Guidelines for UAE by Dariushnia et al (1) highlight these areas and turn to recent research that supports a change in the management recommendations that can be made for these particular patients (1).

We can all appreciate that the initial impressions formed by physicians when learning about new, innovative procedures are difficult to change. The information presented by Dariushnia et al (1) should once again serve as a reminder that the conclusions of case reports and small case series should be acknowledged but held in reserve until larger, better designed studies support or refute those initial conclusions. This certainly seems to be the case with UAE performed in patients with pedunculated fibroids or adenomyosis. The initial sense that patients with adenomyosis are at a significantly increased risk for treatment failure after UAE (2) has not been borne out as larger studies and analyses have been performed. Similarly, an early case report raised concerns about treating pedunculated subserosal fibroids with UAE for fear that the fibroid may detach from the uterus and require surgery for removal (3). This too has not been validated in more recent studies, and, instead, patients with pedunculated subserosal fibroids have been shown to experience symptomatic improvement, fibroid volume reduction, and fibroid infarction after embolization. It is just inappropriate to deny patients with adenomyosis or pedunculated subserosal fibroids the option to undergo a procedure associated with symptomatic improvement rates that far exceed the initial impressions formed by early case reports.

Similarly, it is time for a change in thinking regarding UAE in patients who wish to preserve their fertility. The study by Mara et al (4) does conclude that myomectomy has superior reproductive outcomes compared with UAE, but, if UAE is to be compared with myomectomy in this setting, it must be acknowledged that there are shortcomings in that study and the historical studies that have elevated myomectomy to the de facto standard for these patients. Although the most current data do not support the use of UAE as first-line therapy for all patients with plans for future pregnancy, they have demonstrated that early concerns regarding negative pregnancy outcomes in association with UAE were likely overstated. As a result, UAE should be considered as a reasonable option for patients who are poor candidates for surgical treatment, patients who have had a previous myomectomy, and patients who do not wish to undergo a myomectomy, and must be included in all treatment-planning discussions with these patients.

The Society of Interventional Radiology Quality Improvement Guidelines are meant to be continuously evolving by design. There will always be new insights into UAE with time as changes in technique, changes in materials, and further development of alternative treatment options occur. A critical review of the most current research with an eye on making updated recommendations for patient selection, anticipated success rates, and complication thresholds is necessary to insure that interventional radiologists are doing the best they can for their patients. Those of us performing UAE on a regular basis know that the literature highlighted in this document (1) is what can be expected in clinical practice for patients with adenomyosis and pedunculated subserosal fibroids, as well as for patients who wish to preserve their fertility. Dariushnia et al (1) should be commended for bringing these issues into the spotlight. We are, however, only part of this equation. Evolution of thought must also be expected from those physicians who are initially assessing and advising patients on treatment options, as well as from the entities responsible for the payment for
these services. It is time for this change to occur, especially because the patients described here are aware of the evolution of knowledge in this area and are expecting it to occur.

REFERENCES


