

Volume 7 - Issue 5, 2007 - My Opinion

Interview with Dr J.P. Pelage

Interviewee

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_ Please Tell Us About Your Background in the Area of UFE.

I was trained as a resident and performed my first UFE procedure in the Hôpital Lariboisière, a University Hospital of Paris under the supervision of Dr. Le Dref, one of the pioneers in this field, in December 1993. This is also where the first case of UFE was performed by Prof. Jean-Jacques Merland. I then performed a four-year clinical fellowship in interventional radiology in the same hospital.

The Hôpital Lariboisière has a long tradition of interventional radiology both for neuroradiology and peripheral radiology. It was then the reference hospital for the management of gynaecological and obstetric emergencies such as postpartum haemorrhage. I got involved in women's interventions and set up a specialised consultation for candidates for UFE, ovarian vein embolisation or tubal procedures. I then moved to another university hospital, Paris Ouest, where I was promoted to Associate Professor of Radiology in 2003 and then full Professor of Radiology in 2006. We have adopted the same way of working closely with the gynaecologists with pluridisciplinary discussions of all cases of patients with uterine fibroids.

_ How are You Involved with CIRSE and the UFE Taskforce?

I am a member of CIRSE since my fellowship and have been progressively involved in different committees. First, the standards of practice committee that published joint recommendations with the American Society of Interventional Radiology on UFE. I also got involved in the set up and monitoring of the UFE registry, promoted by the CIRSE Foundation. Finally, CIRSE created a UFE taskforce of which I am Chairman.

We have gathered a group of radiologists and gynaecologists from different European countries with the goal of promoting UFE. The first objective has been recently achieved with the launch of the UFE website, which will be progressively available in different languages to help patients to better understand about uterine fibroids, available treatments and their principles, advantages and side-effects. A section entitled "Find a doctor near you" will provide the list of centres per country where embolisation is available. We have also just started a UFE advisory group dedicated to promotion, training and research in the field.

_ How Does UFE Compare with the Already "Established" Treatments?

From scientific publications including large prospective studies and randomised controlled studies versus surgery, we know that UFE is a valuable alternative to hysterectomy and multiple myomectomy. UFE is usually not a first line treatment as an alternative to a single myomectomy, particularly by laparoscopy or hysteroscopy. All studies show that embolisation is very effective to control heavy menstrual bleeding and bulk-related symptoms. Volume reductions both for the uterus and the fibroids range between 30 and 60% after treatment. Hospital stays are minimal, one or two nights in most cases. Some well-organised centres even offer UFE as an outpatient procedure. Recovery is short and most women will stay out of work for a week. Complications are rare in experienced hands. Different cost analysis, performed both in North America and in Europe, show that UFE compares favourably with hysterectomy and myomectomy despite the cost of the pre- and post-procedural MRI and the need for single use devices such as catheters.

_ Is UFE One of the Main Procedures Performed by Interventional Radiologists?

Due to the high percentage of women presenting with fibroid-related symptoms, we may expect UFE to be a commonly performed procedure. However, it is still mainly available in big hospitals and universities where trained radiologists and specialised fibroid centres are present. In some centres like ours, UFE is one of the many embolisations for gynaecological and obstetric disorders. We treat pelvic arteriovenous malformations, cancer-related bleeding, adenomyosis, and post-operative or post-partum haemorrhage. In fact, UFE is very helpful to train young radiologists to perform all kind of emergency pelvic embolisations.

_ How can We Ensure that Gynaecologists be Informed About UFE so that They can Present this Procedure as a Treatment Option?

Most gynaecologists are now well aware about UFE even if they aren't as familiar with its indications. Scientific meetings and publications will help. Family doctors have so many clinical conditions to manage that it is difficult for them to know about new treatments. We try to inform them through local meetings and publications. The CIRSE UFE website has a section for doctors presenting the various aspects of the technique, indications, results and follow-up. An updated list of publications is also available. For patients, the website seems very promising since it is available in different languages. For patients who don't speak English it is sometimes difficult to get information on the internet.

_ What Trials are Available Comparing Surgical and Non-Surgical Options, and What do They Tell Us About the Safety and Effectiveness of UFE as an Alternative?

There are different high-quality studies in the literature. In particular, the results of two multi-centre randomised controlled studies conducted in the UK (REST study) and the Netherlands (EMMY trial) have been recently published. Both studies compared outcomes from therapies in patients randomly assigned to UFE or surgery and confirm that UFE is equivalent to hysterectomy in terms of quality of life after treatment. Minor complications are slightly higher after embolisation and major complications after surgery. Hospital stay, length of recovery and cost are in favour of embolisation. Not surprisingly, when comparing a conservative treatment to hysterectomy, the rate of reintervention is higher after UFE, particularly in case of clinical failure.

_ How can One Manage Pain in the Best Possible Way?

The best way to avoid complications is good patient selection, best done as a team with radiologists and gynaecologists involved. Some types of fibroids may not respond well to embolisation or may be associated with an increased risk of complications. Patients' expectations should be evaluated before embolisation to avoid problems: very large uteri will never become normal despite satisfactory devascularisation of all fibroids and patients should be informed.

Different protocols are used to reduce patients' discomfort during and after embolisation. Administration of NSAIDs, analgesics, use of PCA pumps or spinal analgesia are commonly performed to manage pain which may be intense during 6 - 12 hours post-embolisation. We are currently investigating the value of embolisation microspheres loaded with pain killers progressively released in the blood circulation at the site of embolisation.

_ What Does the Future Hold for UFE and How is the Treatment Being Developed to Grow Safer and More Effective?

I think that UFE may become a first-line treatment in young patients trying to conceive, particularly if the only treatment on offer is hysterectomy and multiple myomectomy. More studies addressing the issue of fertility should be conducted to verify this statement. The best proof that UFE is a global and effective treatment is that surgeons try to mimic its mechanism of action. Laparoscopic clipping of the uterine artery and transvaginal uterine artery clamping are being investigated as an alternative to UFE.

Erratum:

In the last edition of IMAGING Management, we incorrectly published a picture of the "Gaiffe" machine of 1907, instead of the referred-to CT machine of 1974 in the My Opinion interview. The picture is available upon request.

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