### *4.2 Worsening the prognosis of an existing sarcoma*

Morcellation (by any means of disruption or injury at open, vaginal or laparoscopic surgery) of an unexpected uterine sarcoma can potentially disseminate sarcoma into the pelvis and peritoneal cavity. A diagnosis of metastatic sarcoma carries a poor prognosis with a median survival of 18 months. Data from national cancer registries have reported that sarcoma mortality was higher in the morcellated group than in the non-morcellated group (age-adjusted HR 1.90, CI 1.05–3.44; multivariate HR, 2.50, 95% CI 0.57–10.9). Age-adjusted 10-year uterine sarcoma survival was 32.2% for women treated with morcellation compared with 57.2% for the non-morcellated group (difference 25.5%; CI -55.7 to 18.1).[16,17,22]

### *4.3 Disseminated fibroids (presence of benign fibroids within the abdominal and pelvic cavity)*

The range of risk is considered to be 1 in 120 (uncommon) to 1 in 1200 (rare).[18]

### *4.4 Damage to bowel, bladder, ureters and blood vessels*

There is a risk of damage to the bladder, bowel, ureters and blood vessels with laparoscopic hysterectomy.[23] These data were published in 2007. Since then, there have been advances in techniques and equipment, and the possibility that these rates may now be lower has been highlighted.[24]

Laparoscopic myomectomy, with and without morcellation also carries a risk of these injuries. However, these risks are unknown because the reported literature is based on case reports rather than large trials. The total number of cases of morcellation of fibroids is also unknown. Surgeons should declare the rate of such injuries from their personal or institutional data where available.

## 5. Any extra procedures which may become necessary

General additional procedures associated with myomectomy or hysterectomy should be detailed in local procedure specific consent forms where available. A laparotomy may be required if there is a major complication, or, if the surgeon considers that conversion is necessary for safety or access.

## 6. The benefits and risks of any available alternative treatments, including no treatment

### *6.1 Open myomectomy or hysterectomy*

An abdominal (open) myomectomy or hysterectomy to remove a uterus or fibroid may be performed as an alternative. The benefit is that an unsuspected sarcoma would not be morcellated. However, if this was performed in everyone more harm may be caused overall due to the increased risks of open surgery over laparoscopy. These are, an increased risk of thromboembolism, wound infections, blood transfusion and incisional hernias, with a longer hospital stay and recovery.[4,20,21,25]

It should be noted that when an open myomectomy or vaginal morcellation are performed, simply cutting into the fibroid will cause spillage of cells and if there is an undiagnosed uterine sarcoma, upstaging can still occur.

### *6.2 Contained retrieval during morcellation*

The use of tissue retrieval bags for the contained removal of fibroids or the uterus, once they have been detached has been proposed.[26] However, there is no current evidence that bags reduce the incidence of disseminated fibroids or upstaging of an undiagnosed uterine sarcoma. There is also a theoretical risk that the bags obscure the laparoscopic view, with the potential of causing more intra-abdominal injuries.[4] The decision regarding contained retrieval during morcellation should be based on local practice and individualised patient care.

 

### *6.3 Conservative measures and uterine artery embolisation*

Any management option, including uterine artery embolisation, medical management and no treatment that results in uterine preservation, or preservation of some element of fibroid tissue, runs the risk of leaving an undiagnosed uterine sarcoma in situ;[1] see Section 4 above.

## 7. Patient statement

The woman should be given the opportunity to state in writing any procedures that should not be performed without further discussion. If other procedures are anticipated to become necessary during the planned procedure these should be discussed preoperatively, and a record of the woman's wishes made.

## 8. Preoperative information

A record should be made of any sources of information given to the woman prior to surgery (such as RCOG or locally produced information leaflets; https://www.rcog.org.uk/en/patients/patient-leaflets/).

Existing information sheets for procedures need to be reviewed to ensure they reflect the available current evidence.

## 9. Information and support for women and their families

All women should be provided with relevant and up-to-date information sources. Translation services should be sourced if a language-specific leaflet is not available to ensure that a woman has a full understanding of the procedures planned.

## 10. This consent advice

Please note that the content herein is based on the latest evidence available at the time and will be reviewed again approximately one year from publication.

 

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## Appendix 1

Definition of perimenopause referred to in this consent advice is as per https://www.imsociety.org/menopause_terminology.php.

### Menopause terminology

The International Menopause Society (IMS) and the World Health Organization (WHO), with the aim of standardising the terminology of menopause have put forward the following definition:

**Perimenopause:** the period immediately prior to the menopause (when the endocrinological, biological, and clinical features of approaching menopause commence) and the first year after menopause

## Appendix 2

The full extracted Table 4 from reference 2: Brohl AS, Li L, Andikyan V, Običan SG, Cioffi A, Hao K, Dudley JT, Ascher-Walsh C, Kasarskis A, Maki RG. Age-stratified risk of unexpected uterine sarcoma following surgery for presumed benign leiomyoma. *Oncologist*, 2015;20:433–439 [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4391766/table/T4/?report=objectonly].

## Appendix 3

Reference 27: Agency for Healthcare Research and Quality (AHRQ). *Comparative Effectiveness Review*. No. 195. p. 70. Rockville, MD: AHRQ; 2017 [https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-195-uterine-fibroids-final-revision.pdf]. This reference has been used as a resource during preparation of the consent advice for morcellation for myomectomy or hysterectomy.

 

## Appendix 4: Consent to treatment form

**Patient identifier/label** . . . . . .

**Name of proposed procedure or course of treatment**

Supplementary consent – morcellation for myomectomy or hysterectomy

**Statement of health professional** *(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy).*

I have explained the procedure to the patient, in particular, I have explained:

**The intended benefits**

The main benefit of the use of morcellation is the completion of the entire procedure laparoscopically or vaginally, which is associated with smaller incisions, less pain, reduced risk of infection, reduced risk of thromboembolism, shorter hospital stay and a quicker recovery.

**Serious risks (as detailed in Section 4 above)**

- Unintended morcellation of a uterine sarcoma.
- Worsening the prognosis of an existing sarcoma.
- Disseminated fibroids (presence of benign fibroids within the abdominal and pelvic cavity).
- Damage to bowel, bladder, ureters and blood vessels.

**Any extra procedures which may become necessary**

General additional procedures associated with myomectomy or hysterectomy should be detailed in local procedure specific consent forms where available. A laparotomy may be required if there is a major complication, or, if the surgeon considers that conversion is necessary for safety or access.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet has been provided: *Information for you: Morcellation for Myomectomy or Hysterectomy*

**This procedure will involve**

☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation

Signed . . . . . Date . . . . . .

Name *(print)* . . . . . .

Position . . . . . .

**Contact details** *(if patient wishes to discuss options later)*

. . . . . .

**Statement of interpreter** *(where appropriate)*

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.

Signed . . . . . Date . . . . . .

Name *(print)* . . . . . .

**Top copy accepted by patient?** Yes / No *(please ring)*

 