

Advanced Ovarian Carcinoma Following Bilateral Uterine Artery Embolization

To the Editors:

Wagreich et al¹ published a case report of a patient who was diagnosed with stage III ovarian cancer 9 months following uterine fibroid embolization. Pre-procedure pelvic ultrasound and magnetic resonance imaging reported normal adnexa. The authors hypothesized that the tumor was either present before the procedure or occurred de novo afterwards. They did not suggest that it was related in any way to the embolization. Their literature search did not find any previous reports of ovarian cancer occurring after uterine fibroid embolization.

Based upon this single patient, the authors recommend that all patients undergoing uterine artery embolization now need to be informed of the possibility of preexisting or subsequent development of ovarian carcinoma despite thorough pre-procedure assessment, including imaging. This recommendation is certainly not supported by the medical literature.

Based upon this unsupported recommendation, now published in the peer-reviewed literature, do we now also have to inform every patient with fibroids electing expectant management or medical management of the possibility of preexisting or subsequent development of ovarian carcinoma? Such nonevidence-based recommendations do not belong in the peer reviewed literature and unnecessarily place obstetrician-gynecologists at medicolegal risk.

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Reference

1. Wagreich A, Salame G, Lee YC, et al: Advanced ovarian carcinoma following bilateral uterine artery embolization: A case report. *J Reprod Med* 2009;54:325-326

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and speaker for BioSphere Medical, Inc.

Drs. Wagreich, Salame, Lee and Abulafia reply:

We stand by our report of the occurrence of stage III ovarian carcinoma shortly after bilateral embolization of the uterine arteries (UAE) in the management of a patient with symptomatic uterine leiomyomata.¹

We wish to remind Dr. Jay Goldberg that there is no current accurate screening test for the detection of early ovarian carcinoma. Negative magnetic resonance imaging, computerized tomography or pelvic ultrasound will not identify all patients with ovarian carcinoma prior to UAE. Currently, the only definitive test to rule out ovarian carcinoma with certainty is histopathology, which is not feasible prior to UAE. Furthermore, Dr. Goldberg should be aware (as we referenced in our report) that uterine sarcomas have also been described following UAE for the same reason that there is no accurate imaging modality to differentiate between uterine leiomyomata and uterine sarcoma prior to or following UAE.²⁻⁴ In fact, uterine leiomyosarcoma is diagnosed most commonly after myomectomy or hysterectomy in patients undergoing surgical management of "symptomatic leiomyomata" in whom clinical assessment and/or preoperative imaging indicated only the presence of leiomyomas.

Clearly, we stand by our statement that patients undergoing UAE should receive extensive counseling prior to the procedure. This counseling should include detailed information regarding the overall inability in the absence of histology to definitively rule out the presence of malignancies of the upper genital tract prior to UAE.

Finally, we deeply regret that Dr. Goldberg perceives that this recommendation will "unnecessarily place obstetrician-gynecologists at medicolegal risk." On the contrary, detailed candid (and time-consuming) discussions with patients regarding risks and benefits of procedures and their potential complications are paramount. These informed discussions are not only morally and ethically correct, they will contribute to establishing and sustaining an open patient-physician relationship of trust. Anything less, in our assessment, is a potential setup for unrealized expectations and potential malpractice litigation.

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