Scottish Parliament Region: South of Scotland

Case 200502347: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns regarding the treatment she received at Crosshouse Hospital, Kilmarnock (Hospital 1). She complained of the delay in diagnosing her uterine fibroids and subsequent Benign Intracranial Hypertension (BIH), as well as raising concerns regarding the side effects resulting from her treatment, and the lack of prior information relating to these. Mrs C also raised issues regarding her pain management upon admission to Hospital 1 and also the delay in issuing her discharge letter to her General Practitioner (GP).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C's uterine fibroids were not diagnosed within a reasonable timescale (*not upheld*);

(b) the Prostap therapy caused severe side effects which were not explained in advance (*not upheld*);

(c) upon admission to Hospital 1, adequate pain relief was not initially provided (*not upheld*);

(d) upon discharge from Hospital 1, there was a delay in issuing the discharge letter to Mrs C's GP (*not upheld*); and

(e) when the lumbar puncture was carried out at Hospital 1, the Cerebrospinal Fluid opening pressure was not taken and this led to a delay in diagnosing Mrs C's BIH (*not upheld*).

Redress and recommendations

The Ombudsman has no formal recommendations to make but does suggest that the Board considers making the manufacturer's patient information leaflet available to patients prior to the commencement of Prostap therapy.

Main Investigation Report

Introduction

1. On 24 November 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) about the treatment she received at Crosshouse Hospital (Hospital 1). She complained of the delay in diagnosing her uterine fibroids and subsequent Benign Intracranial Hypertension (BIH) as well as raising concerns regarding the side effects resulting from her treatment, and the lack of prior information relating to these. Mrs C also raised issues regarding her pain management upon admission to Hospital 1 and also the delay in issuing her discharge letter to her General Practitioner (GP). She complained to Ayrshire and Arran NHS Board (the Board) but remained dissatisfied with the outcome and subsequently complained to the Ombudsman.

2. The complaints which have been investigated are that:

(a) Mrs C's uterine fibroids were not diagnosed within a reasonable timescale;

(b) the Prostap therapy caused severe side effects which were not explained in advance;

(c) upon admission to Hospital 1, adequate pain relief was not initially provided;

(d) upon discharge from Hospital 1, there was a delay in issuing the discharge letter to Mrs C's GP; and

(e) when the lumbar puncture was carried out at Hospital 1, the Cerebrospinal Fluid (CSF) opening pressure was not taken and this led to a delay in diagnosing Mrs C's BIH.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence with the Board. In addition, I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A Glossary of the medical terms is at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

5. In June 2001, Mrs C was experiencing chronic pelvic pain and underwent a diagnostic laparoscopy, however, the cause of her pain was not identified at that time. She presented with urinary symptoms in March 2003 and was referred to a uro-gynaecologist (Doctor 1). A scan revealed a fibroid in Mrs C's womb and Prostap therapy was discussed and started on 2 December 2003. This treatment was aimed at reducing the size of the fibroid in preparation for surgery.

6. In January 2004, Mrs C began to develop severe headaches and attended Accident & Emergency (A&E) at Hospital 1 on two occasions, upon the second of which she was admitted. She was given a CT scan of her head and a lumbar puncture. The results of both tests were negative and she was discharged on 15 January 2004.

7. On 16 January 2004, Mrs C returned to A&E at Hospital 1 after collapsing whilst in her GP's surgery and she was re-admitted immediately. Mrs C was subsequently discharged on 27 January 2004 with a diagnosis of migraine.

8. Over the following weeks, Mrs C's condition is reported to have deteriorated and she was suffering from double vision and had limited sight out of her left eye. She was referred, by her GP, to the Eye Clinic, where she was diagnosed with BIH and admitted to the Southern General Hospital (Hospital 2).

9. She was then given another lumbar puncture which recorded a high CSF opening pressure and a diagnosis of BIH was confirmed. This took place in February 2004 and treatment for BIH was commenced thereafter.

(a) Mrs C's uterine fibroids were not diagnosed within a reasonable timescale

10. Mrs C's husband (Mr C) complained to the Board, on Mrs C's behalf, in a letter dated 18 June 2004. In his letter, Mr C advised that, following various investigations suggested by a consultant gynaecologist (Doctor 2), the cause of Mrs C's abdomen pain had not been diagnosed. He did not raise any further specific concerns with the Board relating to the time taken to diagnose fibroids, however, Mrs C added further comment about delay in her letter to the Ombudsman of 16 November 2005. She stated her belief that an earlier diagnosis of uterine fibroids would have made the surgery simpler and she felt that she has 'endured years of unnecessary suffering due to the delay in

diagnosis, unnecessary investigations and treatments for urinary symptoms …'.

11. On 4 August 2004, the Board responded to Mr C's initial letter and they advised that, following a diagnostic laparoscopy in June 2001, there was no sign at that time of any fibroid or other identifiable cause of Mrs C's pain. The Board stated that a laparoscopy gives a better view of the pelvic organs than any other form of imaging and they concluded that the large fibroid, subsequently confirmed in December 2003, must have arisen in the intervening years.

12. Mrs C pursued her complaint and on 3 November 2004, she met with the Director of Nursing (Director 1), the Service Director, Obstetrics/Gynaecology (Director 2) and a Consultant Gastroenterologist (Doctor 3). The discussion summary was issued to Mrs C in a letter dated 17 November 2004, however, there is no indication in that summary of a delayed diagnosis being discussed by either party.

13. I sought clinical advice regarding this issue and, after consulting the clinical records, the Adviser confirmed that no abnormality was seen following the diagnostic laparoscopy on 25 June 2001.

14. The Adviser said that the results of a vaginal examination on 4 December 2002 were normal and he confirmed that a Mirena Intrauterine System (IUS) was fitted under local anaesthetic on 6 March 2002. Whilst there is no record in the notes of examination findings, the Adviser has indicated that the Mirena IUS would have been unlikely to have been fitted easily if the cavity of the womb had been remarkably distorted and compressed by a fibroid.

15. The Adviser concluded by reiterating that Mrs C did not have fibroids when seen on 25 June 2001 and he advised that the diagnosis of fibroids was first confirmed on 2 December 2003, following a scan arranged by Mrs C's GP. The Adviser indicated that urinary symptoms might have been associated with the fibroid earlier and it could have been felt through Mrs C's stomach or an enlarged womb could have been observed upon pelvic examination. However, he advised that this would not have made any difference to the eventual outcome.

(a) Conclusion

16. Mrs C began experiencing problems in 2001 which were not conclusively

diagnosed. Mrs C may have linked these problems to the subsequent diagnosis of uterine fibroids in December 2003 and perceived a delay in diagnosis to have occurred, however, the Board have confirmed that a fibroid was not present when her problems first occurred and I cannot judge a complaint on the basis of hindsight rather than whether the treatment was reasonable, based on the information known at that time. The advice which I have received supports this information and, whilst the Adviser commented that an earlier diagnosis may have been possible on presentation of urinary symptoms, there is no evidence to suggest that this would have had an affect on the eventual outcome. I, therefore, do not uphold this complaint.

(b) The Prostap therapy caused severe side effects which were not explained in advance

17. In his initial complaint letter to the Board, Mr C advised that no formal advice concerning the possible side effects of Prostap therapy was given to Mrs C, prior to commencing the treatment in December 2003. However, he did concede that the nurse administering the initial injection indicated that some patients felt tired and unwell during treatment.

18. Mr C confirmed that Mrs C did indeed begin to feel quite unwell and that she began to develop severe headaches, beginning on 12 January 2004. Mrs C was admitted to Hospital 1 after a second visit to A&E, and a CT scan and lumbar puncture were carried out, with negative results. Mrs C was discharged on 15 January 2004.

19. The following day, after collapsing whilst in her GP's surgery, Mrs C was re-admitted. Mr C advised that, at this stage, Mrs C had suggested that the Prostap therapy was causing the intense headaches she was experiencing but that Doctor 2 had dismissed this possibility.

20. Mrs C was discharged on 27 January 2004 with a diagnosis of migraine, however, following this, her condition is reported to have deteriorated further and she began experiencing problems with her eye sight. As a result, she was referred by her GP to the Eye Clinic, a diagnosis of BIH was made, and she was transferred to Hospital 2.

21. In his letter, Mr C advised that one of the other doctors caring for Mrs C in Hospital 2 had carried out a literature search and found several other cases of BIH being caused by Prostap.

22. In their response to Mrs C, the Board confirmed that Doctor 2 did not warn Mrs C about any possible risk of BIH occurring following Prostap therapy because he was completely unaware of any such association.

23. The Board's Drug Information Unit confirmed that, whilst headache is a relatively common side effect of Prostap, the risk of BIH is not mentioned in the manufacturer's summary of product information. The Board also confirmed that the Committee on the Safety of Medicines (now the Commission on Human Medicines), which collates all adverse reaction reports for the United Kingdom, does not report any link between Prostap and BIH.

24. A literature search was performed by the Board and they were only able to reveal two English Language case reports, going back to 1990, showing an association between Prostap and BIH. They confirmed that the Consultant Neurologist, who had seen Mrs C on 23 January 2004 (Doctor 4), had submitted reports to the manufacturer of Prostap and the then Committee on the Safety of Medicines as he felt that there was an association between the drug and the symptoms Mrs C had experienced.

25. The notes from the meeting of 3 November 2004 confirmed that Director 2 explained that Prostap was widely used in gynaecology and the consultants found it very useful and of great benefit to patients. He confirmed that it was a standard pre-surgical treatment and that BIH was not documented as a known side effect in the standard literature. He advised that he was only aware of two reported cases of BIH associated with Prostap.

26. In Mrs C's letter to the Ombudsman, she advised that she was told that the Prostap injections occasionally caused flushes and sweats, however, she was not advised of any other side effect and she was not given any documentation about the drug.

27. Mrs C advised that she read up on the drug at the first available opportunity and that she was surprised to read all the possible side effects. She did not state specifically what these were but she confirmed that she began to suffer from sore joints, aching muscles, sweats, flushes, insomnia, mild headache and flu-like symptoms and she found it difficult to concentrate. She then developed a severe headache and was found to have high blood pressure and continued to feel extremely ill with constant headache, buzzing in her head,

vomiting, insomnia, aching joints and muscles and she felt exhausted and helpless. She also advised that she was unable to carry out even the smallest of tasks, she was incontinent of urine every time she was sick and she found it difficult to eat, due to nausea.

28. In her complaint to the Ombudsman's office, Mrs C said that following her migraine diagnosis and discharge, she advised that the following weeks were spent mainly confined to her bed, she had difficulty walking and she felt very weak. A home help had to be arranged as Mrs C's son has special needs and, in addition, her mother travelled a long distance daily to attend to her. Mrs C also experienced visual problems, suffering from double vision and a 'blind spot' in her left eye.

29. Mrs C said that her BIH caused her to spend ten months off work sick and when she returned to work she was only able to carry out light duties and work reduced hours. Mrs C is a nurse and she advised that her vision and concentration appeared to have been permanently damaged, affecting her ability to carry out her duties. She stated that she could no longer cope with the long hours and continual stress of her present position and that this had forced her to reduce her hours and seek an alternative post.

30. Mrs C believed that Doctor 2 did not fully appreciate the side effects of Prostap therapy and she stated that, by not informing his patients or their GPs, he was breaching General Medical Council (GMC) guidelines. In support of her complaint, Mrs C provided copies of her research into Prostap and the severe side effects other patients have experienced, although she did concede that most of the reports were from the United States (where Prostap is known as Lupron) and her research had not revealed any similar adverse reaction in the United Kingdom.

31. I sought advice regarding this issue from the Adviser. The Adviser examined the clinical records and noted that Doctor 4, who reviewed Mrs C on 12 March 2004, thought the BIH might have been induced by the Prostap. Doctor 4 communicated this opinion in letters to Mrs C's GP and to a Consultant Occupational Physician.

32. The Adviser observed that, on 29 June 2004, Doctor 3 reported that Mrs C's BIH was a condition in which there is a visual impairment because of a swelling of the optic disc and it was noted that Prostap is a cause of such

swelling.

33. The Adviser informed me that the current British National Formulary (BNF) does not mention BIH as a risk linked with Prostap. He advised that it is a commonly used drug in men and women, for a whole spectrum of conditions and that there have only been two cases, in the English language, associated with BIH. He did note, however, that migraine and other side effects, especially those related to low oestrogen levels in women, are common.

34. Finally, the Adviser telephoned the makers of Prostap and they were aware, in worldwide literature, of only 11 women and one child who have developed BIH whilst on Prostap. There is no record of any men having experienced this problem. In view of the volume and frequency which the drug is being used, the manufacturers did not think that these numbers could be considered a sufficiently strong signal to require mentioning on the product information or to the BNF or Commission on Human Medicines.

(b) Conclusion

35. Whilst I recognise that Mrs C has gone through a traumatic period and has suffered extensively as a result of her BIH, I can find no evidence to prove conclusively that this condition was caused by Prostap therapy or that this was a known side effect which Mrs C should have been warned about.

36. I do acknowledge that Doctor 4 believed there to be a link between Prostap and BIH and I note that he reported this link to various relevant parties, however, Doctor 2 held an opposing view regarding this possible connection. The statistics identified from literature searches by the Board and the manufacturers support this opposing view as they indicate that a small number of people, relative to the high number of users, suffer from BIH whilst on Prostap.

37. It has not been my role to establish whether there is a conclusive link between Prostap and BIH but rather to establish whether reasonable information was given to Mrs C, based on firm evidence available at that time. I appreciate the difficulties Mrs C has faced and I sympathise with her situation, however, in light of the lack of evidence showing a causal link between Prostap and BIH, I do not uphold this complaint.

38. Although it would not be possible to establish exactly what information was

provided at consultations prior to the commencement of Mrs C's Prostap therapy, Mrs C maintains that she was not informed of the potential side effects. She did indicate that she was advised of potential flushes and sweats and Mr C advised that she was told that it may cause her to feel tired and unwell, however, Mrs C stated that she was not made aware of any other side effects and she was not given any documentation about the drug. As the patient information leaflet, available through the manufacturer's website, lists several other possible side effects, it may have been appropriate for more detail to have been provided to Mrs C prior to the commencement of treatment. However, I also note that Mrs C did her own extensive research on the drug and its side effects. Mrs C herself has accepted that her own research did not reveal any similar severe adverse reaction to the treatment in the United Kingdom.

39. It is acknowledged that side effects may differ from patient to patient and it may not have been appropriate for the doctor to have gone through the entire list of potential side effects, however, I consider that the product literature would have been useful for Mrs C's reference. I would, therefore, suggest that the Board considers making the patient information leaflet available to future patients undergoing Prostap therapy.

(c) Upon admission to Hospital 1, adequate pain relief was not initially provided

40. In his initial complaint letter to the Board, Mr C advised that, on 16 January 2004, Mrs C collapsed in her GP's surgery and was to go to A&E at Hospital 1. However, a bed was available and Mrs C was immediately admitted to Ward 3E.

41. Mr C reported that Mrs C was very distressed and in great pain and she was given a painkilling tablet which had no effect. On two occasions, Mr C went to the nurses' station and asked for stronger pain relief to be provided, however, he stated that the nurses and the junior doctor appeared unable to help and it was over two hours before a more senior doctor arrived and administered intravenous(IV) medication.

42. In the Board's response they reported that, upon admission, Mrs C was prescribed Sevredol for her headache. They advised that this was an opioid analgesic containing morphine sulphate and that it was usually prescribed for severe pain uncontrolled by weaker opioid analgesia. This was recorded as

having been administered at 11:15, approximately 15 minutes after admission, as a supplement to analgesia administered in the A&E department.

43. IV diamorphine and Maxalon were then administered one hour and 25 minutes later. The Board explained this timescale by stating that it was necessary for nursing staff to allow the Sevredol time to work before asking medical staff to review the need for further pain relief. The Board apologised if the communication of this was not clear at the time and they confirmed that the nursing staff were following standard practice by allowing time to elapse prior to administering stronger pain relief.

44. Mrs C subsequently replied to the Board in a letter dated 11 August 2004 and she disagreed with part of their version of events of 16 January 2004. She stated that she was advised in A&E to go straight to Ward 3E as a bed was available and that no medication was administered in A&E. She advised that she was given oral medication shortly after admission and that various attempts were made, by junior medical staff, to insert an IV cannula. Mrs C advised that these attempts were unsuccessful and that it was over an hour before a senior doctor arrived to administer IV analgesia.

45. The Board responded on 24 August 2004 and apologised for the inaccuracy in their initial response. They confirmed that Mrs C was correct and that the oral Sevredol administered at 11:15 was the first medication provided. They reported that there was a delay before she could be assessed by the receiving Medical Team and that the Sevredol was prescribed pending medical review. They stated that it would not have been appropriate to prescribe stronger pain relief prior to medical review or to provide further pain relief until enough time had elapsed to establish whether the Sevredol was having an effect.

46. In the subsequent meeting of 3 November 2004, Director 1 apologised for the delayed medical assessment following her admission on 16 January 2004. She accepted that Mrs C's pain was not well managed, however, she advised that, as so much time had elapsed, none of the staff could recollect anything untoward and it had not been possible to pinpoint the reasons for the delayed assessment.

47. Director 1 went on to explain that there should not have been any significant delay in tracing Mrs C's medical records and that, even if there had

been, this would not normally have resulted in any delayed medical assessment. She advised that there were two senior house officers and two pre-registration house officers on the ward that day, in addition to the receiving consultant and staff grade doctor. The physicians held regular education sessions on Friday lunch times, however, none were held that day and, in any case, the receiving unit staff did not usually attend the sessions.

48. In her letter to the Ombudsman, Mrs C reiterated that she had to wait for several hours without any effective analgesia being provided and without a doctor seeing her. She stated that she was in agony and her husband was concerned that her life was at risk and she did not feel that a reasonable explanation has been given for the length of time she had to wait for pain relief.

49. The Adviser has confirmed that the nursing notes record the times when painkillers were administered and these times correspond with the Board's response. The Adviser observed that Director 1 had apologised for the quality of care and had accepted that Mrs C's pain had not been well managed.

(c) Conclusion

50. The Board have acknowledged that Mrs C's pain was not adequately managed, however, due to the length of time that had elapsed, they have been unable to provide a reason for the delays encountered. In cases such as this, it is often difficult to establish details due to the passage of time, as staff are often unable to recall specific aspects relating to the episode of care. Whilst it is regrettable that a fuller explanation is not available to allay Mrs C's concerns, I note that the Board had already acknowledged that Mrs C's pain was not adequately managed and apologised before the Ombudsman's office became involved. I consider their apology is appropriate and consequently I do not uphold the complaint.

(d) Upon discharge from Hospital 1, there was a delay in issuing the discharge letter to Mrs C's GP

51. This matter was not raised prior to the meeting of 3 November 2004 and, during the meeting, Doctor 3 apologised unreservedly for the delay.

52. In Mrs C's letter to the Ombudsman, she stated that, following her discharge on 27 January 2004, she had discovered that the discharge letter from Doctor 3's team was not received by her GP for nearly three weeks post discharge.

53. The Adviser has reviewed the clinical records and confirmed that Doctor 3's medical discharge summary was dictated on 30 January 2004 and typed on 11 February 2004. The Adviser does not believe that this constitutes an unreasonable delay.

(d) Conclusion

54. As the timescale for the issue of the discharge letter does not appear to be unreasonable and as Doctor 3 has already apologised unreservedly for any delay, I do not uphold this complaint.

(e) When the lumbar puncture was carried out at Hospital 1, the CSF opening pressure was not taken and this led to a delay in diagnosing Mrs C's BIH

55. In his letter of complaint, Mr C advised that the lumbar puncture Mrs C received at Hospital 2 showed that her CSF opening pressure was higher than normal. This helped to confirm the diagnosis of BIH and Mr C complained that the CSF opening pressure was not recorded during the lumbar puncture procedure at Hospital 1.

56. In the Board's response, they advised that CSF opening pressures were not measured routinely and that it was not done in Mrs C's case as there was no findings to suggest BIH. The Board did agree to consider introducing the routine measuring of CSF opening pressures and they advised that Doctor 3 and Doctor 4 would be discussing the requirement for this with the consultant physicians to establish whether it would be appropriate to introduce a new guideline.

57. In the meeting of 3 November 2004, Doctor 3 was able to confirm that CSF opening pressures would now be routinely measured in the receiving ward. However, he stressed that this procedure was not routinely carried out in other units, and that, at Hospital 2, it was generally only undertaken where raised intracranial pressure was suspected. He stated that the classical hallmark of BIH is papilloedema (swelling of the optic disc) and he confirmed that this was not evident when Mrs C was admitted to Hospital 1. He advised that it was specifically looked for in A&E, again in Ward 3E and also by Doctor 4 during Mrs C's in-patient stay.

58. In Mrs C's complaint letter to the Ombudsman, she stated that a diagnosis would have been made much sooner, had the CSF opening pressure been taken during the lumbar puncture carried out at Hospital 1. She observed that, since her complaint was made to Hospital 1, it has now become policy to check CSF opening pressures during lumbar punctures and she questioned why the guidelines have been changed if there was no problem to begin with.

59. The Adviser observed that BIH was not diagnosed on Mrs C's first admission and he advised that it, therefore, would not have been normal for a district general hospital to check the opening and closing CSF pressures when performing a lumbar puncture.

60. He confirmed there was nothing to indicate intracranial hypertension as the diagnosis on Mrs C's first two admissions and that the working diagnosis of migraine and sinusitis, with x-ray proof, meant that Hospital 1's management was not unreasonable and they acted in line with normal practice.

(e) Conclusion

61. An earlier diagnosis of BIH may have been possible, had Mrs C's CSF opening pressure been measured during the first lumbar puncture procedure in January 2004, however, the Board have confirmed that it was not standard practice to measure this, if there was no indication of raised intracranial pressure. They have advised that there was indeed no suggestion of raised intracranial pressure when the procedure was carried out at Hospital 1 and the Adviser has confirmed that it would not have been normal practice to record the CSF opening pressure in these circumstances. I, therefore, do not uphold the complaint.

62. It is noted that, subsequent to Mrs C's complaint, the Board have introduced the routine measuring of CSF opening pressures, however, they have confirmed that it remains the practice of other units only to do so when raised intracranial pressure is suspected. The Board should be commended for introducing this additional measure.

19 December 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Hospital 1	Crosshouse Hospital, Kilmarnock
BIH	Benign Intracranial Hypertension
The Board	Ayrshire and Arran NHS Board
CSF	Cerebrospinal fluid
The Adviser	One of the Ombudsman's professional advisers
Doctor 1	A uro-gynaecologist
A&E	Accident and Emergency
CT scan	Computed tomography
Hospital 2	Southern General Hospital, Glasgow
Mr C	Mrs C's husband
Doctor 2	A Consultant Gynaecologist
Director 1	The Director of Nursing
Director 2	The Service Director, Obstetrics/Gynaecology
Doctor 3	A Consultant Gastroenterologist
IUS	Intrauterine System

Doctor 4	A Consultant Neurologist
BNF	British National Formulary
IV	Intravenous

Annex 2

Glossary of terms

Analgesia	A state of insensitivity to pain while the patient remains conscious
Benign Intracranial Hypertension (BIH)	Increased pressure of the cerebrospinal fluid
Cerebrospinal fluid (CSF)	A clear, colourless fluid which fills the ventricles of the brain and the central canal of the spinal cord
CSF opening pressure	The initial reading of cerebrospinal fluid pressure taken during a lumbar puncture procedure, prior to the removal of fluid
Computed tomography scan	detailed x-ray taken by computer
Intravenous (IV)	Within or into a vein
Laparoscopy	A surgical procedure in which a tiny scope is inserted into the abdomen through a small incision
Lumbar puncture	A diagnostic procedure where a sterile needle is introduced into the lower spine to collect cerebrospinal fluid
Maxalon	Anti-sickness drug
Mirena Intrauterine System (IUS)	A hormonal contraceptive device that is placed in the uterus
Opiod	A chemical substance mainly used to provide pain relief

Papilloedema	Swelling of the optic disc
Prostap	Contains the active ingredient leuprorelin acetate - a type of medicine used to decrease oestrogen levels and hence decrease the size of fibroids prior to surgery
Sevredol	Painkilling medicine containing Morphine
Uterine fibroids	Benign smooth muscle tumours of the womb