Why Black and Hispanic Women Face a Heavier Fibroid Burden

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Uterine fibroids, a common gynecological condition, disproportionately affect Black and Hispanic women, who often present with more severe symptoms and require more aggressive interventions. This disparity extends beyond disease prevalence, impacting the entire treatment pathway from initial medical management to surgical outcomes. New research highlights the persistent inequities in how these patients are managed, particularly before excisional procedures.

KEY TAKEAWAYS

- The Pivot: Black and Hispanic women with uterine fibroids present with more severe disease, requiring more medical interventions and transfusions before surgery.
- The Data: Black and Hispanic women were more likely to have preoperative hemoglobin values under 10 mg/dL ($p<.001$) and higher rates of preoperative blood transfusions ($p=.001$).
- The Action: Clinicians must recognize the heightened disease burden in these populations and intensify efforts to optimize medical management earlier to prevent severe anemia and reduce the need for transfusions.

Uterine fibroids are benign tumours of the uterine muscle, yet they can cause heavy menstrual bleeding, pelvic pain and anaemia. Two recent retrospective studies add numbers to a pattern clinicians already suspect: Black and Hispanic women carry a heavier share of the burden, both at diagnosis and in the months before surgery. Read together, they raise a practical question about whether care before the operating room is keeping up with that burden.

How often fibroids are diagnosed

Mitro and colleagues analysed electronic health records from Kaiser Permanente Northern California, an integrated health system, between 2009 and 2022. Eligible members were women aged 18 to 54 with at least 12 months of continuous membership, no earlier fibroid diagnosis and no history of hysterectomy. Among 1,917,794 members, 84,206 (4.4%) received a first fibroid diagnosis during the study period.1

The authors used Poisson regression and standardised the rates to the 2022 US female population, then compared each group with White patients. The incidence rate ratio was 3.11 (95% CI 3.05 to 3.17) for Black patients and 1.37 (1.34 to 1.39) for Hispanic patients. Asian subgroups were also higher than the White reference: 1.29 for Southeast Asian, 1.47 for East Asian and 1.71 for South Asian patients.1 An incidence rate ratio of 3.11 means that, after standardisation, Black patients were diagnosed at about three times the rate of White patients in this system.

What a diagnosis rate can and cannot tell us

The authors are careful to say these are diagnosis rates. If they track true prevalence, the disparities need explaining. If they partly reflect who gets examined, who reports symptoms and who is imaged, the picture is less clear. One detail points that way: all Asian groups were less likely than other groups to have coded symptoms before diagnosis, which suggests the route to diagnosis is not the same for everyone.1

The setting matters too. Kaiser Permanente is an integrated system in which members share one insurer and one record, so access to care is more even than in many studies. I would read the Black patient figure as a strong signal that survives that levelling, and the other figures as a call for better data on symptoms and imaging, not as a settled ranking of groups.

The months before surgery

A chart review by Martinez and colleagues looked at women aged 18 to 50 who had a myomectomy or hysterectomy for fibroids between 2012 and 2021. Their aim was to test whether the known disparities in bleeding symptoms and surgical management also appeared in the medical treatment women received before the operation.2

Black and Hispanic women were more likely to arrive for surgery with a haemoglobin value under 10 ($p<0.001$) and had higher rates of preoperative blood transfusion than White women ($p=0.001$).2 Low haemoglobin before surgery is a clinical concern in itself, because anaemia is generally managed before an elective operation where possible, and transfusion adds its own risks and logistics.

Black women used the highest number of medications before the procedure, followed by Hispanic women, while Asian women used the fewest ($p=0.037$). There was no preferential use of GnRH analogues, intrauterine devices or oral hormonal therapy between groups, and minor procedures were rarely used and did not differ significantly by race.2 The authors conclude that these patients remain under-optimised before surgery and call for research into what prevents better symptom control.

What this does and does not show

Both studies are retrospective, so they describe associations in records, not causes. The surgical paper does not report how long patients took each therapy or how well they adhered, so we cannot say whether treatment started late, stopped early or simply failed. In my view the most useful reading is practical: more medications did not translate into fewer transfusions, which raises the possibility that the problem lies less in the choice of drug than in how well symptoms are controlled, a question these records cannot answer.

The two papers also answer different questions. One counts new diagnoses across almost two million people; the other describes women who already reached surgery. Neither follows a woman from first symptom to operation, so the gap between them, the time between a diagnosis and a decision to operate, is invisible in both. that gap may be where much of the answer lies.

Questions for clinicians and researchers

For clinicians, the findings support checking haemoglobin early in women with heavy bleeding, treating anaemia as a problem to solve before surgery is scheduled, and asking whether a long medication list is actually controlling symptoms. A woman on several drugs who still bleeds heavily has not been optimised, whatever the prescription record says.

For researchers, the open question is the one Martinez and colleagues pose themselves: what prevents better preoperative control in the groups with the highest burden? Useful next studies would record the date of first symptoms, the date and dose of each therapy, haemoglobin at each visit and the reasons a treatment was stopped. Until those data exist, the honest summary is that the burden is unevenly distributed, the pre-surgical care is not closing the gap, and we do not yet know why.

CLINICAL IMPLICATIONS

The data are unequivocal: Black and Hispanic women face a significantly heavier burden from uterine fibroids. They present with more severe anemia and require more blood transfusions before surgery. This is not merely a biological difference; it points to a systemic failure in optimizing their care pathways.

Clinicians must internalize this reality. A Black or Hispanic woman presenting with fibroid symptoms should immediately trigger a higher index of suspicion for severe anemia and a more proactive approach to medical management. Waiting until hemoglobin levels plummet below 10 mg/dL before intensifying treatment is simply not acceptable.

The fact that these women use more medications but still end up severely anemic suggests either inadequate dosing, poor adherence, or a lack of consistent follow-up. We need to move beyond simply prescribing and ensure these therapies are effective and sustained. This might mean more frequent monitoring, patient education tailored to individual needs, or a willingness to escalate treatment earlier.

For healthcare systems, these findings demand a critical review of care protocols for fibroid management, particularly for minority populations. Are referral patterns equitable? Are all appropriate medical and minor procedural options being offered and optimized? The goal should be to reduce the need for transfusions and improve preoperative health, thereby mitigating surgical risks and improving overall outcomes for those who bear the greatest disease burden.

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