

Endometrial Ablation

Introduction

Many women will have tried medical treatment, such as the levonorgestrel (Mirena) intra-uterine system, the oral contraceptive pill or tranexamic acid, before contemplating an irreversible endometrial ablation procedure. For some women medical treatment will have been unsuccessful, for others it may not have been appropriate or desired.

80-90% of women undergoing an endometrial ablation can expect a reduction in their periods and up to 50% of women's periods may stop altogether. This means that up to 10% of women may not be happy with the result of their operation. They have the option of further treatment including a hysterectomy.

There is usually little post-operative discomfort after the first 24 hours. There are no special restrictions (e.g. lifting) during recovery and normal activities can be resumed as soon as you feel well enough. Many people resume normal activities as soon as they go home and most within one week.

What is endometrial ablation?

Endometrial ablation is a procedure that aims to irreversibly destroy or remove as much of the endometrium (lining of the womb) as possible. This lining is a few millimetres thick and is the part of the womb that bleeds at period time. Ablation involves passing either a special telescope (called a hysteroscope) or a radiofrequency treatment device through the neck of the womb (the cervix) into the womb (endometrial cavity). This is performed under local anaesthetic (radiofrequency) or general anaesthetic (radiofrequency or rollerball / resection).

When considering this treatment women must be sure they have completed their family. We do

not recommend this irreversible treatment if your family is not complete. Trying for a pregnancy following this procedure is strongly advised against and is unlikely to be successful. This is because the lining of the womb (endometrium) plays an important role in achieving a successful pregnancy. You will however still need to use contraception after an endometrial ablation.

There are several methods that can be used to perform this operation. You will usually have had a pelvic ultrasound scan to assess your womb to determine your suitability for an ablation procedure and to help decide which type would be most suitable. Your doctor will discuss this with you. The two methods which we use at the RD&E are:

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Radiofrequency ablation (e.g. Novasure)

This is a device that is placed inside the womb and destroys the lining using radiofrequency energy. It has a short treatment time (maximum 2 minutes - average 90 seconds) and is usually performed under local anaesthetic in the outpatient hysteroscopy and ambulatory clinic. It can however be performed under general anaesthetic if there are reasons why it can't be performed under local anaesthetic or because of patient preference.

Before the procedure you should take painkillers. We suggest you take Paracetamol 1g (two standard 500mg tablets) and Ibuprofen 600mg (three standard 200mg tablets) one hour before your appointment time. These are available at chemists and supermarkets. You should not take either if you are known to be allergic to them and should seek medical advice before taking Ibuprofen if you have stomach ulcers, bad heartburn or bad asthma.

You will only be asked to remove your clothes from the waist down and lay on a couch that supports your legs. A nurse will be there to support you at all times through the procedure. A speculum is placed in the vagina to see the cervix. Local anaesthetic is then injected with a very fine needle into the cervix. This is a little uncomfortable. A narrow hysteroscope is then passed into the womb. The findings will confirm your suitability for the procedure. If all is well then a further small amount of local anaesthetic is injected down the hysteroscope into the top of the womb to numb that area also. Most women do not feel this.

The cervix is then gently stretched and the ablation device placed in the womb. A safety check is performed and the device is then activated. Once complete (within 2 minutes) the device is removed and the hysteroscope placed back in the womb to check that the ablation has been successful. Having rested for a few minutes you will then get dressed.

Rarely do women request any additional pain relief. We have Entonox available if necessary.

You should have someone at home with you for the remainder of the day. We recommend that someone brings you and takes you home after your ablation procedure. You need to allow 60 minutes for the appointment., Our experience in Exeter is that most women have a pain score of 3 out of 10 (0 being no pain and 10 being worst pain imagined) during the 2 minute treatment. This reduces to 1 out of 10 as soon as it is completed. The ablation can be stopped at any time at your request, although if it is then the procedure is unlikely to be successful.

Most patients go home within an hour of their procedure. Having avoided a general anaesthetic, most patients are able to return to work the following day but you may need to take paracetamol / ibuprofen / codeine for 24-48 hours if you experience period-like discomfort.

Rollerball endometrial ablation / trans-cervical resection of endometrium

This method of treating the lining of the womb uses special instruments which attach to a larger hysteroscope. These are used to cut away or

destroy the lining of the womb using electrical energy and heat. This technique has the advantage of being able to treat wombs that are enlarged because of fibroids or treating wombs of different shapes. Sometimes fibroids can be removed at the same time using a loop attached to the hysteroscope (trans-cervical resection of fibroids). Fibroids are benign (non-cancerous) growths within the muscle of the uterus. They often cause no problems but if close to the lining of the womb, may increase the surface area of the lining of the womb causing heavier periods. This type of ablation takes longer (up to 20 minutes) and will always need a general anaesthetic.

What happens before the operation?

It is not always necessary to give medication prior to a radiofrequency ablation to thin the lining of the womb. Your doctor may recommend a one week course of progesterone to be started 2 weeks prior to your ablation. You should expect a bleed 2-3 days after finishing the course by which time the lining of the womb should be thin for the procedure.

If you have a levonorgestrel IUS (Mirena) in place the doctor will remove this at the time of your procedure.

To maximise the effectiveness of rollerball endometrial ablation (+/- resection) we recommend thinning the endometrium with a medication that temporarily switches off ovarian oestrogen production. We will recommend that your GP prescribe and administer a single dose of a GnRH analogue by injection 4-5 weeks before the arranged date for your procedure. You may experience some temporary menopausal side effects such as hot flushes and night sweats. These will resolve within 6 weeks of the injection.

Should you develop an illness prior to your surgery or have further questions please contact your Consultant's secretary or Wynard Ward on 01392 406512.

If you are having a general anaesthetic, the anaesthetist will see you on the ward prior to your operation. They will discuss your anaesthetic and pain relief with you. The anaesthetist will usually prescribe painkillers to take before your operation. Someone stays with you the whole time from when you leave the ward until you return.

What happens after the procedure?

If you had your procedure under local anaesthetic we would normally expect you to go home within an hour of completion of the procedure.

If your ablation is performed under general anaesthetic the anaesthetist will wake you up after the procedure is completely finished. You will be transferred to the recovery room and checked regularly by the nursing team until you are sufficiently awake and recovered to return to the day case ward. Most women would be expected to go home within a few hours of their procedure.

Routinely we do not see patients back in the clinic, . We would ask you to keep a record of your menstrual loss over the next 6 months. If your periods have not improved to your satisfaction you should discuss this with your GP who will if appropriate, re-refer you for alternative treatment. Occasionally, although menstrual blood loss may stop or be greatly reduced, cyclical pelvic pain may persist. If this cannot be tolerated in the long term, hysterectomy would be recommended.

When can I get back to normal?

After the operation, there is usually a vaginal discharge which may be blood-stained. For half of women this finishes within a week, but occasionally it may go on for several weeks. It is not usually sufficient to prevent a return to normal activities but sexual intercourse and the use of internal tampons should be avoided.

Normal activities can be resumed as soon as you feel able, usually within a few days.

What problems can occur during or after the procedure?

Infection

Although precautions are taken at the time of the operation to prevent infection, it is possible that the inside surface of the womb may become infected during healing. In this event, the discharge may turn greenish in colour and there may be bleeding which is heavier than a period, together with some abdominal discomfort. If

this happens, treatment with antibiotics may be necessary. You should consult your GP.

Bleeding

You may develop bleeding from the womb during or after the procedure, this will usually settle and but rarely may need further surgery to open up the abdomen to stop it or to perform a hysterectomy. Many women experience light bleeding for up to 4 weeks after the procedure. As long as this is non-offensive then nothing needs to be done. It can take up to 6 months for the maximum benefits from operation to be seen.

Deep vein thrombosis (DVT)

Deep vein thrombosis can complicate any surgery but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation, if performed under general anaesthetic, and walking about early, all help to stop thrombosis occurring. The risk of thrombosis is further reduced if you have your procedure under local anaesthetic.

Uterine perforation

If a perforation (hole in the womb wall) were to occur, it might be necessary to perform an operation to look inside the abdominal cavity (laparoscopy) to ensure there has been no injury to the internal organs. This would allow either sealing off the perforation with stitches or a hysterectomy. These may require a larger cut in your abdomen.

Absorption of fluid into the blood stream

(this only applies to rollerball ablation and resection of fibroids under general anaesthetic)

A careful watch is kept on the amount of fluid used to wash out the womb cavity so that the surgeon can see during the procedure. If a large quantity may have been absorbed into your circulation then it may be necessary to stop the operation before completion. Excessive fluid absorption can sometimes be dangerous and may require close observation post-operatively until it is washed out through your kidneys. It may mean a longer stay in hospital than planned.

The risks of an anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

Local anaesthetic is regarded as safer than general anaesthetic:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include unusual taste in the mouth / tingling tongue and temporary reduction in hearing if some of the local anaesthetic is absorbed into your blood circulation. It passes very quickly.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death.

General information

Will I need to use contraception?

It is unlikely that pregnancy would occur after the procedure and, for this reason, the procedure is only offered to women who are certain they no longer wish to have children. On the other hand, the reliability of the operation in preventing

pregnancy is not known. For this reason, it is important that permanent provision is made for contraception. If necessary endometrial ablation can be combined with a sterilisation operation or continued use of hormonal contraception.

What about cancer of the womb?

The operation does not remove the cervix and cervical screening smear tests should continue to be performed at the recommended intervals. It remains possible that any remaining areas of the lining of the womb may become cancerous, just as they may in any woman who has not had a hysterectomy. There is no reason at the present time to think that the operation is likely to increase the normal chance of cancer of the womb occurring (the overall risk of developing cancer of the lining of the womb is less than 1 case per 5,000 women per year). Endometrial ablation can cause scar tissue to form within the womb cavity making it difficult to see inside the womb with a telescope if ever this were needed to investigate abnormal bleeding in the future. You are advised to report any abnormal bleeding to your GP especially after you feel you have gone through the menopause.

What if I need to have hormone replacement therapy?

The operation should not affect the ovaries, but if for any reason hormone replacement is needed at any time after endometrial ablation, it is important that the type which is given is that used in women who have not had a hysterectomy i.e. it should contain a mixture of oestrogen and progesterone hormones.

Who to contact in an emergency

Wynard Ward: 01392 406512 or your usual General Practitioner.

The Trust cannot accept any responsibility for the accuracy of the information given if the leaflet is not used by Royal Devon staff undertaking procedures at the Royal Devon hospitals.

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