

Endometrial Resection and Ablation

This is a gynaecological procedure which I perform in the operating theatre under general anaesthetic as a “day procedure”.

It is generally used to treat heavy periods and dysfunctional uterine bleeding in a woman for whom further fertility is not required.

Moreover a pregnancy after this procedure would be undesirable as it could be complicated by serious risks of abnormal placentation. Often this procedure is combined with laparoscopic tubal ligation for example to avoid any future pregnancies.

It involves inserting a camera into the uterus through the vagina and cervix. This allows inspecting the endometrial cavity and lining (inside of the uterus) for presence of abnormal masses, fibroids, polyps, suspicious structures and shape of the cavity.

The lining of the uterus (endometrium) is resected away using electric current and specimen thus obtained is sent for histopathological examination. After this layer of endometrium is resected the underlying layer is further ablated with a different current to improve the results and to reduce postoperative bleeding.

Potential risks do exist with this procedure although in general they are thought to be less than the alternative of hysterectomy, which is also used in similar medical circumstances. The lesser risks and quicker recovery are the main advantages of this procedure over hysterectomy.

Infection and more than minimal “normal” bleeding could occur.

A more substantial risk of perforating the uterine wall is uncommon. In rare circumstances perforation of the uterus can result in trauma to vital structures such as bowel or large blood vessels. If this is suspected a laparoscopy and/or Laparotomy would be performed to investigate and treat any suspected injury.

A rare risk of fluid overload exists with this procedure which potentially could result in overnight admission as well as fluid and electrolyte monitoring to treat this complication.

Minimal pain is experienced afterwards, however some spotting or even light bleeding is to be expected. This generally settles within days.

In about 70-80% of cases this procedure leads to either complete cessation of heavy periods (or dysfunctional uterine bleeding) or significant reduction in blood flow. However, about 20% of patients do require further treatment for heavy bleeding (usually a hysterectomy).

Also this procedure is less effective or even inappropriate if the uterus is substantially enlarged, abnormal shape, has multiple fibroids or adenomyosis.

PLEASE REPORT:

SIGNIFICANT PAIN REQUIRING MORE THAN SIMPLE PARACETAMOL OR
ANTIINFLAMMATORY ANALGESIA;

ANY BLEEDING THAT IS GETTING HEAVIER, INVOLVES CHANGING A PAD MORE THAN EVERY HOUR OR DEVELOPS AN OFFENSIVE ODOUR.

The patient goes home several hours after the procedure and can resume normal activity and function the next day. Intercourse and tampon insertion needs to be postponed till any vaginal bleeding stops.

In general I would review the patient in my office in 1 and 6 weeks to discuss the final results and progress.