What is Endometrial Ablation?

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Endometrial ablation is the removal or destruction of the endometrium (lining of the uterus). Endometrial ablation is an alternative to hysterectomy for women with heavy uterine bleeding who are wish to avoid hysterectomy. Most women who have had a successful endometrial ablation will have little or no menstrual bleeding.

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How is endometrial ablation done?

Endometrial ablation is usually done using a hysteroscope or resectoscope. The procedure was developed by Dr. Goldrath in 1979 using a Nd:YAG laser. I brought endometrial ablation to Northern California in 1985 using the laser. Although my results of endometrial ablation using the laser were excellent, it is more efficient to use a high-frequency electrical current delivered through a resectoscope. The resectoscope can also be used to remove fibroids that are inside the cavity of the uterus and polyps.

What are the different types of endometrial ablation using the resectoscope?

The resectoscope can be used in several ways. In a "roller-ball" endometrial ablation a ball-shaped electrode is used to deliver energy to the endometrium, not unlike a microwave. This destroys the endometrium. In another method called "endo-myometrial" resection, a loop electrode is used to shave off the endometrium and some of the underlying tissue. Often the roller-ball is used to coagulate the wall of the uterus after the endometrium is removed. There are a number of variations on these techniques that probably have little effect on outcome. For example, a barrel shaped electrode can be used to "vaporize" tissue, or one type of resectoscope uses a device to automatically remove tissue that is shaved off.

Doesn't a D&C do the same thing?

A D&C is a blind procedure in which the lining of the uterus is scraped. This is similar to
mowing a lawn with your eyes closed - large areas may be missed. In addition, a D&C only scrapes the surface, similar to mowing a lawn. Unless the "soil" is removed, there will not be any long lasting effect. In fact, there has not been a single study published showing any long-term benefit of a D&C.

**What is a "balloon ablation"?**

Although the resectoscope provides excellent results in experienced hands, the technique is difficult to master. Other methods of destroying the endometrium, have been investigated. Two balloon devices have been extensively investigated: the Thermachoice™ and the Vestablute™.

The Thermachoice™ device uses a balloon placed in the uterine cavity through the cervix. Hot water is circulated inside the balloon. The Vestablute™ balloon has metal electrodes on the surface, with thermisters in each electrode to monitor temperature. When the device is activated, radio frequency current is applied to the electrodes, and a computer controls the temperature used to destroy the endometrium.

Both devices showed excellent results in well controlled studies. The Thermachoice™ balloon has received FDA approval, while the Vestablute™ is expected to be approved at the end of 1998.
Will I still have periods after an ablation?

Endometrial ablation was developed to treat abnormally heavy menstrual bleeding. Most women will have no period or very light periods after the procedure. Some women may wish guaranteed that they will never have another spot of blood; only a hysterectomy can make this guarantee. On the other hand, most women with menstrual periods that interfere with their normal activities will be very happy to have light menstrual periods after a short outpatient procedure. Amenorrhea (the lack of any bleeding) occurs in more than 50% of women, and is the "icing on the cake." Most postmenopausal women, however, will not
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How can I still bleed after an endometrial ablation?

The most common cause of continued bleeding is regrowth of the endometrium from adenomyosis (a condition in which the lining of the uterus grows into the uterine wall). Deep adenomyosis is one of the most common causes of failure of the procedure. If deep adenomyosis is suspected, an endometrial ablation may not be the best procedure.

If I have fibroids (myomas) can I still have an ablation?

Fibroids that are inside the uterus (intracavitary or submucous myomas) can often be resected (removed) at the time of an ablation. If fibroids are in the wall of the uterus, they cannot be reached with the resectoscope, although it may be possible to treat these by other methods. If myomas are left in the wall, then there is a chance that they eventually may grow and need surgery even if bleeding is no longer a problem. Factors that effect this is the recent rate of growth of the myomas and the age of the woman, since the closer she is to menopause the less time they will have to grow. Thus a 48 year old woman with moderately large fibroids that have been growing slowly may be a good candidate for treatment of heavy bleeding by endometrial ablation. On the other hand, a 32 year old women with moderate size fibroids in the wall of the uterus that have enlarged significantly in the last year would be very likely to need further surgery after an ablation.

Who else shouldn't have an endometrial ablation?

Since an endometrial ablation destroys the lining of the uterus, the procedure is not for anyone who desires to keep her fertility. Women who have a malignancy or pre-malignant condition of the uterus are not candidates for ablation. Women who have severe pelvic pain, unless the pain is coming from an intracavitary myoma, may be better served by alternative treatments.

Who should consider endometrial ablation?

Most women who have menorrhagia (abnormally heavy menstrual periods) that is not controlled by medicine, and do not have other problems that require a hysterectomy should consider endometrial ablation. The risk is low in the hands of a physician skilled in the procedure. The procedure is done on an outpatient basis, and most women are able to return to their regular activities in several days. A small percentage of properly selected women having an ablation will eventually need a hysterectomy, but the vast majority will not.
Who can help me decide if an endometrial ablation is for me?

It is helpful to see a gynecologist who is familiar with, and who is able to provide all of the alternatives for the treatment of your problem. The physician should be expert at vaginal-probe ultrasound and at diagnostic hysteroscopy. The physician should consider non-surgical treatment, as well as discussing the advantages and disadvantages of all the options available. While the physician can provide you with information, the decision is ultimately yours.

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