Options besides Hysterectomy for Abnormal Uterine Bleeding

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Roberta Speyer: "This is Roberta Speyer for OBGYN.net reporting from the International Congress of Gynecologic Endoscopy. We're talking to Dr. Andrew Brill, Professor of Obstetrics and Gynecology and Director of Gynecologic Endoscopy at the University of Illinois, in Chicago, and Dr. Paul Indman, on the Clinical Faculty at Sanford University, and also in private practice in Los Gatos, California. Thank you for being here with us gentlemen. What are we going to talk about today?"

Dr. Andrew Brill: "I think we both would like to talk about the options available to women who have been advised they need a hysterectomy for abnormal uterine bleeding."

Dr. Paul Indman: "I think that's especially important considering at this meeting of the AAGL there are many new options being presented. I think it's important for women to understand that some of these methods may be great advances and some may not. Some have been thoroughly tested, some of the methods aren't tested. I guess the question that I would throw out is - "How does a woman evaluate what is real and what is frankly hype?"

Roberta Speyer: "A good question, because we certainly hear a lot when we turn on our television sets, and we watch Oprah Winfrey. We find out that there's all kind of things out there, and we should be checking them out or there's terrible horror stories of people who tried things. What do you think, Dr. Brill - how do you evaluate this?"

Dr. Andrew Brill: "Where as the availability of information is at it's all time greatest today because of the media and because of the availability of the World Wide Web, of course, the great danger in accessing information is being unable to differentiate between quality and just reports. I don't think the consumer really is prepared to do that. So ultimately the only way to get at the heart of reality when it comes to any of these methods is to face-to-face ask your physician - what is the evidence, was this a studied procedure, is this not experimental, has it been approved for use, and is there any literature either dispensed by the company or dispensed in the general medical literature that's available for them to review so they for themselves can see is this is a method that is truly evidence based?"

Roberta Speyer: "What would you like to add to that, Dr. Indman?"

Dr. Paul Indman: "I think it's also important not to forget the basics because most women who have abnormal bleeding can be handled with simple methods often that don't require surgery or any fancy techniques at all. And the first question is why is someone bleeding? This can be evaluated by determining whether or not she's ovulating - there's simple methods to determine that. Is there a problem with the uterus? An ultrasound which is looking in the uterus with a hysteroscope is a basic simple procedure. We want to know is there something that requires surgical treatment? In addition, when we're talking about women that come to see me with abnormal bleeding - many of them are managed with birth control pills or simple anti-inflammatory type medicines and don't need any surgery at all. So it's only the minority of women that need surgery, let alone these new procedures."

Dr. Andrew Brill: "I would completely agree with Paul. Anyone who considers a surgical option for abnormal bleeding should have either failed an adequate trial of medicines or should for some health reason be unable to tolerate them because this method can be effective in the majority of women..."
who otherwise don't have any significant abnormalities of their uterus."

Roberta Speyer: "So are there red flags a woman should be aware of when they go to a physician if the solution goes right to hysterectomy or right to some type of a surgical option? Should that alert them to, maybe, get a second opinion?"

Dr. Paul Indman: "Definitely they need to know what's going on, and I know there are fortunately unusual but extreme examples of people making an appointment and they're offered a procedure before they're ever seen. Believe it or not - this does happen. Certainly anyone who offers a solution without finding out the problem is somewhat suspect. Let's take this one step further now, let's say someone has been evaluated and has tried medical management, and it just doesn't work - it fails. Then the question is - is a hysterectomy reasonable or should there be alternatives? There are lots of myths about hysterectomy, and certainly hysterectomy can have side effects, it's major surgery. On the other hand, many women do well, and I think it's important not to dismiss hysterectomy as being an evil thing that in itself is politically incorrect. I think if there's simple alternatives that are less invasive I certainly would much rather have a less invasive alternative, mostly because it's less invasive. Andy, why don't you talk about some of the newer things that we've seen here, the different endometrial ablation techniques?"

Dr. Andrew Brill: "I would like to preface it by saying that it's very important that one is able to differentiate which symptoms can be helped by what particular techniques. And when it comes to abnormal bleeding unto itself, surely non-hysterectomy alternatives should be explored and can be very effective once medicine has been failed. If a woman, however, suffers from discomfort with sex, pressure on her bladder, significant pain, let's say from an abnormally large uterus because she has fibroid tumors, or other abnormalities - then one has to be a little more suspicious about alternate therapies being helpful for those particular symptoms. So up front it's very important for a woman to decide what is it that she wishes to accomplish with whatever therapy she chooses. That is why hysterectomy does have its role, and we do have to state emphatically that hysterectomy is the final solution. It is the only solution that is not temporary, and in no way, I think that Paul and I advocate this as a solution but a woman must keep this in mind that it is the final solution to the difficulty."

Dr. Paul Indman: "I think it's the only solution that has a guarantee. I think there are alternatives that many times are final. Let's look at one alternative - endometrial ablation, that's destroying or removing the lining of the uterus. I did the first endometrial ablation in northern California, and that was in 1985. Many women had gone into menopause, and that was the final solution, and they never had any further bleeding problems. However, it doesn't come with a guarantee, it's a patch. It's a patch that may hold or it may not hold and there are advantages and disadvantages. Recently there have been some new endometrial ablation devices that simplify the technique of doing that. There are two balloons, one is approved by the Food and Drug Administration, another has tentative approval and will be available shortly."

Roberta Speyer: "What are the names of those?"

Dr. Paul Indman: "The balloon that's approved now is the Gynecare ThermaChoice. The VestaBlate System should be released within several months."

Roberta Speyer: "Are there significant differences even at that level of granularity with balloon technology?"

Dr. Andrew Brill: "The technology or the methodology is different if you were to say how do the balloons actually destroy the lining of the uterus, which we call "endometrium." In the hot water balloon you actually have warmth which is transferred to the surface of the uterus, and secondarily it heats up. And in a particular case of VestaBlate with the electrical balloon, here you'd have electricity flowing through the surface of the uterus, which unto itself secondarily will heat it. So the mechanism is different but the end effect is the same."

Roberta Speyer: "It's the same for the patient. So it's more of a choice, is it Dr. Indman, for the physician of how they feel more comfortable operating or what do you think?"
Dr. Paul Indman: "The two balloons have more similarities than differences. The most important thing is that any of the balloon ablation devices as opposed to - I'm going to back up. Normally when we do an ablation we will look inside the uterus and apply energy either with a laser or more recently - electricity to remove, and under direct vision we are seeing what we are doing. This is a way of applying energy to the inside of the uterus, and so we can't see what we are doing. About one-third of women that I see would be good candidates for this because the other two-thirds have fibroid tumors, polyps, or other growths that need to be removed anyway."

Roberta Speyer: "Surgically."

Dr. Paul Indman: "Now there are two studies each comparing the balloon to conventional hysteroscopic surgery. The failures rates - and these are well done studies - are the same. However, the number of women that had no bleeding at all was double in the Vesta group as opposed to the ThermaChoice group. Is that an important difference - probably not. Now we have to realize that endometrial ablation is a procedure to treat heavy bleeding. A successful ablation means a woman no longer has heavy bleeding so if someone's in the bathroom for two days every hour soaking through, wearing diapers, and now has normal periods - we consider that a successful ablation. If someone says - "I don't want a spot of blood" - then don't even consider an ablation."

Dr. Andrew Brill: "I would like to add something to what Paul had to say, and it's in context of what balloon ablation technology brings really to the table of alternatives to hysterectomy for abnormal uterine bleeding. Despite the fact that hysteroscopy which is a telescopic sort of gold standard method of heating the endometrium or endometrial ablation has been around for a number of years. And you've heard that Dr. Indman was one of the first innovators with this technique many years ago - it has not, and I can emphatically say - not taken off in this country. Now it's beyond the conversation here for us to conjecture all the reasons why it hasn't taken off but they surely are complex, and there are a number of them. What's important is that since the technology hasn't taken off that it has not been made available as an alternative to most women in this country who have abnormal uterine bleeding. So the balloon technology itself because it's much less skill intensive and much easier to use now, opens up the ability to have an endometrial ablation in an office or practice that historically may not have offered that option because the physician for one reason or another was not comfortable with the hysteroscopic alternative."

Dr. Paul Indman: "And that's an advantage and a disadvantage. I have some real concerns because the technique is so simple to do that anyone can do it. It's essential to be sure that any woman considering it is an appropriate candidate, if there's anything precancerous, it absolutely should not be done. So you need a physician who is comfortable in ruling out anything precancerous. One of the greatest predictors of failure of an endometrial ablation is something called "adenomyosis." Adeno means glands, when the glands of the lining of the uterus invade the muscles it's called "adenomyosis." So you have trapped glands in the muscle, they make blood, that blood is trapped. That causes extreme pain, and when endometrial ablations fail that's generally why. So it's very important to be as sure as you can that there's not a lot of adenomyosis before doing an ablation because it simply isn't going to work. A woman's going to wind up with a hysterectomy very shortly thereafter so although technically these balloon procedures are simple to do, the evaluation requires great skill, and it should be done before a woman considers any treatment for abnormal bleeding."

Dr. Andrew Brill: "I would reiterate that someone who is skilled in the routine gynecologic care of women is comfortable with surgical techniques should be the one who performs endometrial ablations regardless of what kind of technology is used."

Roberta Speyer: "I'm going down to my doctor in Austin, Texas - we'll use this as an example - and I'll be having this problem. What should I expect - does anyone want to address this? Since we're trying to help women evaluate this technology, what should she expect to happen that will tell her things are going well, and what should be the indications that things aren't going well, as far as if someone that isn't qualified or some of the things you've said? How do I transfer that as a woman, to my own care?"

Dr. Paul Indman: "It's very difficult for a patient to evaluate a physician, I think there's certain
minimums. I think an evaluation of abnormal bleeding is the first step that I use is - which is a vaginal ultrasound. I feel strongly that the physician doing the initial evaluation should be doing the scan, if not - I would wonder why. I think you want to make sure your physician is very familiar with hysteroscopy. Until very recently, I would say that hysteroscopy should be done in an office setting always because it's very simple to do and inexpensive - it should not be uncomfortable. Very recently some insurance companies have not been reimbursing physicians for their supplies, saying, "Doc, you pay for all your supplies or not." As a result, we may have to bring simple office procedures into the hospital setting even though it will cost them thousands of dollars more, that's their choice. At any rate, I think you want a physician who's familiar in hysteroscopy and has done a lot of it. I think your physician should be able to discuss the advantages and disadvantages of all of the methods of treatment available. Hopefully, your physician has had some experience with them, even though the balloon is new enough to where it is unlikely anyone will have had much experience, and that they're familiar with other techniques of evaluating bleeding like hysteroscopy. The balloon is the simple method but there should also be other methods available in case that's not appropriate."

Roberta Speyer: "Do you agree with this, Dr. Brill?"

Dr. Andrew Brill: "I do, and I think it's possible through local inquiry and contacting women's groups in empowering ones self with the media and the web to find out locally what persons have experience treating patients with alternative therapies for abnormal uterine bleeding."

Roberta Speyer: "Also, I imagine that a woman should be aware if she's being told as you said, earlier in the interview - one choice, right up front, very early without any of these diagnostic tools - that's the number one reason you should then get a second opinion, is it?"

Dr. Andrew Brill: "I would rather put it this way, I think every woman should seek a physician who is going to include them in the process of decision. In order to be included in the process of decision one has to be presented with the options, the benefits, and the risks of each option. That person should be allowed to consider these in the context of their own life and their own desires, and come to her own decision as to what she wishes. This is the kind of process I think a patient should pursue in a physician's office."

Roberta Speyer: "That's very good information. I think with the empowerment of that information a woman could go in, evaluate the situation, evaluate her relationship with the physician, and decide if she's moving in the right direction. I really appreciate you both taking the time to share that with the women on OBGYN.net."

Dr. Andrew Brill: "Thank you."

Dr. Paul Indman: "Thank you."

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