

  
**LOS OLIVOS**  
**WOMEN'S MEDICAL GROUP**  
OBSTETRICS – GYNECOLOGY – INFERTILITY

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### Hysteroscopic Endometrial Ablation and/or Myomectomy

A normal menstrual flow usually lasts 4 to 7 days and averages 4 to 6 pads per day. Some women have extremely heavy or prolonged menses that may last longer than one week or necessitate using more than one pad or tampon per hour. Attempts to determine the etiology of the bleeding may include hormonal tests, ultrasound and/or endometrial biopsy. Nonsurgical treatment may include hormonal manipulation. If this does not control the bleeding, surgery is often the only alternative. An endometrial ablation is a technique that can be used as an alternative to hysterectomy for heavy bleeding. It is an option only for women who have completed their childbearing.

Endometrial ablations have been performed since 1981. The procedure results in a decrease in menstrual flow during the normal menstrual cycle. Approximately 50% of women have complete cessation of menses. The procedure is performed as an outpatient procedure and therefore avoids hospitalization. Because it is an outpatient procedure with no incisions, recovery is much shorter than with a hysterectomy.

The technique involves cauterizing the uterus with an electric cautery ball called a “rollerball” or a wire loop to resect the endometrium. A thermal balloon may be used as an alternative. If small fibroids exist they can also be removed using a heated wire loop. This is called a hysteroscopic myomectomy. The procedure is very similar to the uterine ablation because it utilizes the same equipment. The myomectomy can be performed without the ablation to remove only the fibroids and maintain fertility.

Prior to the cauterization the lining of the uterus must be thinned. This can be preformed using medications such as Lupron, birth control pills or with a D & C (dilation and curettage) at the time of the procedure.

Preoperatively, your surgeon may recommend a laminaria or misoprostel tablets to prepare your cervix for the procedure. A laminaria is a dehydrated seaweed stick about 2 inches in length that is placed into the cervix to cause a gradual and non-traumatic dilation of the cervix as the seaweed rehydrates and expands. Misoprostel tablets are placed by the patient into the vagina as deep as possible at least 4 hours prior to the procedure. The tablets cause the cervix to dilate atraumatically. Both procedures for cervical dilation may cause uterine cramping similar to menstrual cramps. Ibuprofen can help relieve the cramps.

Following the surgery, patients may notice a brownish to whitish discharge that may last up to one month. Bleeding like a light period may also occur just after the procedure. If a myomectomy was performed small white “chips” of the fibroid may also be expelled vaginally after the procedure.

In the majority of patients there is either a reduction or cessation of menstrual flow. The procedure does not change your ovarian function or hormonal status, only the amount of menstrual flow. It may take up to 18 months to determine exactly what the final results of treatment will be. Approximately 10 percent of women will have irregular, frequent spotting episodes. This can be treated with a repeat rollerball procedure. Some women who undergo this procedure have no improvement in their menstrual flow and

may desire hysterectomy. Bleeding frequency (long menses or a short menstrual cycle) is usually hormonally dependent and will not change with a uterine ablation. Adenomyosis (endometrial glands within the uterine muscle or myometrium) or uterine fibroids within the myometrium or outside of the uterus may also be the cause of the abnormal bleeding. These conditions will not usually improve with a uterine ablation.

Complications with this procedure are rare. The risks associated with any surgery include but are not limited to the risk of an anesthetic, infection, or bleeding. Most patients are healthy and with modern anesthesia equipment and monitoring, complications of anesthesia are rare. The risks of post-operative hemorrhage are less than 5% but may require additional surgery. Infection rates are less than 5%. Since there is a large volume of fluid instilled into the uterus during the procedure, there is the possibility that excess fluid absorption can cause an alteration in blood electrolytes or trouble breathing. If this occurs, it usually corrects itself fairly rapidly. Finally, although rare, there is a risk of puncturing the uterus with the hysteroscope. If the uterine perforation is not recognized at the time of surgery and the surgery is continued, injury to the bowels or other intraabdominal organs may cause complications which may require additional surgery.

After your surgery, you may be groggy or weak from the anesthetic. These effects wear off at different times for different people. You should be able to drive and do most activities within a day or two. If there was a problem during your surgery, you may be hospitalized.

To prevent infection after the procedure, you should not have intercourse, use tampons, or douche for at least a week. You can shower, bathe, or swim as soon as you feel like it. Fever, pain in the abdomen, heavy bleeding or a foul-smelling discharge should be reported to your doctor. A follow-up appointment should be scheduled one to two weeks after your surgery.

This procedure has been used successfully in many women over the last twenty years. It appears to be a safe and viable alternative of hysterectomy for women seeking to reduce or stop menstrual flow.