

Endometrial Ablation- Preop Counseling/Evaluation

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Patient Selection

- Only for patients who have been sterilized or plan to be sterilized before the procedure
- Should never be used for bleeding after menopause
 - Risk of masking undiagnosed cancer
- Gives better results when used for heavy, regular menses but may still be effective for irregular bleeding
- Should consider methods other than ablation when a patient wants guarantee that she will have complete end of menses
 - still, complete elimination of menses may be achieved in 40-90% of patients using ablation
- Never do when
 - Pregnant
 - Wanting to have more children
 - There is any suspicion of endometrial cancer or *hyperplasia*
 - a type of abnormal growth that may lead to cancer
 - There is an active pelvic infection
 - There is an IUD in place
- Do with caution in any women with

- Prior surgery on her uterus
- Large or misshaped uterine cavity
 - Hot water ablation best option
- Presence of fibroids within the uterine cavity
 - Risk of severe pain after procedure
- Prior C-section (may often still qualify)
- Suspected adenomyosis
 - endometrial tissue growth within the uterine wall
 - Risk of severe pain after the procedure
 - Has less chance of success
 - Hysterectomy is a better option

Pre-procedure Evaluation

- Endometrial biopsy is required before the procedure
 - Simple & done in the office
- Evaluate uterine cavity
 - With either ultrasound or hysteroscope
- Confirm there are no physical indications against the procedure
- Thorough discussion of risks, benefits and alternative treatments
- Confirm permanent birth control is in place and effective
 - Tubal ligation or Essure

Alternatives to Ablation

- Birth control pills
 - Requires taking a pill daily until menopause
 - Three months of use may be needed for control of bleeding
 - Should not be used in women who
 - are over 35 years old and smoke
 - have uncontrolled high blood pressure
 - have a history of breast cancer
 - have had either a stroke or a heart attack
 - Provides extra benefit, after 5 years of use, of decreasing ovarian cancer risk by 50%
- Depo-Provera
 - Shot given every 3 months until menopause
 - 2/3's of women will have either irregular or monthly bleeding for first eight months
 - Can be associated with weight gain
 - Excellent birth control
- Mirena IUD
 - Simple to place, safe and often highly effective
 - Needs to be replaced every 5 years until menopause

- Provides excellent birth control
- Hysterectomy
 - Major surgery although now done, in most, without a large incision and with rapid return to normal activity
 - Allows removal of fallopian tubes during surgery
 - reduces ovarian cancer risk
 - Only method that can guarantee permanent end of menses
 - Does not require removal of ovaries so does not require hormone replacement after surgery

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