MAVEN CENTRE
ADVANCED GYNAECOLOGY & WOMEN'S HEALTH

Suite 5.3, Level 5,
Sunshine Private Hospital
145 Furlong Road, St Albans VIC 3021

P 03 9958 5636 F 03 9958 5635 E reception@mavencentre.com.au W mavencentre.com.au

Endometrial ablation: patient information

If your periods are too heavy, medications aren't working, and menopause seems too far away, endometrial ablation may be a good option for you.

What is endometrial ablation?

Endometrial ablation is a surgical procedure that burns the lining of the uterus (which is called the 'endometrium'). The endometrium is what thickens and sheds every month, when a woman has a period. Burning it attempts to halt this monthly thickening and shedding of the uterine lining.

What can I expect on the day of my endometrial ablation?

As endometrial ablation is performed under a general anaesthetic, you will need to fast for at least six hours prior to your planned procedure. This means you cannot eat, smoke, vape, or use chewing gum for six hours prior. You can slip clear fluids (such as water up until two hours prior to your procedure).

You will be asked to perform a urinary pregnancy test when you are admitted.

When you arrive at the hospital, a nurse will go through a survey to admit you to hospital. You may need to wait around for a little while after this, so best bring something to entertain you while you wait, such as a book.

Your procedure will only take about 20 minutes.

Reasons to consider endometrial ablation

<u>Heavy menstrual bleeding</u>

The main reason for considering an endometrial ablation is if your periods are too heavy. Essentially, if you think that your periods are too heavy, they are!

In most cases, medications are trialled initially, to try to lighten your periods. If they don't work well enough, an endometrial ablation may be a good next option for you.

<u>Completed your family</u>

While it is still possible to fall pregnant after having an endometrial ablation, it can be extremely dangerous for the developing fetus (as it can cause significant fetal abnormalities). There is also an

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increased risk of miscarriage and ectopic pregnancy (when the embryo grows in the Fallopian tube, rather than the uterus), both of which can be dangerous for you.

Therefore, endometrial ablation should only ever be considered if you have completed your family: you should not have an endometrial ablation if there is a chance that you may want to have more children. Hence, it's important that you have reliable contraception going forwards, which may include:

- A Mirena IUD, which can be inserted at the same time as your endometrial ablation
- Having your Fallopian tubes 'tied' (or removed) using keyhole surgery, which can be performed at the same time as your endometrial ablation, through holes in your tummy
- Or vasectomy of your male partner, if relevant

Painful periods / pelvic pain

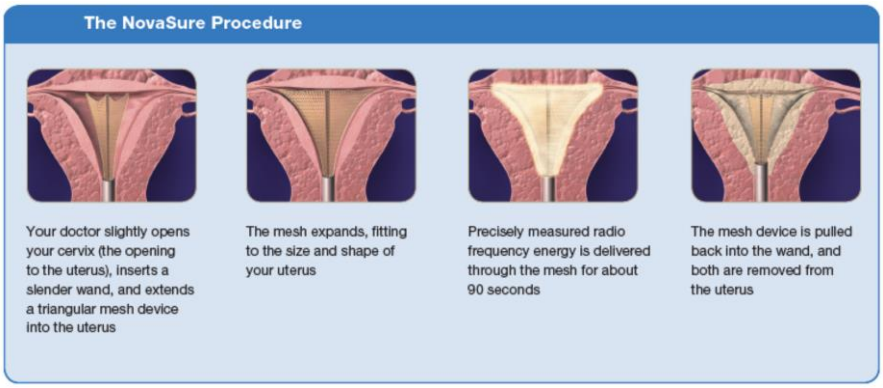
It's important to note that endometrial ablation is NOT a treatment for painful periods or pelvic pain: it is primarily a treatment for heavy (rather than painful) periods.

Different endometrial ablation methods

Endometrial ablation is performed in an operating theatre under general anaesthetic, so you won't feel or remember anything. Your gynaecologist will start by performing a 'hysteroscopy', which means using a very narrow video camera to go through the vagina and cervix, and look at the inside lining of the uterus. If a biopsy (or sample) of the uterine lining hasn't recently been taken, your doctor will do so: this is called a 'dilatation and curettage'.

There are several methods which can be used to perform an endometrial ablation, including:

'Novasure' endometrial ablation



A small metallic fan is opened inside your uterus, so that it presses against the uterine lining. An electric current is run through the fan, which burns the uterine lining.

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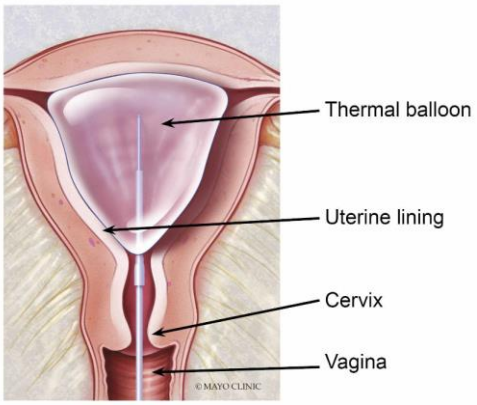
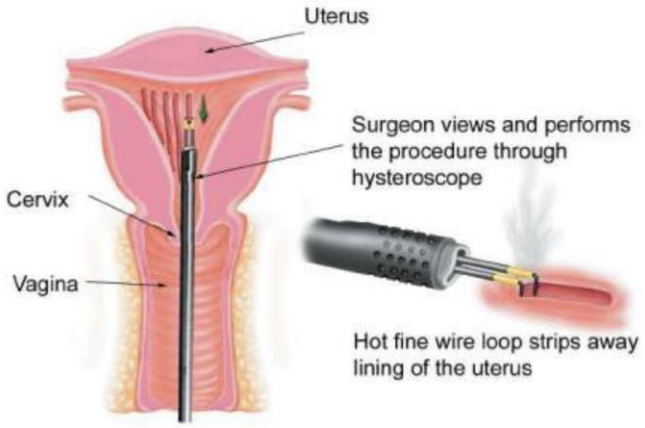
'Thermablate' or 'Cavaterm' endometrial ablation



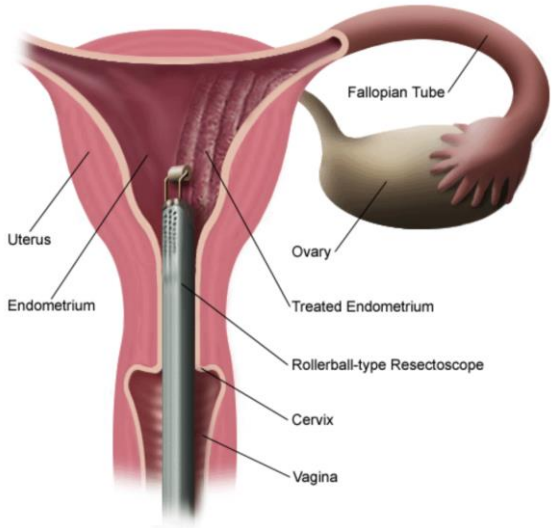
A sterile balloon is inserted into the uterine cavity, then distended with hot sterile liquid. The balloon conforms to the shape of the uterine cavity, and the heat from the liquid burns the uterine lining.

Endometrial resection



Under video guidance, a stiff wire loop with an electrical current running through it is used to shave off strips of the uterine lining, rather like scooping ice-cream.

Rollerball endometrial ablation



Under video guidance, a rollerball with an electrical current running through it is used to burn the uterine lining.

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Broadly speaking, the above methods are equally likely to be effective.

Your gynaecologist will decide upon an endometrial ablation method for you based upon:

- Their expertise with each option
- Which option is available at that particular hospital
- Whether or not you have any fibroids distorting the uterine cavity
- Medical considerations, such as your risk of bleeding

Endometrial ablation success rates

The aim of endometrial ablation is to lighten your period. How likely it is to achieve this depends on several factors, such as:

- Underlying cause of your heavy bleeding: endometrial ablation is less likely to be effective if you are thought (on ultrasound) to have 'adenomyosis'. This is because ablation doesn't treat the underlying problem.

- Your age: the younger you are, the more years of periods you have until you go through menopause. So endometrial ablation is less likely to be effective: you may want to proceed straight to a hysterectomy.

Generally speaking, the average outcomes after an endometrial ablation are:

- No periods at all (called 'amenorrhoea'), which occurs in 40% of women
- Very light periods / spotting (40% of women)
- Lighter periods (10% of women)
- Ongoing heavy periods (10% of women)

Possible complications of endometrial ablation

Generally, having a hysteroscopy and endometrial ablation performed is extraordinarily safe. Possible complications include:

- Uterine perforation, when one of our surgical instruments accidentally goes through the uterine wall (approximately 1 in 200 chance). If this happens, we realise it, and may suggest that you stay in hospital overnight for antibiotics through a drip. Very rarely (less than 1 in 500 cases) we may be worried about internal organ damage, so would proceed (while you're still asleep) to keyhole surgery through your belly button, to make sure no serious injuries have occurred

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- Heavier bleeding, which may be managed using medications, a 'catheter' (small balloon inserted into the uterus to apply pressure for a few hours), or (very rarely) a blood transfusion

Endometrial ablation frequently asked questions (FAQs)

Can I have an endometrial ablation if I've had a Caesarean section previously?

Yes, you can, if your Caesarean was a standard operation, with a horizontal scar on the uterus. If you had a so-called 'classical Caesarean' (where the uterine scar is vertical, which is only very rarely performed), it's fine to have an endometrial ablation using the resection or rollerball methods, but not Novasure, Thermablate, or Cavaterm.

Does it matter where I am in my cycle, when my endometrial ablation is performed?

The Novasure or resection techniques can be performed at any time in your menstrual cycle. The Thermablate, Cavaterm, or rollerball techniques work best if performed just after your period has finished, when the uterine lining is thin.

What if endometrial ablation doesn't work?

As noted above, approximately 10% of women continue to have ongoing heavy periods after an endometrial ablation. Options at this point include medications or hysterectomy.
Hysterectomy is the only 'cure' for heavy periods, in that it is the only option that is guaranteed to lead to no monthly periods at all.

Will having an endometrial ablation put me into early menopause?

No: endometrial ablation does not affect the ovaries, nor cause any hormonal changes. You will go through menopause whenever you were going to, endometrial ablation aside.

What can I expect after an endometrial ablation?

In the week after your endometrial ablation

You can eat and drink as soon as you wake up from your general anaesthetic. Most women can go home without 2 – 4 hours of a general anaesthetic. You need to have a responsible adult pick you up from hospital, as you may still feel a little drowsy from the general anaesthetic.
You may experience some pelvic cramping (like period pain) and light vaginal bleeding. It can help to take simple pain relief, like paracetamol and ibuprofen. Pelvic cramps should improve over the next few days.

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It's normal to have vaginal bleeding for up to a week after your endometrial ablation. It is normal for such bleeding to be heavier than your usual period, and it may stop and start. Use sanitary pads rather than tampons until your next period, to reduce the risk of infection.

If your pain gets worse and / or your bleeding heavier day-by-day, please contact Maven Centre and ask to be reviewed. If you are really concerned after hours, please attend your local Emergency Department.

You should be able to return to light activities on the same day as your procedure, and all of your usual dailiy activities within a day or two.

You can have sex as soon as the bleeding and discharge have stopped, or after 4 weeks. Studies have shown that sexual function actually improves after an endometrial ablation, presumably because heavy bleeding is less of an issue.

<u>In the months after your endometrial ablation</u>

There may be a red-brown discharge for up to 6 weeks following an ablation. It can take up to six months for your periods to settle, after having an endometrial ablation. This is because the scarring of the uterine lining must form and stabilise.

A minority of women find that they continue to experience monthly pelvic cramps, with or without vaginal bleeding. If this occurs, please let your gynaecologist know: an ultrasound should be arranged, to investigate the possible cause.

When to seek medical advice

Please contact your Maven Centre gynaecologist if you notice any of the following:

- Persistent vaginal bleeding that is bright red and / or getting heavier each day
- Passing large blood clots
- A temperature at or above 38°C
- Worsening nausea and / or vomiting
- Severe pelvic pain
- An abnormally smelly vaginal discharge

If you think it is an emergency, and it can't wait until you can see your GP or Maven Centre gynaecologist, please attend your local Emergency Department.

This pamphlet is a general overview of surgical termination, and may not apply to everyone. If you have any further questions, please speak to your gynaecologist.