ENDOMETRIAL ABLATION INFORMATION & CONSENT

We recommend that you read this handout carefully to prepare yourself or family members for the proposed procedure. A proper understanding of the procedure, its preparation, and post-procedure expectations and care can improve your safety and outcome. We strongly encourage you to contact your Care Center prior to your procedure if you still have any questions or concerns.

Definition

Endometrial: Pertaining to the tissue layer that forms the inner lining (endometrium) of the uterine (womb) wall.

Ablation: Removal of a body part or the destruction of its function, as by a surgery, disease, or noxious substance.

Hystero: Of or denoting the uterus (womb)

Scopy: Examination with an instrument for improved viewing, often with magnification and directed lighting.

Heavy or irregular vaginal bleeding is a common problem for women in their reproductive years. The menstrual cycle is designed to prepare a healthy endometrial lining for a fertilized egg to grow in. Once a month, if a woman does not become pregnant, the old lining is shed through the cervical canal with the menstrual period and replaced with a new lining in preparation for pregnancy. This cycle is repeated throughout a woman's lifetime until her ovaries no longer make enough of the hormones needed to continue a regular, monthly cycle. Alterations in this cycle and irregularities of the lining of the uterus (such as polyps or fibroids) can lead to episodes of vaginal bleeding that are unpredictable, heavy, or cause significant discomfort.

Irregular uterine bleeding during your reproductive years is rarely due to uterine cancer. Uterine cancer is more common in older women and women with high levels of estrogen. It is, however, important that the cause of bleeding be investigated and treated. Cancers of the uterus can be cured when discovered early in their development.

There are several tests your doctor may perform to investigate the cause of your abnormal uterine bleeding prior to initiating treatment. It is often necessary to sample the endometrium (with an endometrial biopsy or D&C) to look for concerning overgrowth (hyperplasia) and malignancies (cancer) of the lining. Visualization of the contour and any irregularities of the uterine lining can be accomplished with ultrasound, MRI, or direct visualization using a hysteroscope.

After successfully excluding irregularities of the uterine lining, your doctor may recommend medical treatment. Treatment of heavy uterine bleeding commonly involves the combinations of hormone therapy (estrogen and/or progesterone), anti-inflammatory medications, a hormone-containing IUD (intra-uterine device), or a medication that works with your body's clotting system. This approach is usually very effective, but when medical treatment fails, the next step typically involves surgery.

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Surgical treatment of heavy or excessive uterine bleeding includes dilation and curettage, endometrial ablation and hysterectomy:

- Dilation and curettage can be a useful procedure to treat sudden heavy bleeding that has resulted in severe anemia, but doesn't offer long-term improvement for most women.
- Approximately 600,000 hysterectomies are performed each year in the United States. Almost half of these are done for abnormal or heavy menstrual bleeding.
- For women who wish to preserve their uterus, who wish to avoid major surgery, or are at increased surgical risk (from other conditions), but who are finished with childbearing, treatment may be performed by endometrial ablation.

Endometrial ablation, the destruction of the lining of the uterus, is an alternative to hysterectomy for many women with heavy uterine bleeding who do not respond to medical management. This is a procedure that has traditionally been performed in the outpatient (same-day) surgery center. Most women have a rapid recovery with little discomfort and return to normal activity by the following day. Women who wish to preserve fertility or who have significant menstrual pain are not candidates for endometrial ablation and should consider alternative treatments.

Most women are pleased with the results of their procedure, though only some will have a complete absence of uterine bleeding after ablation. The success of endometrial ablation varies depending on the method of ablation and the presence of irregularities of the uterine contour, such as uterine fibroids.

Preparation

As with all procedures where general anesthesia is administered, you will be asked not to eat or drink anything after a certain time on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken, you will discuss this with your provider and/or the anesthesiologist at your pre-operative visit and instructions will be given to you. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit. The procedure may not be performed if you are currently taking or have recently taken any medication that may interfere with your ability to clot blood (blood thinners, aspirin, anti-inflammatory medicines, etc.). The most common of these medications is aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter).

Procedure

Endometrial ablation is an outpatient procedure that takes between 20-40 minutes to complete..

You will be lying on your back with your knees bent and heels in stirrups as you would for a pelvic examination. A pelvic examination to find out the location of your cervical opening and the size and shape or your uterus will be done by your doctor.

Next, a speculum will be placed in the vagina to hold it open and an antimicrobial soap will be used to clean the vagina and cervix. Again, depending on the method of anesthesia, an injection of numbing medicine into the cervix may be given at this point. The cervix is lightly grasped with an instrument to hold it still while the opening is gradually dilated with surgical instruments until the hysteroscope or ablation probe can be inserted without force.

Hysteroscopy (visualization of the endometrial cavity) is often performed prior to ablation. This involves inflating the cavity of the uterus with a liquid so that each surface can be seen. Miniaturized instruments

can then be placed alongside the hysteroscope to correct any abnormalities of the shape of the cavity. These specialized instruments can be used to remove polyps or fibroids of the lining before the ablation.

Destruction or ablation of the lining can be accomplished by a variety of methods: heating, freezing, and electrical energy. The method used will vary depending on your circumstances, anatomy, and what is available for your doctor's use.

Post Procedure

Recovery from endometrial ablation is rapid and most women will go home within one or two hours of the procedure. Though you may have some discomfort and cramping following the procedure, it is not necessary for you to plan time off from work or your normal activities beyond the day of surgery. It is normal to have some bleeding and discharge following endometrial ablation. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching, and tampon use until told you may resume by your doctor.

Medications such as ibuprofen or naproxen are usually all that is needed for the cramping you might have after your surgery.

Expectations of Outcome

Endometrial ablation is an alternative to hysterectomy for women with heavy or abnormal uterine bleeding. Most women are pleased with the results of their procedure, though only some will have a complete absence of uterine bleeding after ablation. The success of endometrial ablation varies depending on the method of ablation, the presence of irregularities of the uterine contour, and the goals of the treatment. Following endometrial ablation:

- 90% of women will be pleased with the results.
- Between 25% and 40% of women will have complete absence of uterine bleeding.
- 80% of women will have decreased uterine bleeding.

Possible Complications

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or quite delayed in presentation. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- *Perforation of the uterus*: The most serious complication of the procedure is the creation of a perforation or hole in the wall of the uterus. Perforation of the uterus may lead to injury of other structures and organs within the abdomen (blood vessels, nerves, intestines, and bladder), bleeding, or infection. Perforation is not common but may require another operation to be treated appropriately.
- *Infection*: Endometrial ablation involves placing an instrument through the vagina and cervix into the uterus. Because of this, it is possible to introduce a microorganism (such as bacteria or yeast) from the vagina into the uterine cavity. Microorganisms are normally present in the vagina and cause no infection or other symptoms. However, a serious infection can happen if these same microorganisms are present within the cavity of the uterus. Signs of infection that you should be mindful of are: foul-smelling vaginal discharge, tenderness or pain in the vagina and pelvis for more than two days, bleeding lasting more than 10 days, fevers, shaking chills, nausea, vomiting, weakness, and feeling ill.

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- *Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE)*: In any operation (especially longer operations), you can develop a clot in the vein of the leg (DVT). Typically, this presents 2-7 days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can also become swollen. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.
- *Bleeding/Discharge*: Most women will have watery or bloody discharge for several weeks following the ablation. If you develop a foul smelling or greenish vaginal discharge, please contact your doctor.
- *Hematometrium*: Blood may collect in the uterine cavity if scarring from the procedure prevents its exit. This may lead to cyclic abdominal pain.
- *Injury to Abdominal Organs*: There is a small risk of internal injury, particularly to the bowel, with endometrial ablation. This risk is reduced through careful surgical techniques and safety systems built into ablation devices.
- *Pregnancy*: Although the chance of pregnancy is reduced following endometrial ablation, it is possible to become pregnant. Pregnancy following endometrial ablation is very dangerous to both you and the fetus. You should not have an endometrial ablation if you plan to become pregnant in the future and should use some form of birth control after endometrial ablation.
- *Detection of Malignancy*: Another rare risk of any endometrial ablation procedure is that it may decrease your doctor's ability to make an early diagnosis of cancer of the endometrium. The reason for this is that one of the warning signs of endometrial cancer is bleeding, and endometrial ablation decreases or eliminates bleeding.
- *Treatment Failure*: While endometrial ablation has been shown to be effective, it will not always "cure" abnormal or heavy uterine bleeding. 1 out of 10 women who have an endometrial ablation will be dissatisfied with their results.
- *Fluid Imbalance*: In addition to water, fluids used to inflate the cavity of the uterus for hysteroscopy contain dissolved sugars, starches, and salts. These substances give the fluids certain desirable properties for visualization of the uterine cavity. When too much fluid flows from the uterus and enters the abdominal cavity or blood stream, an imbalance in the water content of the blood may result. Careful choice of fluid and monitoring of fluid delivery make this an uncommon complication.
- *Lower Extremity Weakness/Numbness*: This is possible following procedures where the patient is in the lithotomy (legs up in the air) position on the operating table for a long period. This is a rare event and is usually self-limited, with a return to baseline expected.
- *Chronic Pain*: As with any procedure, a patient can develop chronic pain in an area that has undergone treatment. The pain typically disappears over time, though some feeling of numbness or pain may persist. If persistent, further evaluation may be necessary.

Patient Initials _____

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Patient Name Date

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Patient/Health Care Agent/Guardian/Relative Signature

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Physician Signature

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Witness Signature

Patient Initials _____