University Hospitals of Derby and Burton NHS Foundation Trust

Outpatient Endometrial Ablation Treatment - Full Clinical Guideline

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1. Introduction

Endometrial ablation is a procedure that destroys the uterine lining (endometrium). The destruction is achieved through various methods, the most commonly used being high temperature fluid within a balloon (Thermablate EAS) or application of bipolar radiofrequency electrical energy (Novasure). These procedures are safer, technically easier to perform, involve shorter hospital stays, and can be performed under local anaesthetic in an outpatient setting.

Endometrial ablation is an alternative surgical treatment for heavy menstrual bleeding when medical treatments fail to provide adequate relief.

Endometrial ablation is a minimally invasive surgical alternative to traditional hysterectomy and should be offered to suitable women suffering from incapacitating heavy periods to allow reduction in menstrual loss and improve their quality of life.

2. Purpose and Outcomes

The purpose of this guideline is to allow appropriate patient selection for outpatient endometrial ablation to treat heavy menstrual bleeding.

3. Abbreviations

EAS	-	Endometrial Ablation System
OPH	-	Out Patient Hysteroscopy
PO	-	Per Oral
SC	-	Subcutaneous
TVS	-	Transvaginal Scan
UCL	-	Uterine Cavity Length

4. Patient Assessment and Selection

- History of heavy menstrual bleeding not responding to medical treatment/ significantly affecting patient's quality of life.

- Has had a normal transvaginal ultrasound (TVS) with no suspicion of submucous fibroid or abnormal cavity shape. If in doubt, or no scan done, then consider initial diagnostic OPH to assess the shape of endometrial cavity before considering ablation treatment.

- To perform pipelle endometrial biopsy to rule out endometrial hyperplasia. Please note and document following when taking a pipelle endometrial biopsy in clinic:
  - Pain tolerance
  - Ease or difficulty of cervical cannulation
  - Uterine position (eg. Acutely retroverted)
  - Uterocervical length (in CM)

- Outpatient Hysteroscopy if indicated: This is especially important if history of irregular periods with intermenstrual bleeding or TVS suggestive of any possible intracavitary lesion.

- Patient should have completed child- bearing and should be made aware of need for effective ongoing contraception after ablation treatment. Pregnancy may still occur and if so, could have serious complications.

5. Patient Eligibility

- Normal endometrial biopsy within past 6 months (to exclude hyperplasia)
- Normal size and shape of uterine cavity (UCL 8-12cm for Thermablate EAS)
- Normal cervical smears (high grade abnormality excluded)
- Easy pipelle biopsy, well tolerated by patient
- Easy outpatient hysteroscopy, well tolerated by patient (if patient has had one done)
- Patient has given informed consent for outpatient endometrial ablation

6. Check List for Clinician Booking Outpatient Endometrial Ablation

- Consent patient (either use the consent form used for OPH or use general consent form and but tick "local anaesthesia".
- Provide patient with the leaflets for Outpatient Endometrial Ablation and Outpatient Hysteroscopy (these should be available at the reception desk)
- Discuss contraception is needed after endometrial ablation and document method chosen.
- Complete the OPH referral form highlighting "For Outpatient Endometrial Ablation"
- Prescribe pre-treatment analgesia as per the protocol below.

7. Pre-Treatment Analgesia Protocol (please note site specific):
RDH site:

1) **Ibuprofen Modified Release*** 800mg PO at 7 am (patient to self-administer)
2) **Paracetamol** 1gm PO at 7 am (patient to self-administer)
   If patient allergic to Ibuprofen (or contraindicated):
   - patient >65kg, another 1 gm Paracetamol PO at 9am or on arrival
   - patient <65kg, another 500mg Paracetamol at 9am or on arrival
3) **Tramadol** 100mg stat 30 minutes before procedure (given by the nurse on arrival)

Additional options:
- **Ondansetron** 4mg PO 30 minutes before procedure (given by the nurse on arrival)
- **Diazepam** 5mg/ 10mg (discretionary on arrival depending on patient's anxiety)

QHB and SRP Tamworth sites:

- **Paracetamol** 1gm PO 1 hour prior to procedure (patient to take)
- **Diclofenac** 50-100mg PR, 1 hour prior to procedure
- **Oromorph** 5mg PO, 1 hour prior to procedure
- **Diazepam** 5-10mg (optional)

8. Post-Treatment

- Observe in recovery as necessary before discharging the patient.
- Opioid analgesia if required (Oromorph / sc Morphine)
- Recommend that patient should preferably not drive following procedure (If this is not avoidable, she should stay bit longer in the recovery (up to an hour)
- Patient advised to keep stock of Paracetamol and/or Ibuprofen at home for analgesia for 1-2 days post operatively
- Give patient satisfaction questionnaire to fill (prospective audit)
- Follow-up in 4 months in gynaecology clinic (not offered routinely)

9. Monitoring Compliance and Effectiveness

As per agreed audit forward programme

10. References

Endometrial Ablation: Patient Information Royal College of Obstetricians & Gynaecologists 2015

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Patient Information

Outpatient endometrial ablation (Thermablate/ Novasure) under local anaesthetic

Endometrial ablation is a minimally invasive technique for the removal or destruction of the inner lining of the womb in order to treat heavy periods. It is approved by the National Institute of Clinical Excellence (NICE) as a preferred surgical alternative to hysterectomy for treating heavy periods in women with a normal (or slightly enlarged) womb.

This leaflet gives information about the procedure, what are the alternatives, advice for when you go home afterwards and contact numbers for any queries.

How does it work?

Periods are due to the shedding of the womb lining each month. The aim of endometrial ablation is to permanently remove the womb lining and seal the underlying blood vessels, therefore making the periods significantly lighter (in about 50% of cases) or even stop completely (in about 30% of cases).

Endometrial ablation is an effective alternative to hysterectomy for the treatment of heavy periods in women who wish to keep their uterus or avoid major surgery.

How is it done?

Endometrial ablation can be done with local anaesthetic in an outpatient clinic. With the development of newer ablation devices (with actual treatment time of 90 - 150 seconds), most hospitals including UHDB, offer this procedure in an outpatient setting without need for a general anaesthetic, which means recovery following the procedure is much quicker. There are various ways to perform this procedure.

At UHDB, we offer two methods namely balloon endometrial ablation (Thermablate) and radiofrequency ablation (Novasure). Your doctor will help you decide if the Thermablate/ Novasure procedure is right for you.

Thermablate is a balloon thermal ablation device with soft flexible thin catheter (6mm in diameter) that has a silicone balloon at the tip. This balloon catheter is passed into the uterus through the neck of the womb (cervix). The balloon expands to fit the size and shape of the uterine cavity during the treatment cycle. The other end of the catheter is connected to an automated treatment control unit, which

circulates very hot glycerine based fluid (173ºC) through the balloon to treat the lining of the uterus. When the treatment is complete, the balloon catheter is withdrawn and discarded. The procedure including preoperative local anaesthetic takes around 10 minutes to perform, although the actual ablation treatment cycle takes just under 2 minutes 30 seconds.

You will have a camera test (hysteroscopy) before and after the endometrial ablation procedure. This is to check the cavity and its direction allowing accurate placement of the balloon catheter and subsequent re-look to check the immediate effect of ablation on the uterine lining after completion of the treatment cycle. This ensures the treatment is safely performed.

Novasure is an alternative device for endometrial ablation and can also be done as an outpatient procedure while you are awake. It uses radiofrequency energy instead of thermal energy used in balloon ablation treatment.

Novasure is performed using a slender wand that is inserted into the womb after opening the neck of the womb (cervix). This wand opens into a triangular- shaped netted device into the uterus that is adjusted to fit to the size and shape of your womb. Then, precisely measured radiofrequency energy is delivered through the netting for about 90 seconds.
Post treatment, the netted device is pulled back into the wand and both are removed from the uterus. Camera test (hysteroscopy) before and after treatment is performed similar to that with balloon ablation treatment.

Preparing for the procedure

You must continue to eat and drink as normal before the procedure. **In fact we recommend you have a good breakfast before coming to hospital.**

You will be asked to get changed into a gown and will be supported by a healthcare assistant throughout the procedure.

About 1½ - 2 hours before the procedure you are advised to take the painkillers (ibuprofen modified release 800 mg tablet and paracetamol tablet 1gm) which you should have already been prescribed.

About 30 minutes before the procedure, a nurse will give you oral tramadol 50-100mg with/ without an anti-sickness tablet.

You will be asked to provide a urine sample for checking a pregnancy test.

What will I feel during the procedure?

The whole procedure will be performed while you are awake and conscious.

During the procedure, your doctor will use a local anaesthetic injection to numb the cervix. You will also be offered ‘gas and air’ (Entonox - you may have used this form of pain relief in labour) as additional pain relief.

You are likely to experience bad period like cramping and/or discomfort during the short treatment cycle. Rarely, this pain may be severe enough for the doctor to stop the treatment before completion; but most women tolerate this well with preoperative oral painkillers as mentioned above.

What will I feel after the procedure?

You may feel moderate cramping like period pains. The nurse may give you a morphine injection or other painkillers such as paracetamol or codeine to make you comfortable.

You will be advised to remain in the hospital for an hour to make sure you are not feeling sick or unwell. You will then be allowed home. You are advised to keep mild painkillers (paracetamol and ibuprofen) in stock at home to take over the next 24 - 48 hours.

You should arrange for someone to collect you from hospital, as we advise you not to drive yourself home. You can eat and drink as normal and take rest that day. We recommend you should consider taking a day off work following the procedure.

What can I expect after I go home?

Most women can return to work and family commitments by the next day.

It is usual to feel some pain after this procedure. Take painkillers such as paracetamol or ibuprofen - follow the doctor's/manufacturer's instructions and do not exceed the stated dose.

After the procedure there may be vaginal blood loss like a period for the next 7 - 10 days. Try to use sanitary towels rather than tampons during this time to minimise the risk of infection. This is usually followed by a watery dark bloody discharge for up to 4 weeks as most of the lining of the womb is replaced by inactive tissue.

It is advisable to avoid sexual intercourse/penetration until after your vaginal bleeding or discharge has settled.

What are the risks following the procedure?

Your doctor will explain the risks of all treatment options. Some of the risks associated with endometrial ablation treatment include bleeding, infection, perforation of the uterus, injury or thermal burn of internal organs within the abdomen or around the uterus such as bowel/ bladder leading to serious injury. These problems are very rare. If you are concerned about any of these risks, or have any further queries, please speak to your consultant.

You should call your GP or contact us on the numbers provided if you develop a fever, worsening pelvic pain that is not relieved by oral painkillers, nausea, vomiting, bowel and bladder problems.

Rarely you might develop cyclical or constant pelvic pain after an endometrial ablation which is due to scarring in the cervix and there is collection of blood in the uterus. This has been noted to be more in women who have had sterilisation.

What are the benefits of the procedure?

The overall success rate of this procedure is about 75%, so 7 out of 10 women are likely to have much lighter periods or no periods following treatment. Your periods

may stop completely but in some women, periods may continue, but lighter than before. A small number of women may have 1 or 2 heavy periods after the procedure before settling down to a lighter pattern. Every woman is different but it can take up to 3 months to fully heal on the inside before you and your doctor can tell the effect of endometrial ablation treatment on your periods.

The effect is believed to be permanent and it avoids the need to take medications on a long term basis and more importantly it can avoid the need for a hysterectomy in most women suffering from heavy debilitating periods. There is a small possibility that the lining of the womb may regrow to its former condition especially if the procedure is done in younger women (under 40 years of age). If this happens, a repeat procedure may be considered, while the opportunity to have a hysterectomy still remains.

What are the alternatives to outpatient endometrial ablation?

Thermablate or Novasure endometrial ablation can also be done as a day case procedure under general anaesthetic, if you prefer not to be awake during the procedure or if the doctor and/or you feel you will not be able to cope with the procedure in the outpatient setting. However, this will slow your recovery due to the after-effects of a general anaesthetic.

Some women with lots of fibroids, especially those in the cavity of the womb, may not be suitable for an ablation procedure. Your doctor may request further investigations to assess and discuss an alternative treatment such as a hysterectomy or myomectomy (removal of fibroids).

Women who are uncertain whether their family is complete are advised against any ablation procedure. Pregnancy after an endometrial ablation is likely to be dangerous for both fetus and mother. You are advised to continue using effective contraception or sterilisation following this procedure.

Do I continue to have regular cervical smears?

Yes as the cervix is not removed.

Hormone replacement therapy?

If you are having HRT before or after endometrial ablation, you should ensure that it still contains a progestogen component, so that you take a combined form of HRT.

If you have any queries, or require further information please contact

Gynaecology Outpatients - Royal Derby Hospital (between 8.30am and 5pm) on 01332 789217 or 01332 786525

Gynaecology Ward 209A – Royal Derby Hospital (out of hours enquiry) on 01332 785617 or 01332 785017

Gynaecology Outpatients – Queens Hospital Burton on 01283 566333 Ext: 5251 or 5093

Sir Robert Peel Day Case Unit Ambulatory Clinic on 01827 263804 Ext: 3804

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