Endometrial Ablation vs. Hysterectomy

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Dr. Mark Perloe: "I'm here with Dr. Tulandi from McGill University in Montreal, and we're going to talk about endometrial ablation versus hysterectomy."

Dr. Togas Tulandi: "The treatment of abnormal uterine bleeding could be medical treatment or surgical treatment. Most people who elect to have a surgical treatment do so because they want a long-lasting cure, but people who want endometrial ablation do so because they want to avoid major surgery. In selection of endometrial ablation, it is important to tell the patient that this is not to eliminate the bleeding but to decrease the bleeding - so patient selection is very important."

Dr. Mark Perloe: "What other factors point towards successful surgery?"

Dr. Togas Tulandi: "Number one is patient selection. Number two is the surgeon's expertise, if you're using a hysteroscopic technique."

Dr. Mark Perloe: "There are a lot of new techniques that are out there; we hear about microwave, cryoprobe ablations, balloon techniques, resection techniques, or hysteroscopic vaporization techniques. What are your thoughts and what's your take on this plethora of techniques? What should someone do to figure out which technique is best?"

Dr. Togas Tulandi: "Again, it depends on the surgeon's familiarity with the technique. If they know how to do a good hysteroscopic procedure, there's nothing wrong with that. The technique is more difficult; it depends on the expertise of the surgeon. The norm hysteroscopic technique is certainly easier. There are many techniques, as you mentioned; one of them is microwave endometrial ablation. There is a good randomized study conducted by David Park in Aberdeen, showing the technique is as good and your results are as good as resection. This is a good randomized study."

Dr. Mark Perloe: "In failures, the patients who come back afterwards who are not happy with the results, are they frequently candidates for another ablation technique, or do they often go on to hysterectomy, or is medical treatment considered again prior to another surgery?"

Dr. Togas Tulandi: "In general, they don't want to go back to medical treatment. Usually our patients have been treated medically, and that's why they chose surgical treatment. Now it depends, again, on the patients. Most of them will go through a hysterectomy, some of them will say, "okay, why don't you redo it" - and we have done two, three patients successfully."

Dr. Mark Perloe: "Have you seen any patients who've had pregnancies after this, and have they been successful? How have you managed that, or are patients generally too old?"

Dr. Togas Tulandi: "Luckily, I have never had any patient who got pregnant. But again, it is important that we tell..."
the patients before an endometrial ablation you should not get pregnant."

"Is adenomyosis a contraindication in your practice? Do you treat those patients differently or advise them differently when approaching ablation?"

"At the moment, no, it's not contraindicated in my practice. I have to admit that the failure rate is higher for women with adenomyosis. The problem is we don't know which comes first - adenomyosis or the endometrial ablation."

"What about insurance companies - do you see them mandating this? In our country, they quite often will mandate an ablation technique before moving on to hysterectomy, even when the ablation technique may not be the appropriate choice for that patient."

"In Canada, we have social medicine. We're lucky that it's dictated to us on what to do, so everything is based on medical decision or indication."

"Do you see new alternatives to management and dysfunctional bleeding coming up in the near future?"

"Like everything else, I think more and more medical treatment is being instituted. We have been using a lot of Cyklokapron in the past two or three years trying to decrease the amount of surgery but most of them still come back for another procedure."

"What sort of pre-treatment do you use before the ablation, and do you feel that that plays a role in the success of the operation?"

"I think most people will use GnRH analogue. Some people use danazol or birth control pills. My favorite is GnRH analogue, but five weeks before a procedure. Some other people will use suction curettage before endometrial ablation, especially microwave - apparently the results are the same."

"I have a colleague in St. Petersburg, Russia, who reported on 250 cases, and that's the technique they used. They did not have the analogue available, and they found that the suction was adequate preparation. We've used GnRH analogues in our practice, mostly, and have been very pleased with the results of that."

"One thing which is important and interesting is that Dr. McCausland from California has just published a paper - he called it "Partial Endometrial Ablation," and he leaves the posterior wall intact. He did not ablate the posterior wall. The purpose is so the patient can still bleed. Again, he will tell the patient this is not to eliminate the bleeding but to decrease the amount of bleeding. So basically, he wants to prevent intrauterine adhesions."

"Do you advise these patients any differently in the subsequent use of hormone replacement therapy and menopause?"

"I will still use estrogen and progesterone. I think it's important to use progesterone."

"Have you seen any malignancies in patients who've been treated with estrogen alone after ablation?"

"So far I have been lucky - I've never seen these patients, but we are very careful. We do an
endometrial biopsy in all patients before endometrial ablation. If there is hyperplasia, especially in typical cells, then we don't do it. So you might as well have resected."

"Thank you so much. I appreciate it"

"Thank you."

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