Endometrial ablation

Endometrial ablation is one of the surgical options for treatment of heavy menstrual periods. In the past, the only surgical treatment option for many women suffering from heavy, painful periods was removal of the uterus (hysterectomy). Endometrial ablation has been developed as an alternative to hysterectomy; it destroys or removes the lining of the uterus to prevent bleeding.

How does it work?

The uterus consists of three layers – an outer lining called the serosa, a middle muscular layer called the myometrium and an inner lining, the endometrium. Each month, hormonal changes cause the inner lining of the womb (endometrium) to thicken in readiness for implantation by a fertilised egg. If conception does not occur it breaks down, leading to menstrual bleeding. Since menstrual blood arises entirely due to shedding of this inner lining (endometrium), its destruction effectively halts or reduces blood loss during menstruation.

Types of endometrial ablation

A range of different methods may be used to destroy the uterine lining. The first generation methods included laser energy and a heated cutting wire to remove the uterine lining: these are no longer used very often. Newer methods have now been developed using radio waves, electricity and heated water. These are called newer generation techniques.

Second generation methods are usually automatic and use heat energy delivered to the uterine lining based on the shape and size of the cavity. With second generation, depending on the method, an instrument is passed into the uterus but this does not have a camera attached. Often with these methods, a hysteroscopy is performed just before the actual ablation procedure. Hysteroscopy is a procedure where a telescope with a camera is inserted into the uterine cavity through the vagina and cervix, this allows the surgeon to have a look and ensure that it is safe to perform the ablation. Using second generation techniques, the procedure may be performed in outpatients under local anaesthetic and most patients are discharged home after a few hours.

If there are large submucosal fibroids in the womb (see the WHC Fact Sheet on Fibroids), then they may need to be removed prior to the ablation by a separate procedure.

After the procedure

Recovery is normally quick, with a return to normal activities within a few days. You may experience some cramping pain in the pelvic region for several hours after the procedure and this may continue to occur for the next 2-3 days. Light blood loss normally occurs for several days, followed by a watery discharge for two or three weeks.

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There is a small risk of infection resulting in pelvic pain, an offensive discharge or vaginal irritation which develops and worsens after a few days. If this occurs, you should see your hospital doctor for assessment and treatment.

Outcome and side effects

About 10% of patients who undergo endometrial ablation stop menstruation altogether. In a further 70%, bleeding is effectively reduced. Many women who have painful periods also report significant improvement.

It may take between 8 to 12 months to be certain of the effects of endometrial ablation. The effects are believed to be permanent, but in some women, especially those under the age of 40 years, menstruation may return. If this happens, depending on the severity of your symptoms, a second procedure may be considered or you may be advised of other alternative treatments, including hysterectomy.

Overall, 70% to 80% of women are satisfied with the operation. Complications can sometimes occur, but serious complications such as fluid overload, perforation of the uterus, heat damage to other internal organs and haemorrhage are uncommon.

Following the operation, pregnancy is most unlikely in women who have no periods. However, since there is still a slight chance of pregnancy, you are advised to continue with contraception until you have reached the menopause.

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This Women's Health Concern fact sheet provides information and guidance, to be used in consultation with your own healthcare professional. It has been developed by the medical advisory council of the British Menopause Society and it will be updated when guidance changes and/or new data becomes available.

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