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Beware: pregnancy and second-generation endometrial ablation

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Abstract With the promotion of second-generation endometrial ablative techniques—namely thermal balloon endometrial ablation and microwave endometrial ablation—as alternatives to hysterectomy for dysfunctional uterine bleeding, with phrases like “three-minute hysterectomy,” some women become complacent about contraception after ablation. Some even assume that “hysterectomy,” as widely used in the popular press, means “no more children.” Pregnancy after endometrial ablation does not represent a failure of the technique. The failure is due to poor counselling or to women not taking the advice to use appropriate contraception after the procedure.

Keywords Endometrial ablation · Pregnancy

Case Report

With the promotion of second-generation endometrial ablative techniques—namely thermal balloon endometrial ablation (TBAE) and microwave endometrial ablation (MEA)—as alternatives to hysterectomy for dysfunctional uterine bleeding, with phrases like “three-minute hysterectomy” [1], some women become complacent about contraception after ablation. Some even assume that “hysterectomy,” as widely used in the popular press, means “no more children.” Pregnancy after endometrial ablation does not represent a failure of the technique. The failure is due to poor counselling or to women not taking the advice to use appropriate contraception after the procedure.

Case 1

A 38-year old woman was referred by her general practitioner in April 2002 with a history of worsening menorrhagia for 1 year. She had a 22-year-old daughter, and her family was complete. Her cervical smears were up to date, and full blood count and thyroid function tests were normal. After consultation, she chose thermal balloon ablation. The procedure was performed on 11 October 2002. She was well at her 6-week follow-up.

At her 6-month follow up, she reported irregular cycles and dysmenorrhoea. She also had breast tenderness. She was prescribed painkillers and reassured that it can take 6–12 months for full effect of the treatment. At her 1-year follow-up on 13 October 2003, she still had irregular periods and dysmenorrhoea and wanted something to be done. It was decided that she could benefit from MEA. This entailed having an ultrasound scan to measure myometrial thickness. The scan unexpectedly revealed a viable intrauterine pregnancy of 9 weeks' gestation and a small fibroid.

The woman was seen with her partner, and the adverse outcome of pregnancy following ablative procedures was explained. She opted to terminate the pregnancy. The couple will use the sheath for contraception.

Case 2

A 40-year-old woman presented on 5 April 2001 with a 1-year history of menorrhagia. She had two children. She had been investigated in 1990 for menorrhagia with hysteroscopy and endometrial biopsy, and a ventro suspension for retroverted uterus was done the same year. She had also had a laparoscopy for pelvic pain, which revealed no abnormality. After consultation, TBAE was planned and was performed on 10 August 2001. She was fine at her 6-week follow up.

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At her 6-month follow-up, she complained of spotting continuously since November 2001. She also complained of increased weight with abdominal distention and breast tenderness. An ultrasound scan arranged for the next day unexpectedly revealed a viable intrauterine pregnancy of 14 weeks, with reduced liquor. She requested termination of pregnancy because her family was complete. For future contraception she chose sterilisation.

Discussion

Ablative procedures using second-generation techniques for dysfunctional uterine bleeding are now commonplace and effective. Hysterectomy as a primary procedure for dysfunctional uterine bleeding should rarely be used. All the manufacturers involved with ablative procedures (Microsulis and Gynecare) warn about pregnancy complications after these procedures. But MEA especially has been presented nationally in the press as a “three-minute hysterectomy” [2].

Patients who have ablative endometrial procedures should expect a 13–70% amenorrhoea rate. Some assume that this means they cannot conceive. It must be emphasised to the patients that they can get pregnant and also that when they do, the outcome may be very poor.

“Forty pregnancies have been reported, and 75% of these either miscarry or electively opt for termination in the first trimester. A few have gone to term with healthy babies. There have been some premature and one dangerous pregnancy with placenta accreta. No reports of placental insufficiency per se have been reported, though that may be the mechanism for the miscarriage” (Martin Weisberg, Senior Medical Director, Gynecare, personal communication).

Most pregnancies after endometrial ablation will miscarry. Complications of ongoing pregnancy are expected to be high due to the endometrial fibrosis similar to Asherman’s syndrome [3], including possible complications of placenta accreta and uterine rupture. Because of the potential problems with future pregnancies, it is recommended that reliable birth control be emphasised to women who undergo endometrial ablation.

References

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