Hysteroscopic Rollerball Ablation

Introduction

Hysteroscopic endometrial rollerball resection/ablation is the process where *the lining of the womb (endometrium)* is removed or destroyed.

Removal of the endometrium is now a successful treatment for women with heavy menstrual bleeding (HMB) who no longer desire to have children.

Endometrial rollerball ablation or resection is an alternative treatment to hysterectomy, the traditional treatment for HMB.

With hysteroscopic surgery the benefits are:

- significantly fewer complications
- no abdominal (tummy) cut
- day surgery with a much shorter hospital stay (about 4 hours) and
- an overall shorter recovery period.

What is an endometrial rollerball resection or ablation?

An endometrial rollerball resection/ablation is a surgical operation designed to treat heavy and/or irregular menstrual bleeding and performed when you are asleep under an anaesthetic.

- An operating telescope (called a resectoscope) is passed into the womb (uterus) via the cervix.
- Special instruments can then be passed through the telescope into the uterus to help in removing/destroying the womb lining.
- After the procedure, the womb heals by scarring. Periods from then on are generally very much lighter.

How do I know this operation is right for me?

If you have heavy or irregular periods then this operation is an option for you. Because the womb lining is treated, pregnancies are not advised after a resection or ablation so you should have completed your family and should not desire further children. The operation is particularly suited to women who have heavy period bleeding but who do not, for personal or medical reasons, wish to have a hysterectomy.

What investigations might I need before the operation?

Your gynaecologist will decide with you what investigations you may need before surgery.

These may include blood tests and possibly an ultrasound scan to detect if you have any fibroids in the womb or you may be advised to have a hysteroscopy before the resection/ablation treatment.

A hysteroscopy allows the inside of the womb to be assessed before definitive surgery, and affords the opportunity for the womb size and shape to be estimated. It also permits a small sample of the womb lining to be biopsied to confirm that there are no abnormal cells present. The pre-treatment hysteroscopy will usually be arranged as an outpatient procedure.

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Will I need any treatment before the operation?

Occasionally, if your womb lining is particularly thick, your gynaecologist may prescribe a medication to thin the womb lining before endometrial rollerball ablation/resection.

This increases the chance of success of the procedure and will usually take the form of a single injection of a drug called a GnRHa (Gonadotrophin Hormone Releasing Analogue), 4-6 weeks before surgery.

Side effects of GnRHa include:

- hot flushes
- night sweats
- headaches and
- your periods may stop.

These effects are all short-lived and will cease after about 6 weeks.

When will I be admitted for my operation?

You will usually be admitted on the day of your operation and should generally be allowed to go home later that day.

How is the operation carried out?

You will be given a general anaesthetic for the operation.

- The cervix (the opening to the womb) is then gently stretched or dilated to allow an operating hysteroscope (called a resectoscope) to be inserted through the cervix into the womb (uterus).
- The resectoscope is connected to a fluid system which allows a fluid (Glycine) to flow into the uterus via the resectoscope and then back out of the resectoscope through a suction channel.
- Fluid is required to slightly distend the uterus to allow a clear view and the flow and suction technique ensures that the fluid used for the operation can be closely monitored.
- The view of the operating site (inside the uterus) is also aided by a camera system connected to the resectoscope which allows the surgeon to carry out the operation with the aid of a monitor similar to a TV screen.
- Once the uterus has been distended an electrical current is passed through a cutting loop attached to the resectoscope and the womb lining is ‘shaved off’ in strips (the resection). The electrical current in the cutting loop helps to ensure a cleaner cut and aids in coagulating (sealing) any blood vessels at the same time.
- Alternatively current is passed through a small metal ball (rollerball). The heated ball is rolled over the womb lining, the heat transferring from the ball to the womb lining, destroying it.
- We will usually take still pictures before and after the operation so that you will be able to see the effects of the surgery.

The whole procedure takes about 30 minutes on average and you will usually be given a

dose of antibiotics during the procedure.

What happens after the operation?

You will have some vaginal bleeding and abdominal cramps after the operation but should be able to go home after a few hours. You will be advised to rest for a few days but full activity and work can usually be resumed within 2 weeks.

Vaginal bleeding will reduce to a blood stained discharge within 2 weeks or so. The bleeding or discharge may last up to 3-4 weeks in some women. To avoid an infection, you should not use any tampons or have sexual intercourse during this time. You may resume sexual activity once the bleeding or discharge has stopped.

Your first two periods after your operation may be heavy but by the third you should notice a reduction in the amount of loss.

What are the possible risks and complications of hysteroscopic surgery?

There is a small risk of complications from all hysteroscopic surgery.

As with other invasive operations on the womb there is a small risk of an infection of the uterus. This will usually present as an offensive vaginal discharge and you will need to be treated with antibiotics from your GP.

Occasionally the bleeding from the uterus may need to be controlled by the pressure of an inflated catheter inserted into the uterus. Bleeding problems that occur at operation can be stopped by the pressure from the catheter for 2-4 hours after the operation.

The risk of perforation of the uterus (making a small hole in the uterus) is about 1-2 per 1000 operations. If this occurs, there is a very small risk that bowel injury might occur. If necessary a laparoscopy (putting a small telescope into the tummy) may be performed at the time of your operation to check this.

As fluid is used to distend the uterus for the operation, excessive fluid absorption can occur in 1-5% of hysteroscopic resections. This can usually be managed by blood test monitoring and injections that temporarily increase the passage of urine (diuretics), and may require a longer stay in hospital.

Despite these potential risks endometrial resection / ablation is usually a safe procedure.

What is the outcome of hysteroscopic surgery?

Follow up studies after hysteroscopic endometrial resection or ablation show that satisfaction rates for patients are high.

About 3 or 4 patients in 10 may not have any further periods. Furthermore the long term rate of patients needing to have a repeat resection or hysterectomy after treatment is small, with over 85% of patients avoiding further surgery.

What happens when I get home?

After you have been discharged from hospital you may still have some abdominal cramps so it will be useful to have some pain killers like Paracetamol (Panadol) or Ibuprofen available to take as per the manufacturer's instructions. You should rest for a couple of days and then gradually resume your normal activities.

Useful Contact Numbers

Stoke Mandeville Hospital (SMH)
Consultant Gynaecologists: 01296 316239/316548
Ward 16B: 01296 418110/418111

Wycombe Hospital (WH)
Consultant Gynaecologists: 01494 425009/425724

Please Note:
This leaflet explains some of the most common side-effects that some people may experience. However, it is not comprehensive. If you experience other side-effects and want to ask anything else related to your treatment please speak to Ward 16B on 01296 418110/418111.

Approvals:
Gynae Guidelines Group: V2 Jun 2010/Dec 2011, V3 Feb 2016, V4 Jun 2019
Divisional Board: Jan 08, V2 Jun/April 2012, SDU V3 Apr 2016, V4 AR/SDU Jul 2019
Clinical Guidelines Subgroup: Not required
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MSLC: V2 March 2012
Equality Impact Assessment: V2 Jun 2011, V3 Jun 2016 , V4 Jun 2019
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