

The
**Journal of Obstetrics & Gynaecology of
India**

Vol. 43 No. 2

April 1993

EDITORIAL

**ENDOMETRIAL ABLATION IN CLINICAL
PERSPECTIVE**

Dysfunctional uterine bleeding is one of the commonest problems encountered in gynaecological practice. About 20% - 30% of women suffer from this problem at sometime during the span of their reproductive years.

It is not uncommon to deal with patients who have undergone successive curretages, and series of cyclic courses of hormonal treatment, who turn to us in despair for relief of their problems.

In India, when marriages take place at an early age, childbearing is often completed before the age of thirty years. Many women have undergone the operation of tubectomy who now present with recurrent bouts of menorrhagia not responding to conservative therapy, or when patients are averse to further

hormonal treatment because of unacceptable side-effects, these are the patients who face the prospects of undergoing a hysterectomy.

In most major institutional gynaecological services 25% - 30% of all hysterectomies are performed for dysfunctional uterine bleeding.

Ablation should be considered in women in whom hysterectomies is the only alternative procedure because of heavy bleeding which limits her social activity or causes anaemia.

The patient should be properly counselled, and selected for the procedure only after detailed clinical pelvic sonographic, and diagnostic hysteroscopic examinations have been undertaken to exclude unexpected pathology.

After suitable counselling which includes

explanation of the procedure, possible complications, recurrence rates ranging from 5% - 10%, the patient is explained the advantages of minimally invasive surgery and short hospital stay. Many women are averse to loosing the uterus, and agreeable to accepting the less invasive procedure of endometrial ablation.

Since Asherman (1948) first described the syndrome which bears his name, gynaecologists have attempted to evolve numerous methods to duplicate the clinical picture. These included rigorous curettage, intracavitary radium, cryotherapy, superheated steam, quinacrine, methylcyanoacrylate, oxalic acid, and silicone rubber. Only intracavitary radium was successful in destroying the basalis of the endometrium and controlling bleeding. The risk from radiation and future malignancy led to its decline.

In 1981, a successful endometrial ablation using the Nd : YAG laser was described by Goldrath, later unipolar electrical resectoscope was used to accomplish the same results (De Cherney and Polan 1983).

Other lasers line Carbon Dioxide, Argon and Potassium titanyl phosphate 532 have been used, and are under evaluation. However, non-hysteroscopic endometrial techniques are currently under investigation including radio frequency induced endometrial destruction (Philpps et al 1990). A blind technique has the advantage of being less skill dependant than the hysteroscopic procedures.

While it is pleasing to both investigators and patients to achieve amenorrhoea, endometrial ablation should be considered successful if a sufficient reduction in bleeding occurs to warrant avoidance of all further

surgery. About 20% to 30% of women do experience some hypomenorrhoea. Such results can be achieved in almost 85% of women by both the Nd : YAG laser and the resectoscope.

The electrical method using the resectoscope will continue to be popular in the present times, because of wider availability of these equipments and lower costs.

The majority of gynaecologists trained in conventional abdominal and vaginal surgery, who wish to undertake endoscopic surgery, must acquire training in the newer methods, learn to operate in a new environment, accomodate to the two dimensional image seen through the telescope, familiarise themselves with the newer set of instruments, and understand their limitations. They must be aware of complications, that can arise due to anaesthesia, during the procedure due to faulty instrumentation - like perforation, electrical burns and due to fluid overload as a result of distension media or complication resulting from CO₂ distension.

Hysteroscopic surgery offers many advantages over conventional surgery. Being minimally invasive, it promises to be the surgery of the future. Failure to appreciate the risks and failure to acquire adequate and continuous update in training in the learning period will inevitably lead to complications.

Endoscopic surgery has come to stay, it will form an essential part of practice which the patient will expect and demand; Hence the need for the gynaecologists to undergo meticulous training for as the saying goes 'Old dogs must learn new tricks or perish'.

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