OUTPATIENT ENDOMETRIAL ABLATION: PATIENT REPORTED EFFICACY AND ACCEPTABILITY

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INTRODUCTION

The RCOG defines heavy menstrual bleeding (HMB) as 'Excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life.'

Endometrial ablation is used in the management of 23% of cases of HMB. Traditionally this is carried out under general anaesthetic, but local anaesthesia only is technically possible. This study looks to determine the patient reported efficacy and acceptability of endometrial ablation under local anaesthetic.

METHOD

All 29 endometrial ablations carried out in an NHS Trust as an outpatient procedure were included for data collection.

The most recent 29 inpatient endometrial ablations carried out by the same surgeon were included for comparison. Outpatient procedures were carried out using a direct cervical block; inpatient procedures using general anaesthetic. All procedures used Thermablate.

The primary outcome was patient reported reduction in menstrual bleeding at three months. Secondary outcomes include patient satisfaction, complications and the need for further intervention. Outcome data were collected at the time of three month follow-up. Any further gynaecological appointments for heavy menstrual bleeding were also recorded. In order to assess acceptability of the procedure, patients having the outpatient procedure were asked two questions:

(I) To grade the pain of the procedure out of 10;
(II) whether or not they would have the procedure as an outpatient again.

These questions were asked immediately following the procedure.

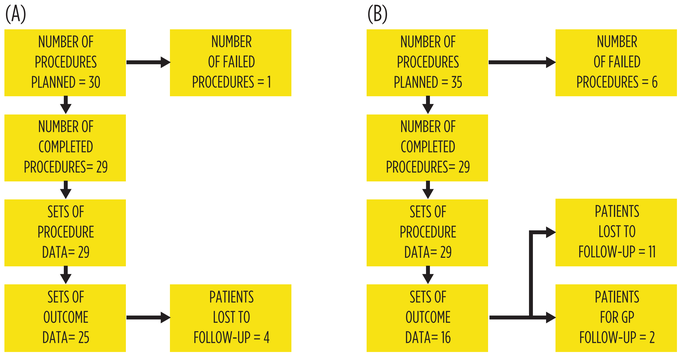

FIGURE 1: DATA COLLECTION FOR (A) OUTPATIENT AND (B) INPATIENT ENDOMETRIAL ABLATION

RESULTS

Data collection is summarised in figures 1. Median age of women opting for inpatient and outpatient procedure were 43 and 46 years respectively.

No significant difference was found in outcomes between women having outpatient and inpatient procedures with 72% of outpatients and 75% of inpatients reporting reduction of bleeding at 3 months (p=1) (Figure 2).

97% of outpatient procedures were free from immediate operative complications (with one patient in pain requiring a two hour stay in the department), as compared to 100% of inpatient procedures. No procedures had to be terminated early in either group. 11% of outpatient and 15% of inpatient procedures had later complications, 75% of which were infection requiring antibiotics. For both procedures direct perioperative mortality was zero.

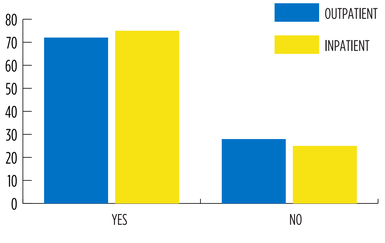

FIGURE 2: PATIENT REPORTED REDUCTION IN BLEEDING

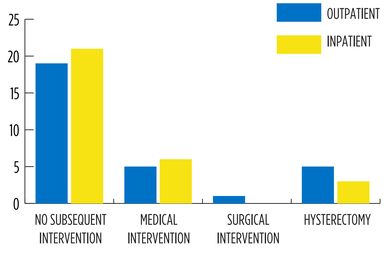

FIGURE 3: FURTHER TREATMENT OF HMB

Of women who underwent the outpatient procedure, 31% required further treatment for heavy menstrual bleeding, with 28% of women having inpatient procedures having further treatment (p=1). Numbers of women requiring hysterectomy were 17% and 10% for outpatient and inpatient procedures respectively (p=0.71) (Figure 3).

The median pain score for women who underwent the procedure as outpatients was 5/10 (LIQR 3.5, UIQR 7.0). (Figure 4) Perceived pain did not affect whether women reported a reduction in bleeding or required further treatment. Among the same group of women, acceptability of endometrial ablation as an outpatient procedure was 100%. 76% of women reported being satisfied with the outcome at their three month follow up.

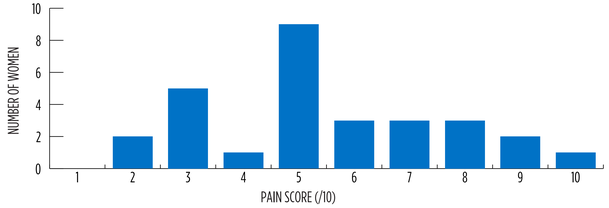

FIGURE 4: PATIENT REPORTED PAIN SCORE – OUTPATIENT ENDOMETRIAL ABLATION

DISCUSSION

Strengths and weaknesses

Strengths include inclusion of all women who have undergone an outpatient endometrial ablation in the trust, and the use of a comparison group. The study's novelty and that it establishes reason for increasing the availability for outpatient endometrial ablation are also strengths. Weaknesses include the limited demographic data, the loss of patients to follow-up, and the relatively small population overall. A disadvantage of the procedure itself is that it is less suitable for nulliparous women in the outpatient setting.

Comparisons with other studies

The rates of reduction in bleeding reported here are inline with those stated in NICE guidance on the use of endometrial ablation techniques for the management of heavy menstrual bleeding. A study of seventy women with medication resistant menorrhagia who had undergone a Thermablate endometrial ablation found that 93% of patients would have the procedure again. A reduction in pain score could be achieved by, in addition to cervical block, performing an intrauterine cornual block, which has been shown to reduce pain scores by around two points out of ten. A study from Europe found outpatient endometrial ablation to be more cost effective than inpatient procedures (a difference of €800). Main savings were in anaesthetics, cost of staying on the ward and overheads.

Implications and Future Research

- Outpatient procedure is as effective as the inpatient procedure, and acceptable to women
- Does not carry risks of general anaesthetic
- Should be more widely utilised
- Would require access to training as well as appropriate equipment in outpatient areas

CONCLUSION

In the management of HMB, outpatient endometrial ablation under direct cervical block is as effective as inpatient procedure, as well as being acceptable to women. It is not associated with risks of general anaesthetic and is likely to be cost-effective. Although not suitable for all women, it should be considered an alternative to the inpatient procedure.

References

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