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 25% of cases of HMB. Traditionally this is carried out under general anaesthetic, but local anaesthetic only is technically possible. This study aims 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 outpatient endometrial ablations carried out by the same surgeon were included for comparison. Outpatient procedures were carried using a direct cervical block; inpatient procedures using general anaesthetic. All procedures used ThermaPearl.

The primary outcome was patient reported reduction in menstrual bleeding at three months. Secondary outcomes include patient satisfaction, complications and the need for further interventions. Outcome data were collected at the time of three month follow-up. 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) Would they have the procedure again?
(ii) Whether or not they would have the procedure as an outpatient again.

Data collection is summarised in figures 1. Median age of women opting for inpatient and outpatient procedure were 45 and 46 years respectively.

RESULTS

Data collection is summarised in figures 1. Median age of women opting for inpatient and outpatient procedure were 45 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).

92% 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 98% of inpatient procedures. No procedures had to be terminated early in either group. 12% of outpatient and 5% of inpatient procedures had to be terminated early, which was a significant difference (p=0.03) (Figure 3).

16% of procedures completed under local anaesthetic, performed as an intracervical 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 £191). Main savings were in anaesthetics, cost of staying on the ward and overheads.

CONCLUSION

Outpatient procedure is as effective as the inpatient procedure, and 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.

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 comparator 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 risk of patients to follow-up, and the relatively small population examined. A disadvantage of the procedure is that it is less suitable for multiparous women in the outpatient setting.

References