ACOG
The American College of Obstetricians and Gynecologists

FAQs

Endometrial Ablation

Frequently Asked Questions

What is endometrial ablation?

Endometrial ablation destroys a thin layer of the lining of the uterus. Menstrual bleeding does not stop but is reduced to normal or lighter levels. If ablation does not control heavy bleeding, further treatment or surgery may be needed.

Why is endometrial ablation done?

The lining of the uterus—the endometrium—is shed by bleeding each month during menstruation. Some women have heavy bleeding or bleeding that lasts longer than normal.

Endometrial ablation is used to treat many causes of heavy bleeding. In most cases, women with heavy bleeding are treated first with medication. If heavy bleeding cannot be controlled with medication, endometrial ablation may be used.

Endometrial ablation does not involve removal of the uterus and it does not affect a woman's hormone levels.

Who should not have endometrial ablation?

Endometrial ablation should not be done in women past menopause. It is not recommended for women with certain medical conditions, including

- disorders of the uterus or endometrium

- endometrial hyperplasia
- cancer of the uterus
- recent pregnancy
- current or recent infection of the uterus

Can I still get pregnant after having endometrial ablation?

Pregnancy is not likely after ablation, but it can happen. If it does, the risks of miscarriage and other problems are greatly increased. If a woman still wants to get pregnant, she should not have this procedure.

Women who have endometrial ablation should use birth control until after menopause. Sterilization may be a good option to prevent pregnancy after ablation.

A woman who has had ablation still has all her reproductive organs. Routine cervical cancer screening and pelvic exams are still needed.

What happens before having endometrial ablation?

The decision to have endometrial ablation should be made between you and your obstetrician–gynecologist (ob-gyn) . You should talk about the procedure's risks and benefits.

A sample of the lining of the uterus is taken (endometrial biopsy) to make sure you do not have cancer. You also may have the following tests to check whether the uterus is the right size and shape for the procedure:

- Hysteroscopy —A device called a hysteroscope is used to view the inside of the uterus.
- Ultrasonography —Sound waves are used to view the pelvic organs.

If you have an intrauterine device (IUD) , it must be removed. You cannot have endometrial ablation if you are pregnant.

How is endometrial ablation done?

Ablation is a short procedure. Some techniques are done as outpatient surgery, meaning you can go home the same day. Others are done in the office of your ob-gyn. Your cervix may be dilated (opened) before the procedure. Dilation is done with medication or a series of rods that gradually increase in size.

There are no incisions (cuts) involved in ablation.

The following methods are those most commonly used to perform endometrial ablation:

- Radiofrequency—A probe is inserted into the uterus through the cervix. The tip of the probe expands into a mesh-like device that sends radiofrequency energy into the lining. The energy and heat destroy the endometrial tissue, while suction is applied to remove it.
- Freezing—A thin probe is inserted into the uterus. The tip of the probe freezes the uterine lining. Ultrasound is used to help guide the procedure.
- Heated fluid—Fluid is inserted into the uterus through a hysteroscope. The fluid is heated and stays in the uterus for about 10 minutes. The heat destroys the lining.
- Heated balloon—A balloon is placed in the uterus with a hysteroscope. Heated fluid is put into the balloon. The balloon expands until its edges touch the uterine lining. The heat destroys the endometrium.
- Microwave energy—A special probe is inserted into the uterus through the cervix. The probe applies microwave energy to the uterine lining, which destroys it.
- Electrosurgery—Electrosurgery is done with a resectoscope. A resectoscope is a thin telescope that is inserted into the uterus. It has an electrical wire loop, roller-ball, or spiked-ball tip that destroys the uterine lining. This method usually is done in an operating room with general anesthesia . It is not as frequently used as the other methods.

What should I expect after the procedure?

Recovery takes about 2 hours, depending on the type of pain relief used. The type of pain relief used depends on the type of ablation procedure, where it is done, and your wishes.

Some minor side effects are common after endometrial ablation:

- Cramping, like menstrual cramps, for 1 to 2 days
- Thin, watery discharge mixed with blood, which can last a few weeks. The discharge may be heavy for 2 to 3 days after the procedure.
- Frequent urination for 24 hours
- Nausea

Ask your ob-gyn when you can exercise, have sex, or use tampons. In most cases, you can expect to go back to work or to your normal activities within a day or two.

You should have follow-up visits to check your progress. It may take several months before you experience the full effects of ablation.

What are the risks associated with endometrial ablation?

- There is a small risk of infection and bleeding.
- The device used may pass through the uterine wall or bowel.
- With some methods, there is a risk of burns to the vagina, vulva , and bowel.
- Rarely, the fluid used to expand your uterus during electrosurgery may be absorbed into your bloodstream. This condition can be serious. To prevent this problem, the amount of fluid used is carefully checked throughout the procedure.

Glossary

Cervix: The lower, narrow end of the uterus at the top of the vagina.

Dilation: Widening the opening of the cervix.

Endometrial Biopsy: A procedure in which a small amount of the tissue lining the uterus is removed and examined under a microscope.

Endometrial Hyperplasia: A condition in which the lining of the uterus grows too thick. A specific type of endometrial hyperplasia may lead to cancer.

General Anesthesia: The use of drugs that produce a sleep-like state to prevent pain during surgery.

Hormone: A substance made in the body by cells or organs that controls the function of cells or organs. An example is estrogen, which controls the function of female reproductive organs.

Hysteroscopy: A procedure in which a device called a hysteroscope is inserted into the uterus through the cervix to view the inside of the uterus or perform surgery.

Hysteroscope: A thin, lighted telescope that is used to look inside the uterus and do procedures.

Intrauterine Device (IUD): A small device that is inserted and left inside the uterus to prevent pregnancy.

Menopause: The time in a woman's life when menstruation stops; defined as the absence of menstrual periods for 12 months.

Menstruation: The monthly discharge of blood and tissue from the uterus that occurs in the absence of pregnancy.

Obstetrician–Gynecologist (Ob-Gyn): A doctor with special training and education in women's health.

Pelvic Exam: A physical examination of a woman's reproductive organs.

Sterilization: A permanent method of birth control.

Ultrasonography: A test in which sound waves are used to examine internal structures. During pregnancy, it can be used to examine the fetus.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy. Also called the womb.

Vulva: The external female genital area.

If you have further questions, contact your ob-gyn.

Don't have an ob-gyn? Learn how to find a doctor near you.

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