PROCEDURE

# Endometrial ablation

Endometrial ablation uses heat, cold, or other energy to destroy the uterine lining and reduce heavy menstrual bleeding.

**PURPOSE**
Reduce heavy menstrual bleeding

**PROCEDURE TYPE**
Therapeutic, minimally invasive through the cervix

**WHERE IT IS DONE**
Outpatient clinic or operating theatre

**ANAESTHESIA**
Local, moderate sedation, deep sedation, or general

**HOW LONG IT TAKES**
About 10 to 45 minutes

**PREPARATION**
Pregnancy testing, uterine assessment, medication and fasting instructions

**RECOVERY**
Same day; no driving after sedation or general anaesthesia

**MAIN RISKS**
Uterine injury, infection, bleeding, nearby organ injury

**RESULTS**
Bleeding response becomes clear over several months

## Overview

Endometrial ablation destroys most of the endometrium, the lining inside the uterus, to reduce unusually heavy or prolonged menstrual bleeding.

The procedure is performed through the vagina and cervix and usually requires no abdominal cuts. Depending on the device, the lining may be treated with radiofrequency energy, heated fluid, a heated balloon, cold, microwave energy, or electrical energy.

The uterus remains in place. Unlike hysterectomy, ablation does not remove it.

Ablation is for people who do not want a future pregnancy. It is not birth control, and pregnancy afterward can be dangerous. Reliable contraception is needed until menopause.

## Why the procedure is performed

Endometrial ablation may be offered when heavy bleeding affects daily life and medicines have not helped enough, caused unwanted effects, or are unsuitable.

The goal is lighter periods; complete cessation is not guaranteed. Ablation may work less well with large fibroids, an unusually shaped uterus, or adenomyosis.

Ablation is not mainly a treatment for pelvic pain. If pain is your main concern, ask whether another treatment is more appropriate.

## Who should and should not have it

Ablation may be suitable if you have heavy bleeding from a non-cancerous cause, have completed childbearing, and have a uterine cavity that can be treated safely.

It should not be performed during pregnancy or if you want a future pregnancy. It is generally avoided after menopause and may be avoided or delayed if you have:

Each device has limits related to uterine size, shape, and previous surgery. Your healthcare team should explain whether these apply to you.

- Endometrial cancer or precancerous endometrial hyperplasia
- An active pelvic or uterine infection
- Unexplained bleeding that has not been assessed
- An intrauterine device, or IUD, that has not been removed
- A uterine shape, scar, or fibroid that prevents safe device placement

## How to prepare

Follow your treating facility's instructions because preparation varies by technique and anaesthesia.

You may have an ultrasound or hysteroscopy, which uses a thin camera to examine the uterus. An endometrial biopsy is often taken to check for cancer or precancerous changes.

Tell the team about all medicines, supplements, allergies, previous uterine surgery, and any chance of pregnancy. Do not stop blood thinners or other prescribed medicines unless the clinician managing them tells you to.

You may need to:

Ask what anaesthesia is planned and whether someone must stay with you afterward.

- Take a pregnancy test
- Have an IUD removed
- Avoid food and drink before sedation or general anaesthesia
- Take medicine to thin the lining or help open the cervix
- Arrange for someone to drive you home

## What happens during the procedure

You lie on a table with your legs supported. A speculum is placed in the vagina, and the cervix may be numbed and gently widened.

A narrow device passes through the cervix into the uterus. A hysteroscope may also be used to inspect the cavity. The device then treats the lining with the selected energy.

If awake, you may feel pressure or menstrual-like cramps. Sedation makes you sleepy; general anaesthesia makes you unconscious. Most people go home the same day.

## Recovery and what to expect afterward

Strong period-like cramps are common for several hours, with milder cramps sometimes lasting a day or two. Use only recommended pain medicines.

Rest on the day of the procedure. Watery or blood-stained discharge may continue for several weeks; pads are often recommended. Follow your facility's instructions about exercise, tampons, vaginal sex, bathing, and swimming.

Do not drive home after sedation or general anaesthesia. Follow instructions about when driving is safe, particularly while taking medicines that cause drowsiness.

Many people return to light activities or desk-based work within a day or two. Recovery may take longer after general anaesthesia or for physically demanding work.

## Risks and possible complications

Possible risks include:

Heavy bleeding may continue or return, and some people later need another procedure or hysterectomy. Scarring can also cause new or worsening cyclical pelvic pain.

Pregnancy remains possible and has increased risks, including pregnancy loss, ectopic pregnancy, and serious placental problems. Continue effective contraception after ablation.

Scarring may make later sampling of the uterine lining difficult. New bleeding after a long period without bleeding, or any bleeding after menopause, requires medical assessment.

- A hole in the uterus, called uterine perforation
- Burns or injury to the cervix, vagina, bowel, bladder, or nearby tissue
- Infection or bleeding
- Reactions to anaesthesia or sedation
- Excess fluid entering the bloodstream with some techniques
- Blood or fluid trapped inside the scarred uterus, causing pain

## Results and follow up

Cramping and discharge should gradually settle. Your team may schedule follow-up or ask you to contact them if recovery is not progressing as expected.

Periods may not change immediately. Bleeding often becomes lighter over several months, and the final effect may take several menstrual cycles to judge.

Tell your healthcare team if heavy bleeding continues, returns after improving, or is replaced by significant monthly pain. Further assessment may include imaging, hysteroscopy, or endometrial sampling.

## Alternatives

Alternatives depend on the cause of bleeding, your health, and whether you want a future pregnancy:

Monitoring without immediate treatment may be reasonable if serious causes have been excluded and symptoms are manageable.

- Anti-inflammatory medicines: May reduce bleeding and cramps.
- Tranexamic acid: A non-hormonal medicine taken during each period that preserves fertility.
- Hormonal treatment: Pills, progestogen tablets, injections, or other hormones may reduce bleeding but can cause side effects.

- Hormonal IUD: Can greatly reduce bleeding while providing contraception, although irregular bleeding may occur at first.
- Removal of a polyp or fibroid: Hysteroscopic surgery may treat a specific growth causing bleeding.
- Uterine artery embolisation: Reduces blood flow to fibroids; future pregnancy requires careful discussion.
- Hysterectomy: Permanently stops uterine bleeding but involves major surgery, greater risk, and longer recovery.

## When to call your healthcare team

Contact your healthcare team promptly for:

Seek emergency care for severe abdominal pain, fainting, breathing difficulty, chest pain, confusion, or bleeding that rapidly soaks through pads, especially with weakness or dizziness.

For routine follow-up, contact the team if discharge or cramping lasts longer than expected, periods remain very heavy after several months, or bleeding returns after improving.

- Fever, chills, or foul-smelling discharge
- Worsening pain or pain not controlled by recommended medicine
- Bleeding that is heavier than expected
- Difficulty passing urine
- Vomiting that prevents drinking
- A positive pregnancy test at any time after ablation

## Common questions

Will I be asleep?

You may receive local anaesthetic, sedation, or general anaesthesia, depending on the device, facility, and your needs.

Can I drive home?

Not after sedation or general anaesthesia. Arrange for an adult to take you home.

How painful is endometrial ablation?

If awake, you may feel pressure and strong period-like cramps. Cramping afterward usually

improves within a day or two.

When will I know if it worked?

It may take several menstrual cycles to judge the full effect.

Will I still have periods?

Periods may become lighter, less frequent, or stop, but complete cessation is not guaranteed.

Can I get pregnant afterward?

Yes, but pregnancy can be dangerous. Reliable contraception remains necessary until menopause.

## Sources

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