Endometrial ablation for treatment of heavy menstrual bleeding: For whom it may not work?

Introduction

Heavy Menstrual Bleeding (HMB) is the most prevalent form of abnormal uterine bleeding, a complaint that affects approximately 14% of reproductive aged women and presents both a health and financial burden [1]. For decades, hysterectomy had been the only treatment approach when medical treatment is contraindicated or ineffective. Endometrial ablation (EA) has been introduced as an alternative to radical treatment since late 80’s and early 90’s and has gained substantial popularity as a convenient procedure of less cost and high safety profile. Thereafter, evidence from the literature has supported EA as a second line treatment if medical treatment fails or is contraindicated [2]. Second generation EA devices (also known as global EA) have been well-established in gynecologic care and are offered to all eligible women. Because second generation devices allow office-based treatment under local anaesthesia, EA has become widely acceptable by both patients and health care providers and has become the most common treatment of HMB in the United States [3].

Although EA provides fewer complications and significantly less costs than hysterectomy [4], treatment failure, defined as recurrence of symptoms that necessitates reintervention, presents a major concern. Treatment failure is time-dependent and accordingly, the incidence of reintervention has been increasingly recognizable while 2–3 decades passed since EA was introduced [5]. Failure of EA reached up to 26% after 8 years of treatment [3]. Because failure of EA doubles treatment burden in terms of morbidity and costs and because EA failure seems to vary widely among reports, identification of determinants of treatment success had become imperative to improve patient selection and counselling [6].

In this review, our objective is to present available evidence on predictors of long-term failure of EA. We also aim to explain the mechanisms by which these predictors may contribute to recurrence and to recommend strategies that could improve treatment outcomes and minimize the need for intervention.

Endometrial ablation: An overview

EA refers to a set of procedures that aim to destroy the endometrium beyond its natural capacity to regenerate. Although the term seems to be relatively recent, trials on endometrial destruction were initiated many decades ago. One of the oldest trials was conducted by Droegemueller et al., who treated 11 women with dysfunctional uterine bleeding using cryosurgery of the endometrium based on a Frigitronics nitrous oxide cryosurgical system [7]. One decade later, ND: YAG Laser was first introduced by Goldrath et al., as a method of vaporization of the endometrium. This study presented the actual introduction of EA to the literature; results from Goldrath et al., study supported both the efficacy and safety of endometrial destruction over 20 months of follow-up. Twenty one out of 22 responded to this approach and no major events were reported [8]. In 1987, hysteroscopic resection of the endometrium was introduced by DeCherney et al., using modiﬁed urologic hysteroscope. Destruction of endometrial lining was achieved using coagulating current. This procedure was highly successful and no complications were reported [9].

These techniques were gradually established as treatment options for HMB and are now the most commonly used for the treatment of heavy menstrual bleeding.
options and in the 90’s, evidence from the literature was reviewed and these modalities were considered in clinical guidelines as an alternative to hysterectomy [10]. Nineteen ninety six and afterwards, new modalities of endometrial ablation, that do not necessitate direct visualization of the uterine cavity, have emerged and have been known as second-generation EA or global EA [11]. Because older methods (first generation) require special training and are associated with risk of uterine perforation and fluid overload, new EA modalities have provided obvious privilege in terms of safety and feasibility [12].

| Study Country       | Study period               | Sample size | Type of ablation                                                                 | Average follow-up duration | Failure rates |
|---------------------|----------------------------|-------------|----------------------------------------------------------------------------------|------------------------------|---------------|
| [13] Canada         | August 1990 to May 1995    | 301         | Rollerball ablation or a combination of rollerball and endometrial resection     | 60 months                   | 27%           |
| [14] UK             | October 1994 to April 1995 | 43          | Microwave endometrial ablation                                                   | 36 months                   | 16.3%         |
| [15] UK             | between June 1994 to August 1996 | 188       | Resectoscopic endometrial ablation                                               | 60 months                   | 24.5%         |
| [16] USA            | January 1998 to June 2003  | 109         | Resectoscopic endometrial ablation and thermal balloon ablation                  | 24 months                   | 29.1%         |
| [17] Hungary        | 1997 to 2000               | 75          | Radiofrequency endometria ablation                                               | 84 months                   | 8%            |
| [18] USA            | Between January 1999 to December 2004 | 3,681       | Resection and ablation first-generation endometrial ablation procedures (no Laser endometrial ablation), Thermal balloon endometrial ablation, hydrothermal endometrial ablation and radio-frequency endometrial ablation | 96 months                   | 21%           |
| [19] USA            | January 1998 to December 2005 | 816         | Radiofrequency and thermal balloon endometrial ablation                          | 60 months                   | 16%           |
| [20] USA            | January 2003 to June 2010  | 1,169       | Rollerball, thermal balloon, radiofrequency, cryoablation                       | 39 months                   | 13.4%         |
| [21] UK             | July 2007 to August 2011   | 200         | thermal balloon, radiofrequency endometrial ablation                             | 50 months                   | 16%           |

Endometrial ablation: Baseline predictors of failure

Identification of baseline characteristics that would increase the probability of treatment failure poses an appropriate strategy to reduce the rate of surgical reintervention and improve patient counselling. However, baseline predictors of failure seem to widely vary among studies. Some of these predictors are summarized in Table 2 [5,18-20,23-26]. A younger age at EA has been the most consistent predictor of failure among most of these studies [18-20,23-26]. The impact of age may be ascribed to procedure-menopause interval; failure of EA is time dependent and accordingly, older women may get to menopause within few years and avert failure. While approaching menopause, bleeding pattern also tends to be irregular rather than heavy. A younger age also predicted
Table 2: Predictors of long-term failure of Endometrial Ablation (EA).

| Study | Country | Study period | Sample size | Type of ablation | Predictors of failure | Average follow-up duration |
|-------|---------|--------------|-------------|-------------------|-----------------------|----------------------------|
| [5]   | USA     | April 1998 to December 2011 | 1,178       | Radiofrequency ablation | Uterine length, procedure duration, and radiofrequency ablation (RFA) index | 51.6 months |
| [20]  | USA     | January 2003 to June 2010 | 1,169       | Rollerball, thermal balloon, radiofrequency, cryoablation | Age and type of ablation | 39 months |
| [23]  | USA     | July 2005 to February 2008 | 142         | Hydrothermal ablation | Younger age, tobacco products, menometrorrhagia | 12.4 months |
| [19]  | USA     | January 1998 to December 2005 | 816         | Radiofrequency and thermal balloon endometrial ablation | Age ≥45 years, parity of 5 or greater, prior tubal ligation, history of dysmenorrhea | 60 months |
| [18]  | USA     | Between January 1999 to December 2004 | 3,681       | Resection and ablation first-generation endometrial ablation procedures (no Laser endometrial ablation), Thermal balloon endometrial ablation/hydrothermal endometrial ablation and radio-frequency endometrial ablation | Age <40 years | 96 months |
| [24]  | Egypt   | September 2000 to September 2001 | 45          | Thermal balloon ablation | Younger age, greater uterine depth, inadequate balloon pressure | 24 months |
| [25]  | The Netherlands | January 1995 to September 1998 | 130         | Thermal balloon ablation | Young age, retroverted uterus, endometrial thickness of at least 4 mm, prolonged duration of menstruation + Uterine depth and dysmenorrhea reduced treatment effectiveness | 24 months |
| [26]  | USA     | January 1990 to January 2000 | 174         | Rollerball ablation | Previous tubal ligation, age <35 years | 49 months |

postablation pain; perhaps due to a longer exposure to higher estrogen levels that would stimulate estrogen dependent lesions [27]. Although predictability of age variable seems to be universally accepted among different ablation devices, a cutoff point has not been settled yet with 30 and 45 being the most frequently adopted. A cutoff point of 45 years and 40 years were associated with adjusted hazard ratios (HR) of 2.6 (95% confidence interval [CI] 1.3–5.1) [19] and HR 3.2 (95% CI 2.4–4.2), respectively [18]. Accordingly, CIs are overlapping and the differences do not seem to convey a strong clinical prediction. Age less than 35 years was associated with future bleeding but hysterectomy rate was not higher than other age groups [26]. Accordingly, establishing patient selection of women between 40 and 45 years may be influenced by other clinical circumstances.

Tubal ligation has been also recognized as a potential predictor of treatment failure [19,26]. Although it has not been defined as a predictor in all studies, tubal ligation was recognized as a risk factor for postablation cornual and tubal hematometra (postablation syndrome) which necessitates intervention [28–30]. The syndrome was not restricted to a particular ablation device [19,29,30]. It is, therefore, justifiable that women with prior tubal ligation be counselled for the risk of reintervention particularly for postablation pain. Women were also at risk of significant postoperative pain if they were less than 40 years old or if they experienced preablation dysmenorrhea [27]. Dysmenorrhea is another risk factor that has been considerably recognized both in practice and in the literature. Preablation dysmenorrhea was defined as a predictor of EA failure and is commonly addressed during counselling in current practice [19,25,27]. The presence of dysmenorrhea may signify underlying endometriosis or adenomyosis which cannot be definitely excluded prior to EA. Therefore, EA will not largely relieve patient complaint.

The role of tobacco use was addressed in 2 previous studies specially as predictors of postablation pain [23,27]. However, this association was not explained given the anticipated relation between smoking and hypoestrogenism [31]. Although the relation between smoking and pain perception is debatable, there is evidence that smoking may increase pain intensity in women with chronic pain owing to central mechanisms [32]. Nevertheless, evidence on smoking contribution in EA failure or its mechanism is lacking and interpretation of this information in practice is still limited. Other predictors of failure were described in individual studies.

Endometrial ablation: Perioperative predictors of failure

While most studies primarily assessed how baseline characteristic would impact treatment success, few studies address the role of perioperative measurements including premedications, preprocedure sonographic findings, uterine measurements, and procedure parameters. However, it is generally accepted that a particular uterine length would not allow EA; one of the earliest guidelines for EA, published in 1995, stated that EA should be performed for uterine length <12cm [10]. Although this cutoff point was considered in many studies, A greater success was recognized when a lower cutoff is used [33,34]. A cutoff point of 10cm is now widely adopted [35]. This explains why uterine depth was not frequently evaluated as a predictor of failure in most studies. According to El-Nashar et al., a uterine length ≥9cm was not connected to failure. However, women with uterine lengths <9cm were more prone to amenorrhea [19]. Shaamash and Sayed found that uterine depth would predict EA failure in women treated with thermal balloon EA. The range of uterine depth was 7.5–12cm but no particular cutoff was defined [26]. A recent study found that uterine length >10.5cm was associated with REA failure particularly those caused by post-ablation bleeding [5].
On the other side, there is no much information in the literature on the role of uterine width. Uterine length and width could be measured sonographically prior to the procedure and automatically at the time of REA procedure. Shazly et al., found that failure of REA is higher if uterine width exceeded 4.5cm [5]. This is particularly predictive of postablation pain and may indicate an undiagnosed uterine adenomyosis or a uterine width that extends beyond ablation zone leaving active peripheral endometrial tissue behind a central obliterated cavity. A radiofrequency ablation (RFA) index was thus established as: REA procedure duration divided by uterine surface area (uterine length multiplied by uterine width). This equation seemed to be more predictive than uterine length, width, or duration alone [5]. Other perioperative predictors include uterine retroversion and endometrial thickness which were found significant by one study on thermal balloon EA and were not significant by another larger study that included a mixed a cohort of thermal balloon EA and REA [19,25]. Premedications were not given in the latter study.

Endometrial ablation failure: Conclusion

Although the probability of further intervention following EA is considerable, EA remains an appealing alternative to hysterectomy. It is anticipated that proper patient selection would substantially lower the rate of reintervention. Unfortunately, potential predictors have not been meta-analyzed to data owing to the wide heterogeneity of available studies. However, it seems that age is the most acceptable predictor to date. Using either 40 or 45 years as a cutoff is not definite and it should be made according to other clinical circumstances. Tubal ligation and dysmenorrhea should also be considered. Perioperatively, women should be advised that EA success would be lower if uterine length is greater than 10 to 10.5cm. RFA index is a novel index that considers uterine surface area rather than uterine length alone. However, further studies are needed to validate its use. There is currently no evidence that uterine position, endometrial thickness, and premedication change long-term outcomes. Although adoption of a selective strategy is justifiable, further research on the impact of its implementation on long-term outcome is recommended.

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