What are the risk factors for pain after endometrial ablation?

A history of dysmenorrhea or tubal sterilization increases the likelihood of new or worsening postablation pain by 74% (adjusted odds ratio [OR], 1.74; 95% confidence interval [CI], 1.06–2.87) and more than 100% (adjusted OR, 2.06; 95% CI, 1.14–3.70), respectively, according to this retrospective cohort study.

Wishall KM, Price J, Pereira N, Butts SM, Della Badia CR. Postablation risk factors for pain and subsequent hysterectomy. Obstet Gynecol. 2014;124(5):904–910.

EXPERT COMMENTARY

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Heavy menstrual bleeding is a common gynecologic problem and can negatively affect a woman's quality of life.[1] Endometrial ablation is an effective treatment option.[2] Despite its efficacy, however, endometrial ablation has failure rates ranging from 15% to 30%.[3,4] Two consistent reasons for failure are persistent bleeding and new or worsening pain. Endometrial regrowth and intrauterine scarring are thought to be key factors in this pain process.[5]

Details of the trial

Wishall and colleagues conducted their retrospective cohort study using patient data from two large academic medical centers. The primary outcome was the development of new or worsening pain following endometrial ablation. The two most commonly used endometrial ablation devices in this study were thermal balloon ablation and bipolar radiofrequency ablation.

Twenty-three percent of patients developed new or worsening pain following the ablation, a finding in accordance with earlier studies looking specifically at pain after endometrial ablation.[6] In addition, 19% of patients underwent hysterectomy after ablation—again, within the range commonly reported in the literature.[3,4]

Risk factors for new or worsening pain after ablation included a preprocedure history of dysmenorrhea or tubal sterilization. White race was protective of postprocedure new or worsening pain (adjusted OR, 0.55; 95% CI, 0.34–0.89).

Risk factors for hysterectomy after ablation included a history of cesarean delivery (adjusted OR, 2.33; 95% CI, 1.05–5.16) and uterine abnormalities on imaging, including leiomyoma, adenomyosis, a thickened endometrial lining, and polyps (adjusted OR, 3.96; 95% CI, 1.25–12.56). When the ablation procedure was performed in an operating

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WHAT THIS EVIDENCE MEANS FOR PRACTICE

This study reinforces the idea that patient selection for conservative procedures such as endometrial ablation is one of the most important steps in the process. In light of these findings, I recommend that women with a history of dysmenorrhea or tubal sterilization be counseled about the potential for postprocedure pain and subsequent treatment failure.

›› MATTHEW R. HOPKINS, MD

FAST TRACK

Counseling women with a history of dysmenorrhea or tubal sterilization as to potential pain or treatment failure could enhance patient selection for endometrial ablation

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Examining the
EVIDENCE

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room, the risk of postprocedure hysterectomy decreased (adjusted OR, 0.24; 95% CI, 0.07–0.77). In histopathologic analysis of the hysterectomy specimens, leiomyomas or adenomyosis, or both, were the most common findings, consistent with other reports on pathologic findings in this setting.[7]

Placing these findings in context

Overall, the findings of Wishall and colleagues support those of other studies exploring endometrial ablation, an effective uterine-conserving procedure for the treatment of heavy menstrual bleeding. All conservative procedures have inherent failure rates and can lead to unintended adverse effects. Common reasons for failure after endometrial ablation include bleeding or pain, or both.

Although there are discrepancies between studies in regard to some of the individual predictors of failure or development of pain, the collection of retrospective studies on this subject to date have made it clear: There are predictors of treatment failure. Future efforts should focus on model development and prospective validation of these models to improve patient selection.

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