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Case Report

Postablation Tubal Sterilization Syndrome-a Case Report

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Abstract

Background: Endometrial ablation is a minimally invasive, readily available procedure for the management of persistent heavy uterine bleeding (HUM) with good results. Complications though rare, have included post-ablation tubal sterilization syndrome.

Case: A 39-year-old multiparous lady with persistent, unresolved HUM despite conservative therapy and a history of bilateral tubal ligation with filshie clips underwent an uncomplicated hysteroscopy with Novasure endometrial ablation. Subsequently, she had severe recurrent cyclic pelvic pain of over 6months duration, which was relieved after a total laparoscopic hysterectomy with pathology showing thickened and dilated proximal tubes with hematosalpinx.

Conclusion: Physicians performing endometrial ablation should have a high index of suspicion for, be able to diagnose and treat post ablation tubal sterilization syndrome.

Background

Endometrial ablation, which is the surgical destruction of the endometrial lining of the uterus, has gradually become an increasingly popular treatment option for abnormal uterine bleeding in women due to its minimally invasive nature and it accounted for up to 60% of all surgical procedures performed for heavy menstrual bleeding in England between 2003-06 [1]. It has been accomplished with or without hysteroscopic visualization using either a resectoscope or various non-resectoscopic ablation devices. Current FDA approved non-resectoscopic devices include Novasure, Her Option, Thermachoice, Hydro ThermAblator and Microwave Endometrial Ablation.

Although not common, complications such as uterine perforation, hemorrhage, pelvic infection, hematometra, thermal injury and post tubal sterilization syndrome in women with prior bilateral tubal sterilization procedures has been seen.

Case Presentation

A 39year old multiparous patient with a history of bilateral tubal ligation with filshie clips was seen and evaluated for persistent heavy menstrual bleeding associated with symptomatic anemia and a hemoglobin level of 8.4 g/dl.

She had an endometrial biopsy done, which revealed secretory endometrium and Pelvic ultrasound was unremarkable for a defined intracavitary lesion. She was placed on Iron supplements and opted for endometrial ablation after both medical and surgical management options of her abnormal uterine bleeding have been discussed.

After obtaining an informed consent, she underwent an uneventful hysteroscopy with Novasure endometrial ablation with no demonstrable intrauterine lesion seen.

She had an uneventful post procedure period and consequently became amenorrheic but commenced having severe cyclical pelvic pain from the second month post ablation, over a period of 6 months duration during which time she had numerous analgesics courses as well as a cervical dilatation and empirical treatment for pelvic inflammatory disease. Pelvic ultrasound done during this period did not reveal any abnormality. Due to the debilitating nature of the chronic pelvic pain, she consented to and underwent a total laparoscopic hysterectomy, which resulted in resolution of the pain. Pathology report indicated benign bilateral thickened and dilated proximal tubes with hematosalpinx and filshie clips intact.

Discussion

Post ablation tubal sterilization syndrome initially reported in 1993 has been found to occur in up to 10% of patients post endometrial ablation.

Proposed reasons include bleeding from active endometrium trapped in the uterine cornua and intrauterine scarring associated with uterine contracture [2,3].

Presentation is similar to that of hematometra and usually of cyclical pelvic pain post endometrial ablation especially in patients with prior bilateral tubal sterilization although sometimes the pain can be intermittent.

Ultrasound is not reliably sensitive; however, there can be avascular fluid-filled collections in the corneal region and/or fallopian tubes bilaterally [4] but MRI, which is more sensitive might reveal the blood filled tubes during the cramping episode.

Definitive treatment is hysterectomy although cases of laparoscopic excision of the proximal tubal stumps have been documented [5].

Conclusion

The introduction of endometrial ablation has led to a significant reduction in the need for hysterectomy as an option for heavy uterine bleeding.

However, physicians performing endometrial ablations should have a high index for post ablation tubal sterilization syndrome and be able to both diagnose and treat when it occurs.

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Attempts should also be made at possibly discussing this side effect as part of the informed consent process.

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