Long-term efficacy of transcervical endometrial resection with no preoperative hormonal preparation

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Received 24 April 2004; received in revised form 2 July 2004; accepted 31 July 2004

Abstract

Objective: To assess the level of patient satisfaction after transcervical endometrial resection (TCRE) with no preoperative hormonal preparation.

Study design: A retrospective audit of a continuous case series was accomplished on 131 consecutive patients who underwent TCRE for dysfunctional uterine bleeding. Data of postal questionnaires were analysed and subjected to survival analysis.

Results: Thirty-three cases were lost to follow-up; thus, the data on 98 of the 131 (74.8%) patients were analysed. The average follow-up period was 94.8 months (60-132). Twenty (20.4%) women required D&C and 15 (15.3%) had hysterectomy. In eight of the 15 cases, the indication for hysterectomy was not related with the primary operation. The chance of avoiding hysterectomy reached a plateau after 72 months, at 78.3% (SE: 5.05%). The chance of avoiding D&C at up to 36 months was 98.6% (SE: 1.4%), and reached a plateau after 107 months at 67.11% (SE: 6.1%); 55.8% of the patients became amenorrhoeic, the remaining cases reporting good improvements in the amount and duration of bleeding, and dysmenorrhoea. Eighty-six of the 98 patients (88%) were satisfied or very satisfied with the result.

Conclusions: TCRE affords reasonable long-term effectiveness in the treatment of dysfunctional uterine bleeding, even without any preoperative hormonal endometrial preparation.

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Keywords: Endometrial Resection; Metrorrhagia; Hormonal preparation; Long-term follow up; Survival analysis

1. Introduction

Dysfunctional uterine bleeding affects 20–30% of women, most of them undergoing hysterectomy [1]. The prospective, epidemiological study carried out by Oxford University and the Family Planning Association between 1968 and 1974 on 17,032 women suggested that a minimum of 20% of women undergo hysterectomy by the age of 55 [2]. The procedure of transcervical endometrial resection (TCRE) was introduced in the late 1980s and markedly changed the treatment of dysfunctional uterine bleeding [3–6].

Numerous papers have been published on the short-term effects of the procedure, but only a few discuss the long-term consequences or the findings of the long-term follow-up of patients who undergo TCRE [7–11]. The experience to date is that the efficacy of the operation cannot be assessed correctly merely a few years after the surgery, as further surgical treatment might be necessary even after a very long time if either the patient or her doctor feels that the TCRE did not lead to the expected result.

The technique was introduced in Hungary in 1993 [12,13], and our experience relating to the first 100 cases was presented in 1998 [14]. The aim of the present study was to examine the long-term effects of TCRE performed without any hormonal pretreatment for thinning the endometrium on the menstrual period and dysmenorrhoea. We wanted to establish how satisfied our patients are with the long-term
results of the operation, and how many of them are able to avoid hysterectomy.

2. Materials and methods

One hundred and thirty-one consecutive patients underwent TCRE in our Department between November 1992 and November 1996.

The indication for the operation was intractable uterine bleeding with no response to hormonal treatment. A negative histology of endometrial biopsy (D&C) within 1 year was mandatory, but diagnostic hysteroscopy was not routinely performed. Each patient had to have a complete family with no desire for further pregnancy, and the uterus had to be smaller than a 12-week uterus. No preoperative hormonal treatment was applied to thin the endometrium, and no perioperative antibiotic treatment was administered except the two cases where the cardiac status of the patients made this necessary.

The detailed steps of the procedure were published previously [13]; here we merely summarise the basic steps. After dilatation of the cervix up to Hegar size 10, we introduced a 10 mm passive resectoscope fitted with a roller ball electrode to treat the fundal area and with a loop electrode for the rest of the uterine cavity, with a 30° fore-oblique hysteroscope, using 4% sorbitol as a medium for dilatation–irrigation. A Hamou Hysteromat was used to ensure an intrauterine pressure of 100–120 mmHg with a flow rate of 150 ml/min. (All equipment was manufactured by Karl Storz GmbH, Tuttlingen, Germany.) The fundal endometrium was ablated with the roller-ball electrode in a majority of the cases, while the rest of the cavity was treated with the loop electrode. In a majority of the cases, the operation was performed under general anaesthesia, but an appreciable number involved local anaesthesia with intravenous sedation. The mode of local anaesthesia used was described earlier [15].

Several years later a postal questionnaire was sent out, containing open-and closed-type questions to assess the current status of the patients and the events that had occurred since the operation. A copy of the used questionnaire is attached to the end of the paper.

The data were analysed by means of Excel and SPSS computer programs.

3. Results

The completed postal questionnaire was returned by 82 of the 131 patients. Answers were collected by telephone interview from a further 15 women, and all details of the data on one more patient were available from her clinical notes. Thirty-three cases were lost to follow up; thus, the data on 98 of the 131 (74.8%) patients were analysed in this long-term follow-up study. Of the 98 women 69 underwent TCRE alone, while 29 underwent TCRE and myomectomy in the same session. The follow-up period was 5 years in five cases (5.1%), 6 years in 14 cases (14.3%), 7 years in 22 cases (22.4%), 8 years in 23 cases (23.5%), 9 years in 14 cases (14.3%), 10 years in nine cases (9.2%) and 11 years in 11 cases (11.2%). The average follow-up period was 94.8 months (minimum: 60, maximum: 132).

The average age of the patients at the time of surgery was 43.5 years (minimum: 26, maximum: 70). The length of the menstrual period was on average 26.9 days (minimum: 14, maximum: 35), while the duration of the menstrual bleeding was on average 6 days (minimum: 3, maximum: 19). Ninety of the patients were parous, and eight were nulliparous. The main complaint in 46 cases was irregular and heavy period bleeding, and in 44 cases was regular but heavy bleeding. In eight cases, the period bleeding lasted for more than 10 days; one patient complained of postmenopausal bleeding. In nine women, heavy dysmenorrhoea accompanied the bleeding disturbances. The complaints started on average 11.3 months before surgery. D&C was resorted to at least twice before surgery in an effort to eliminate the symptoms; hormonal treatment was administered to 45 patients, the most common regime involving progesterone. The average size of the uterus was equivalent to that of a 5.5-week pregnant uterus (minimum: 4, maximum: 10). The uterine cavity length was on average 8.4 cm (minimum: 6, maximum: 12). The diameter of the submucosal fibroids varied in the range 0.5–6 cm (average, 2.6 cm). Eight patients had fibroids larger than 4 cm in diameter for removal. All of the fibroids, even those with diameter >4 cm were removed totally during the endometrial resection procedure. On the classification of the European Society of Hysteroscopy [16], the distribution of the fibroids was five of type 0, eight of type I, 12 of type II, and four of mixed type.

In 77 patients, we used a roller-ball electrode to treat the endometrium in the top of the cavity and around the tubal ostia, and a loop electrode to remove the endometrium from the rest of the cavity. In 21 cases, a loop electrode was used to resect the endometrium even from the fundal area.

The average amount of irrigant fluid utilised for one procedure was 4527 ml (minimum: 2000, maximum: 16,000). The absorption did not exceed the 1500 ml limit: the average absorption was only 374 ml (minimum: 0, maximum: 1200). All but one patient absorbed less than 1000 ml of irrigating fluid. On that one with 1200 ml of absorption we checked serum electrolytes and cardiovascular and respiratory signs postoperatively. All of these values were within the normal range. TCRE was performed under general anaesthesia in 91 cases (92.8%), and under local anaesthesia with intravenous sedation in the remainder. All the seven patients who had the procedure under local anaesthesia with intravenous sedation were satisfied (three patients) or very satisfied (four patients) with the result of the operation. Regarding to the small group of patients we did not perform any statistical analysis on them. The duration of the procedure varied between 10 and 60 min, with an
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