

# Pregnancy following balloon thermal endometrial ablation

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## Abstract

The need for contraception is a concern for both patients and their physicians after endometrial ablation. The reported pregnancy rate after endometrial ablation is quite low, quoted as approximately 0.7%. However, the rate may be significantly higher in younger ovulatory patients.

We present a case of a patient who became pregnant following cave term endometrial ablation. Her pregnancy was complicated by recurrent exacerbation of asthma and chest infections and she required ITU admissions during pregnancy. She was delivered by emergency caesarean section after failed induction of Labour.

## INTRODUCTION

Pregnancy after endometrial ablation is uncommon. These pregnancies are high risk as can be associated with complications such as disorders of abnormal placental adherence, haemorrhage, preterm delivery, and hysterectomy. Although rare, planned pregnancies following endometrial ablation have been reported, but most are unintended and associated with higher complication rate. High termination rate (49%) has been reported for pregnancies conceived after endometrial ablation.

## CASE REPORT

A 42 years old lady balloon thermal endometrial ablation (Cavaterm), in February 2006 for heavy periods. She had earlier requested for hysterectomy. However due to her high BMI, the options including Mirena coil and endometrial ablation were discussed. She was not keen on Mirena coil and had requested endometrial ablation. She was counselled regarding contraception before the procedure. After ablation she did not have any period and found to be pregnant after 3 months which was confirmed by pregnancy test. It was her 6<sup>th</sup> pregnancy (G6P3+2). The pregnancy was unplanned but she was happy to continue the pregnancy. She had a booking BMI of 39. Her past medical history included CIN 3 which was treated with LLETZ and excision biopsy of a lesion on left breast. She suffered from severe asthma which was not very well controlled and she had been using oral prednisolone and salbutamol inhalers for the last 10 years.

She was booked at 10 weeks gestation. She had nuchal translucency (NT) scan at 13 weeks, giving her an adjusted

risk of trisomy 21 as 1:227. She was counselled regarding trisomy 21 and offered invasive testing which she declined. During the anomaly scan, placenta was noted to be low lying but subsequent scans suggested that placenta had moved and was away from the internal os.

She had multiple ante-natal admissions with exacerbation of her asthma, breast and groin abscess and cellulites with bilateral leg oedema. She had a Glucose Tolerance test at 28 weeks, which was normal. She was admitted to ITU (Intensive Therapy Unit) on two occasions with acute asthmatic attacks. The decision of induction of labour was made at 38+5 weeks of gestation. This was carried out by artificial rupture of membrane and syntocinon augmentation. She had an emergency caesarean section for failure to progress in the first stage. A live healthy female baby weighing 3.6 kg was delivered. She developed wound infection postoperatively and was discharged home 2 weeks later.

## DISCUSSION

The overall pregnancy rate after endometrial ablation has been estimated at approximately 0.7% however the rate may be significantly higher in younger ovulatory patients. There are approximately 70 cases of post ablation pregnancy in the literature so far. Thirty-one viable pregnancies resulted, with a high proportion of complications. These included a perinatal mortality rate of 12.9% (4 cases), and an overall prematurity rate of 42%, which reduced to 31% after excluding iatrogenic deliveries performed for other complications. Eight (26%) cases had a morbidly adherent

placenta and a further two cases required a manual removal of placenta. Seven (39%) of the term births were reported as having malpresentations and 71% of the total births were by caesarean section. These complications are likely due to post ablation uterine changes including intrauterine adhesions, contracture of the endometrial cavity, and deficient endometrium (similar to Asherman syndrome).

The need for contraception is a concern for both patients and their physicians after endometrial ablation. Therefore, strong consideration must be given to contraception when counselling patients for endometrial ablation.

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