Doi: https://doi.org/10.3329/ewmcj.v14i1.83418

Case Report

SILENT BLOOM IN A BURNT SOIL: A POST ABLATION PREGNANCY ENDING IN HYSTERECTOMY

Fardous A[1], Rahman RRB[2], Menshway A[3]

Article History:
Received: 31st July 2025
Accepted: 28th August 2025

Key words:
Endometrial ablation; Post-ablation pregnancy; Abnormal placentation; Hemorrhage; Hysterectomy; Fertility complications

Abstract

Background: *Pregnancy following endometrial ablation is rare but associated with severe obstetric complications, including abnormal placentation, uterine rupture, and hemorrhage. Early identification and a multidisciplinary approach are vital in managing these high-risk cases.*

Case Presentation: *We report the case of a 33-year-old woman with a history of endometrial ablation who presented at 8 weeks gestation with severe vaginal bleeding and abdominal pain. Ultrasound confirmed retained products of conception, and surgical evacuation was performed. However, uncontrollable bleeding ensued, prompting a CT scan that revealed active hemorrhage from a uterine artery branch and hemoperitoneum. Laparoscopy was initially planned to investigate suspected uterine perforation, but due to hemodynamic instability and ongoing hemorrhage, an emergency laparotomy and total abdominal hysterectomy were performed. Interventional radiology was consulted but could not proceed due to the emergent nature of the case.*

Conclusion: *This case highlights the high-risk nature of pregnancy after endometrial ablation and the need for urgent, coordinated surgical management in the face of massive hemorrhage. Recognition of complications, prompt imaging, and decisive multidisciplinary action were essential to the patient's survival.*

EWMCJ Vol. 14, No. 1, January 2026: 91-93

Background

Endometrial ablation is commonly used for the treatment of heavy menstrual bleeding in women who have completed childbearing. While it significantly reduces fertility, pregnancy is still possible and often associated with catastrophic complications, including abnormal placentation (particularly placenta accreta spectrum), uterine rupture, miscarriage, and massive hemorrhage. Patients with a history of uterine surgery are at increased risk of abnormal placental implantation, as outlined in the RCOG Green-top Guideline No. 27.[1]

This case report illustrates the critical challenges of managing early pregnancy in a post-ablation uterus and the urgent need for surgical intervention when conservative measures fail.

Case Presentation

A 33-year-old woman, gravida 4 para 3, with a history of endometrial ablation 18 months prior, presented to the emergency department at 8 weeks gestation. She reported sudden-onset lower abdominal pain and heavy vaginal bleeding. She had not sought antenatal care prior to the presentation.

Initial assessment revealed hypotension (BP 88/55 mmHg), tachycardia (HR 112 bpm), and pallor. Bedside ultrasound confirmed a non-viable intrauterine pregnancy with retained products of conception

1. Dr. Amena Fardous, Senior Clinical Fellow, Prince Charles Hospital, Wales, Ex-Registrar, East West medial College Hospital, Dhaka.
2. Prof. Ratu Rumana Binte Rahman, MBBS, FCPS, Professor of OBGYN, East West medial College Hospital, Dhaka.
3. Dr. Ahmed Menshawy, MBBS, MRCO, Senior Clinical Fellow, Prince Charles Hospital, Wales.

Address of Correspondence: Dr. Amena Fardous, Senior Clinical Fellow, Prince Charles Hospital, Wales, Ex-Registrar, East West medial College Hospital, Dhaka. E-mail: dramenafardousponni@yahoo.com

(RPOC). No clear signs of uterine rupture or adnexal pathology were noted at that time. Hemoglobin was 8.2 g/dL on admission.

Surgical evacuation of the uterus was urgently performed under general anesthesia. Intraoperatively, brisk hemorrhage was noted and failed to respond to uterotonics and intrauterine tamponade. Suspecting uterine perforation and persistent bleeding, the team planned for diagnostic laparoscopy.

CT imaging was obtained to assess for perforation and source of bleeding. The scan revealed active contrast extravasation from the left uterine artery branch and minimal free fluid in the pelvis consistent with hemoperitoneum.

Interventional radiology was contacted for possible uterine artery embolization. However, given the patient's hemodynamic instability and the rapid progression of bleeding, embolization was deemed unfeasible in the emergency setting. .[11,12]

Due to the volume of hemorrhage and the worsening hemodynamic status, laparotomy was performed instead of the planned laparoscopy. Intraoperative findings included an engorged, actively bleeding uterus with no perforation identified. Hemostasis was not achievable, and a total abdominal hysterectomy was performed to control the bleeding. The estimated blood loss was approximately 2.5 liters. The patient received four units of packed red blood cells and two units of fresh frozen plasma.

Postoperatively, the patient made a good recovery and was discharged on postoperative day six with outpatient follow-up.

Discussion

Pregnancy after endometrial ablation is a high-risk condition. Despite a significant reduction in fertility, conception can still occur, particularly when the ablation is incomplete or endometrial tissue regenerates.[2,3] Literature indicates that these pregnancies often implant abnormally due to endometrial scarring and a disrupted uterine lining. [2,4,9]

In this case, the early pregnancy was complicated by heavy bleeding, likely due to abnormal placentation or fragile myometrial vessels secondary to ablation. [4,5]. Surgical evacuation was unsuccessful in controlling the hemorrhage, and uterine artery rupture was ultimately identified on CT.

Endometrial ablation aims to destroy the functional layer of the endometrium to reduce menstrual bleeding, typically performed in women who have completed childbearing. Several techniques exist, including thermal balloon ablation, radiofrequency, cryoablation, and resectoscopic methods using rollerball or loop electrodes.[9] The procedure involves inserting the device transcervically into the uterine cavity under direct visualization or ultrasound guidance. The cavity is irrigated, and tissue destruction is achieved by uniform thermal or electrical energy application. After the procedure, hemostasis is secured, and the uterine cavity is inspected to ensure complete ablation.[9,10]

CT imaging was crucial in identifying the bleeding source and excluding uterine rupture. While uterine artery embolization is often effective in controlling obstetric hemorrhage, it requires hemodynamic stability and time to mobilize a radiology team.[11,12] In this case, the decision to proceed with emergency laparotomy and hysterectomy was life-saving and consistent with guidelines for managing massive obstetric hemorrhage.[7,8,10]

The RCOG Green-top Guideline No. 52 emphasizes the need for timely escalation and surgical intervention when conservative measures fail.[7] Hysterectomy, while drastic, remains a definitive solution for uncontrollable hemorrhage when uterine preservation is not possible.

Learning Points

Pregnancy following endometrial ablation is rare but associated with significant morbidity and mortality.

Patients must be clearly counselled that endometrial ablation is not a form of contraception and that pregnancy, although unlikely, remains possible and high-risk.

Early recognition of complications such as abnormal placentation and vascular injury is essential.

CT imaging can provide critical information in hemodynamically unstable patients to guide surgical decision-making.

Interventional radiology may not always be feasible in emergency situations, underscoring the need for preparedness for surgical intervention.

A multidisciplinary approach—including obstetricians, radiologists, anesthetists, and emergency surgeons—is key to optimal outcomes.

Patient Perspective

"I had no idea I could get pregnant after the ablation. It was a terrifying experience, but I'm grateful to the team for acting quickly and saving my life."

References

1. Royal College of Obstetricians and Gynaecologists. Placenta Praevia, Placenta Accreta and Vasa Praevia: Diagnosis and Management. Green-top Guideline No. 27. RCOG, 2018.
2. Wortman M, Daggett A, Ball C. Pregnancy following endometrial ablation: case reports and review of the literature. J Minim Invasive Gynecol. 2010;17(6):723–730. doi:10.1016/j.jmig.2010.06.009
3. Yu L, Wang Y, Wang H, Yang H. Pregnancy outcomes following endometrial ablation: a review of the literature. Int J Gynaecol Obstet. 2019;146(2):147–152. doi:10.1002/ijgo.12866
4. Bahadori F, DeCherney AH. Endometrial ablation: long-term outcomes and pregnancy complications. Clin Obstet Gynecol. 2014;57(3):539–544. doi:10.1097/GRF.0000000000000051
5. Peterson WF, Woodruff JD. The pathogenesis of placenta accreta. Obstet Gynecol Annu. 1973;2:210–226.
6. Deans R, Abbott J. Review of intrauterine adhesions. J Minim Invasive Gynecol. 2010;17(5):555–5569. doi:10.1016/j.jmig.2010.04.016
7. Royal College of Obstetricians and Gynaecologists. Prevention and Management of Postpartum Haemorrhage. Green-top Guideline No. 52. RCOG, 2016.
8. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 183: Postpartum Hemorrhage. Obstet Gynecol. 2017;130(4):e168–e186. doi:10.1097/AOG.0000000000002351
9. Price N, Goldstein S. Comparison of endometrial ablation technologies. Curr Opin Obstet Gynecol. 2004;16(4):293–297. doi:10.1097/00001703-200408000-00001
10. Pacheco LD, Saade GR, Hankins GDV. Medical and surgical management of postpartum hemorrhage: A review. Clin Obstet Gynecol. 2010;53(1):164–176. doi:10.1097/GRF.0b013e3181cc437f
11. Royal College of Radiologists. Standards for Providing a 24-Hour Interventional Radiology Service. London: RCR, 2019.
12. Delafield R, Malhotra A, Gupta S. Uterine artery embolization in the emergency setting: limitations and considerations. Cardiovasc Intervent Radiol. 2022;45(3):398–406. doi:10.1007/s00270-021-03040-1

Ethics Statement:

Patient Consent:

Written informed consent was obtained from the patient for publication of this case report.

Peer-Review History:
The peer review history for this paper can be accessed here: https://ewmch.com/review/