

## 3.5 Hysterectomy and endometrial ablation hospital admissions

### Context

This data item examines hospital admissions for hysterectomy and endometrial ablation for women 40 years and over. Hospital admission data are sourced from the Admitted Patient Care National Minimum Data Set. This includes both public and private hospitals. Rates are described as the number of admissions per 100,000 people. Repeat admissions for one person and transfers to other hospitals are both counted as separate admissions.

Hysterectomy and endometrial ablation are surgical procedures used to treat heavy menstrual bleeding.

Hysterectomy is an operation in which the uterus (womb) is removed. In some cases, the ovaries and/or fallopian tubes are also removed. Common indications for hysterectomy include heavy menstrual bleeding, fibroids and uterine prolapse. Less common indications include chronic pelvic pain, severe endometriosis, endometrial hyperplasia and endometrial cancer. A hysterectomy can be undertaken through abdominal, vaginal or laparoscopic surgery.

Endometrial ablation is a surgical procedure to permanently remove the lining of the uterus, commonly via electrical or thermal (heat) ablation. It is used to treat abnormally heavy menstrual bleeding (menorrhagia), which is commonly caused by hormonal disorders (frequently termed dysfunctional uterine bleeding). Endometrial ablation is less suitable if the bleeding is caused by larger uterine fibroids. Endometrial ablation may be performed where non-surgical treatments, for example, hormonal medications, non-steroidal anti-inflammatory medications or hormone-releasing intrauterine devices have not been effective.

Both endometrial ablation and hysterectomy are effective for treating heavy menstrual bleeding. While hysterectomy is associated with a longer operating time, a longer recovery period and higher rates of post-operative complications, it offers permanent relief from heavy menstrual bleeding.<sup>1</sup>

A hormone-releasing intrauterine device can be an effective alternative to hysterectomy and endometrial ablation for heavy menstrual bleeding. However, for women who have large fibroids, the hormone-releasing intrauterine device is much less likely to be effective.

# Hysterectomy and endometrial ablation hospital admissions

## Magnitude of variation

In 2012–13, there were 34,181 hysterectomy and endometrial ablation admissions to hospital, representing 297 admissions per 100,000 women (the Australian rate).

The number of hysterectomy and endometrial ablation admissions to hospital across 315\* local areas (SA3s) ranged from 131 to 687 per 100,000 women. The number of admissions was **5.2 times higher** in the area with the highest rate compared to the area with the lowest rate. The average number of admissions varied across states and territories, from 225 per 100,000 women in the Northern Territory, to 349 in Western Australia.

After excluding the highest and lowest results, the hysterectomy and endometrial ablation hospital admission rate across the 296 remaining local areas was **3.3 times higher** in one local area compared to another.

Admission rates for endometrial ablation or hysterectomy were markedly higher in inner and outer regional areas than in major cities or in remote areas. There was no clear link between rates and socioeconomic status.

## Interpretation

Potential reasons for the variation include differences in:

- the criteria used by doctors when deciding what treatment to recommend
- use of the hormone-releasing intrauterine device by general practitioners and specialists
- decision-making criteria of clinicians and patients in assessing the need for hysterectomy and endometrial ablation
- availability of specialists, who may regard travel to very remote areas as a significant barrier.

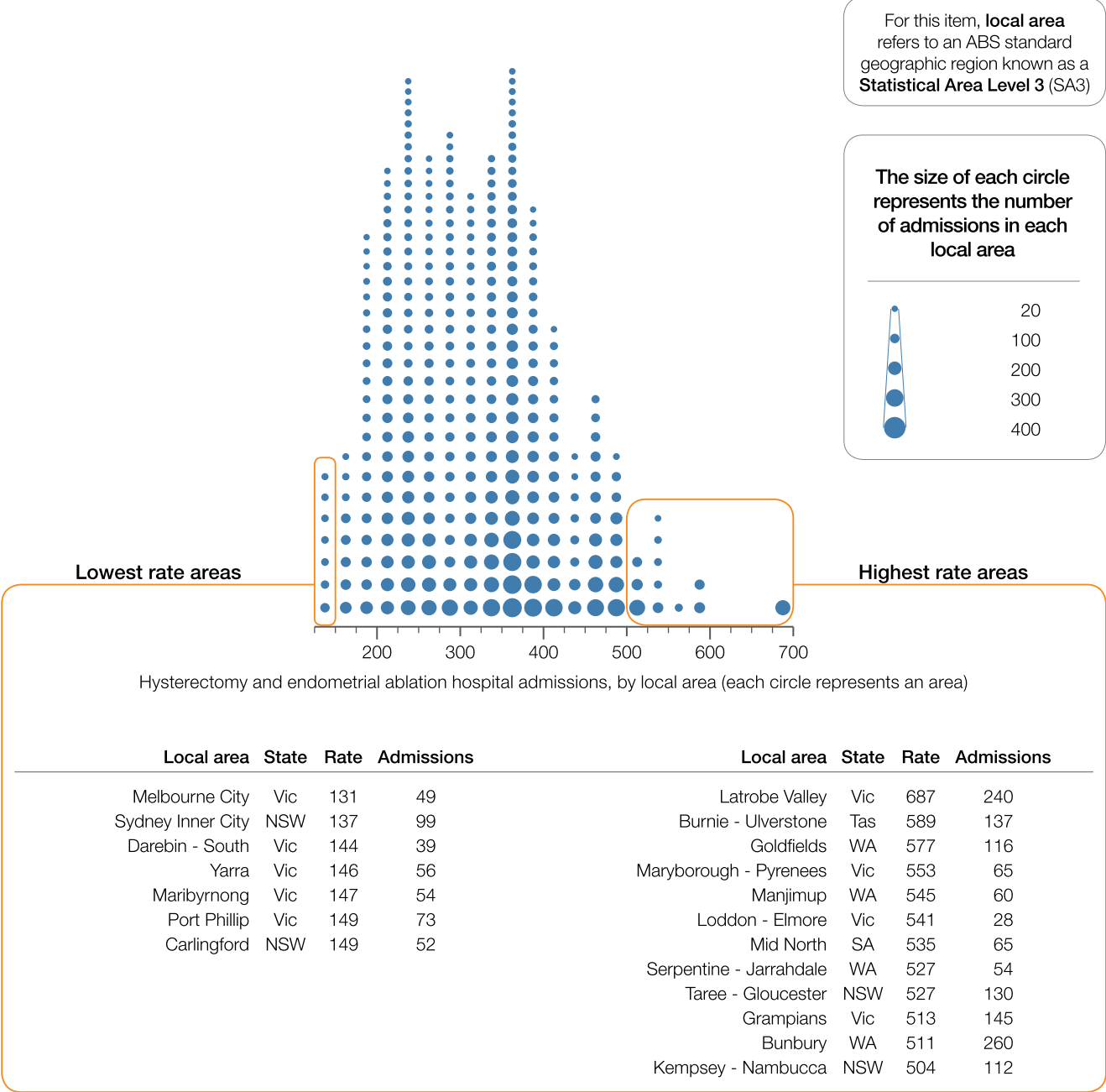
To explore this variation, further analysis could focus on:

- separating the data for ablation and hysterectomy to review the variation for each procedure
- opportunities for data linkage to map admission data against rates of dispensing for hormone-releasing intrauterine devices to determine whether lower use can be linked to higher rates of endometrial ablation and hysterectomy
- the influence of the private and public sectors on rates of ablation and hysterectomy.

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\*There are 333 SA3s. For this item, data were suppressed for 18 SA3s. This is because of confidentiality requirements given the small numbers of admissions in these areas.

Figure 44: Number of hysterectomy and endometrial ablation admissions to hospital per 100,000 women, age standardised, by local area, 2012–13



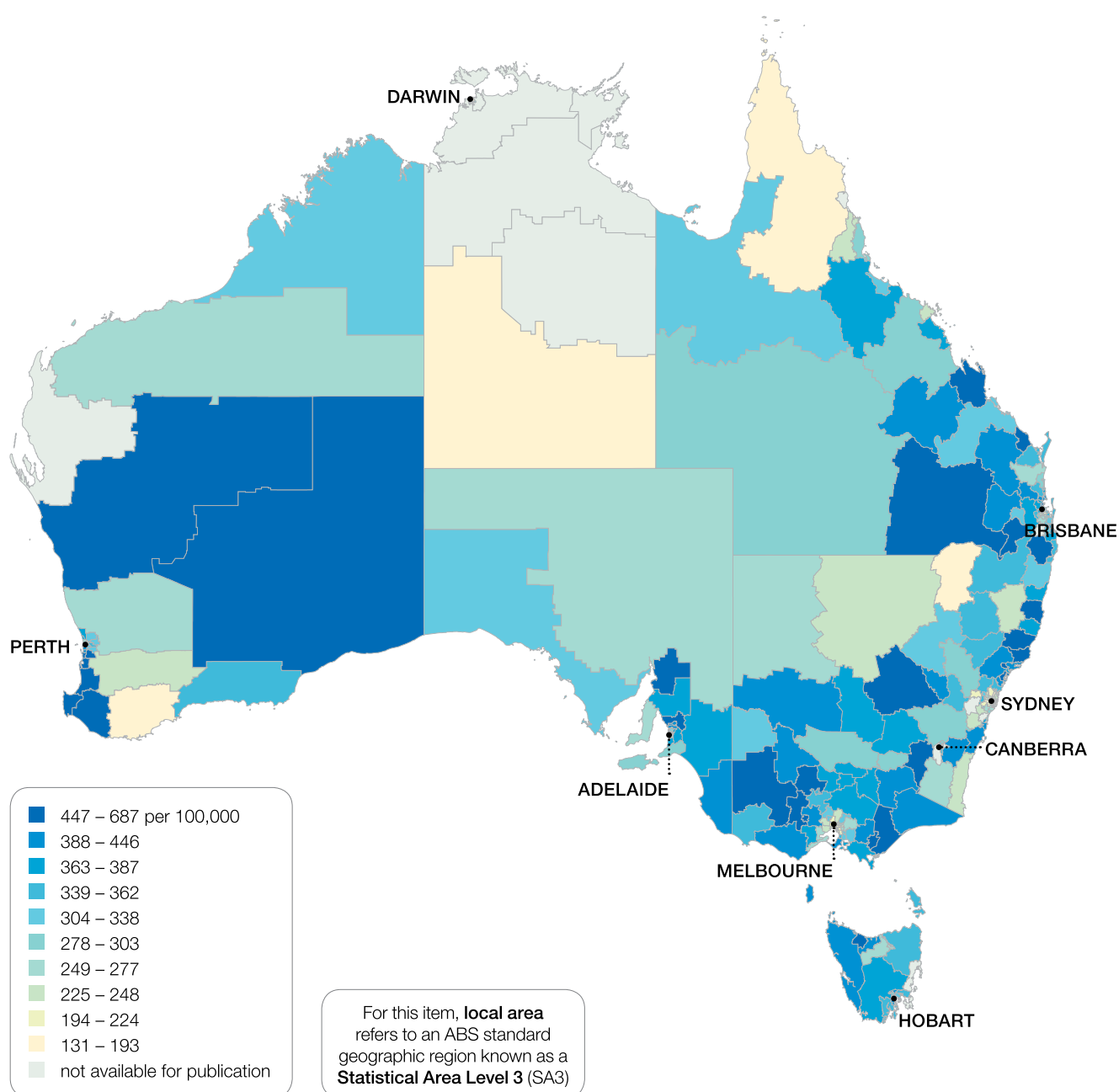
**Notes:**  
Rates are standardised based on the age structure of the Australian population in 2001.  
State/territory and national rates are based on the total number of admissions and women in the geographic area.  
The term local area refers to an ABS standard geographic region known as a Statistical Area Level 3 (SA3).  
Includes all public hospitals, private hospitals and day hospital facilities.

For more technical information please refer to the Technical Supplement.

**Sources:** National Health Performance Authority analysis of Admitted Patient Care National Minimum Data Set 2012–13 (data supplied 09/04/2014) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013.

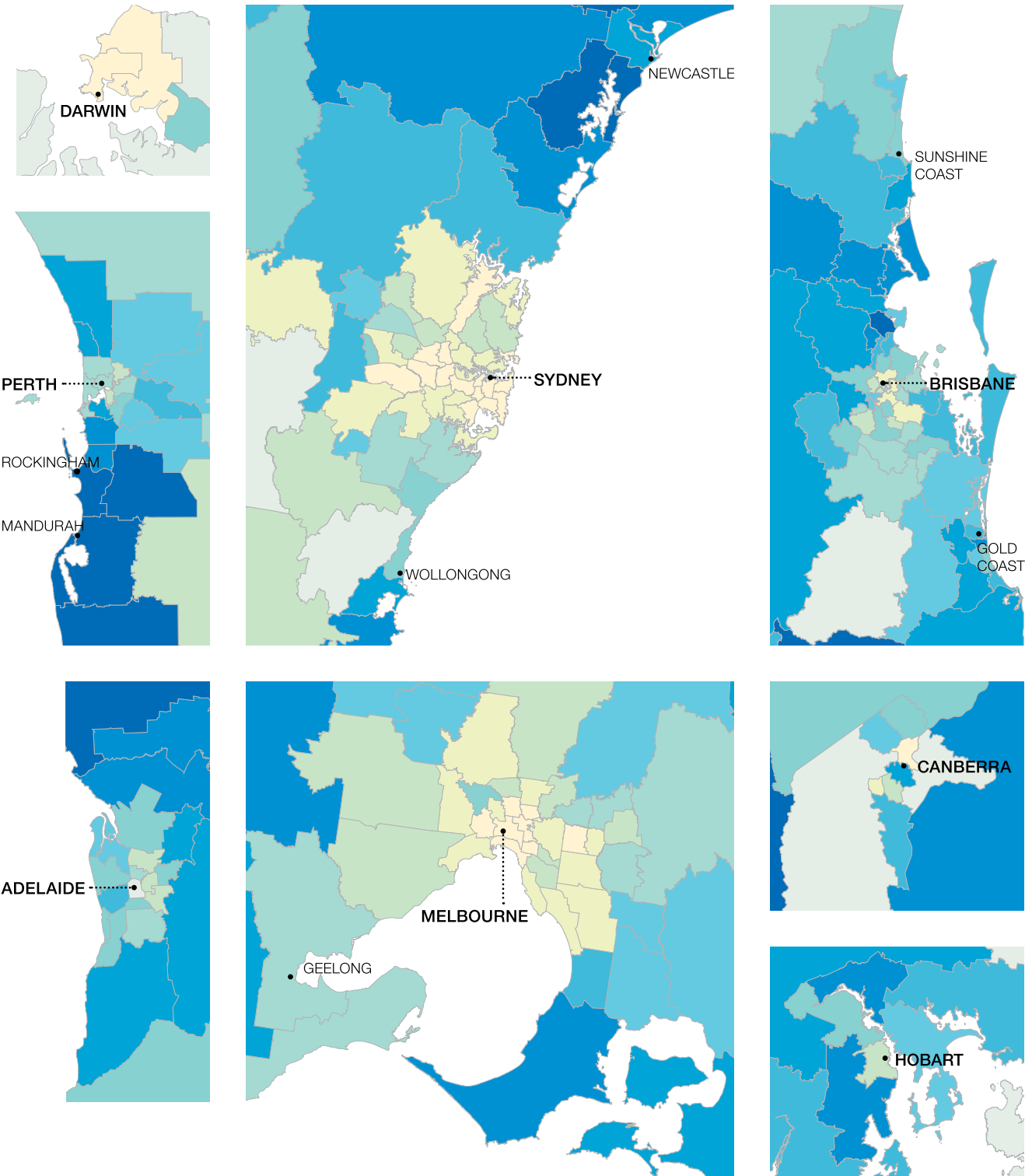
# Hysterectomy and endometrial ablation hospital admissions

Figure 45: Number of hysterectomy and endometrial ablation admissions to hospital per 100,000 women, age standardised, by local area, 2012–13



**Sources:** National Health Performance Authority analysis of Admitted Patient Care National Minimum Data Set 2012–13 (data supplied 09/04/2014) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013.

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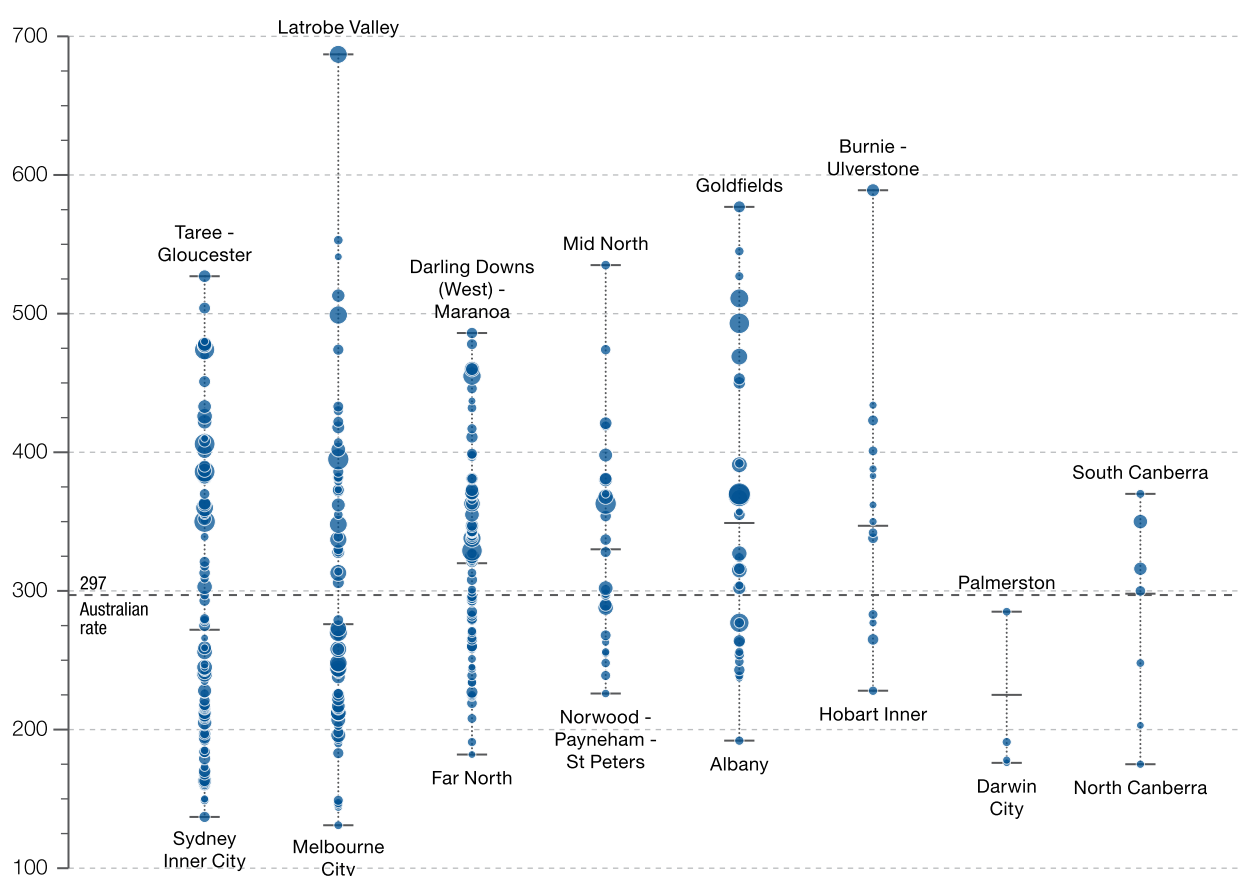


Sources: National Health Performance Authority analysis of Admitted Patient Care National Minimum Data Set 2012–13 (data supplied 09/04/2014) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013.

# Hysterectomy and endometrial ablation hospital admissions

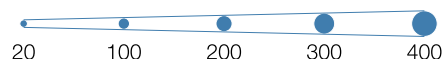
Figure 46: Number of hysterectomy and endometrial ablation admissions to hospital per 100,000 women, age standardised, by local area, state and territory, 2012–13

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Highest rate	527	687	486	535	577	589	285	370
State/territory	272	276	320	330	349	347	225	298
Lowest rate	137	131	182	226	192	228	176	175
No. admissions	10,042	8,008	7,366	2,782	4,275	874	250	558



For this item, **local area** refers to an ABS standard geographic region known as a **Statistical Area Level 3 (SA3)**

The size of each circle represents the number of admissions in each local area

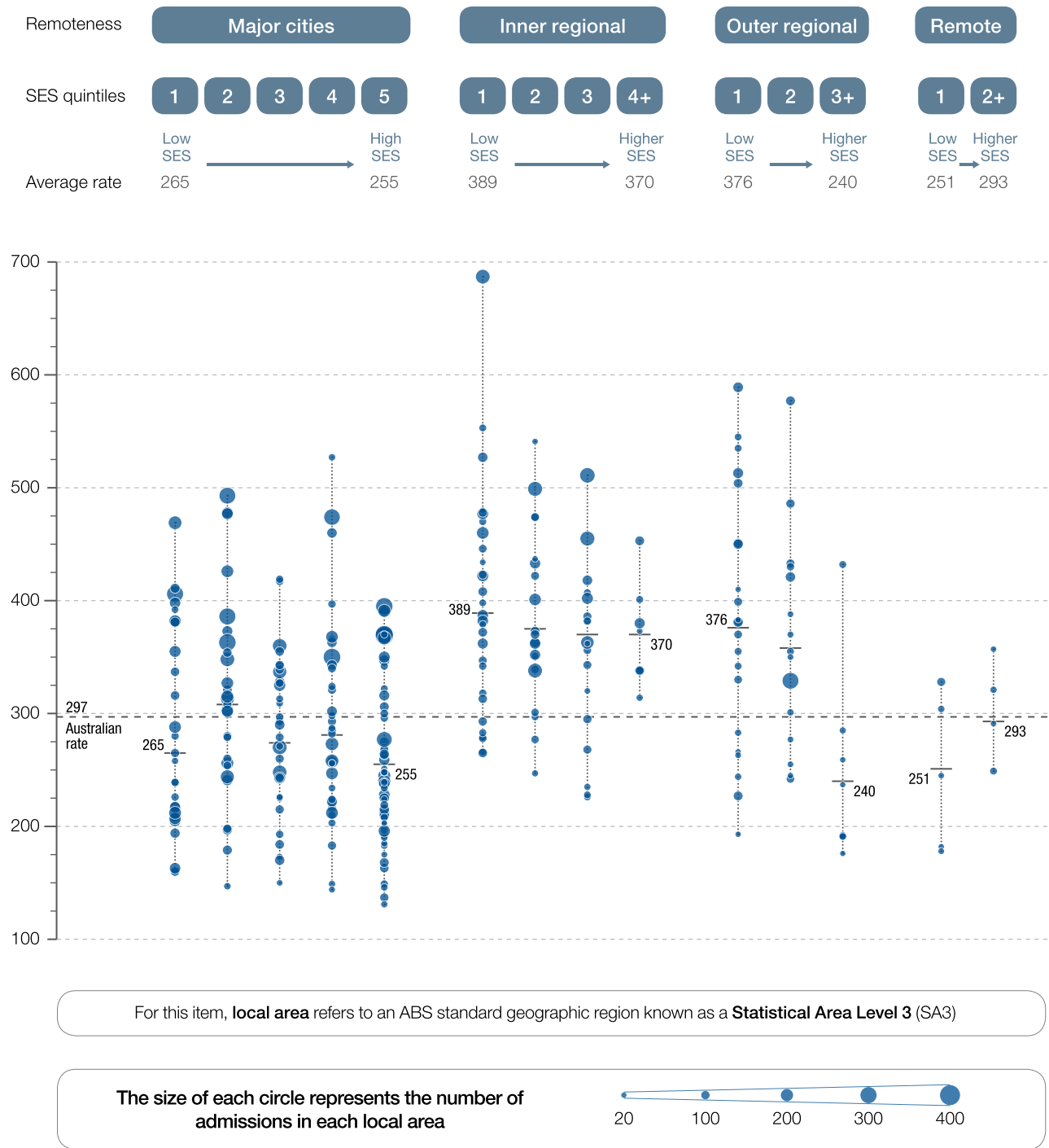


## Notes:

Rates are standardised based on the age structure of the Australian population in 2001. State/territory and national rates are based on the total number of admissions and women in the geographic area.

**Sources:** National Health Performance Authority analysis of Admitted Patient Care National Minimum Data Set 2012–13 (data supplied 09/04/2014) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013.

Figure 47: Number of hysterectomy and endometrial ablation admissions to hospital per 100,000 women, age standardised, by local area, remoteness and socioeconomic status (SES), 2012–13



**Notes:**  
Rates are standardised based on the age structure of the Australian population in 2001.  
The national rate is based on the total number of admissions and women in Australia.  
Average rates are based on the total number of admissions and women in the local areas within each group.

**Sources:** National Health Performance Authority analysis of Admitted Patient Care National Minimum Data Set 2012–13 (data supplied 09/04/2014) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013.

# Hysterectomy and endometrial ablation hospital admissions

## Resources

- American College of Obstetricians and Gynecologists – Committee on Gynecological Practice. *Management of Acute Abnormal Uterine Bleeding in Non-Pregnant Reproductive Aged Women*. 2013. Available at: [www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co557.pdf?dmc=1&ts=20150713T0336418910](http://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co557.pdf?dmc=1&ts=20150713T0336418910).
- Royal College of Obstetricians and Gynaecologists. *Standards for Gynaecology: Report of a Working Party*. 2008. Available at: [www.rcog.org.uk/globalassets/documents/guidelines/wprgynstandards2008.pdf](http://www.rcog.org.uk/globalassets/documents/guidelines/wprgynstandards2008.pdf).
- Royal College of Obstetricians and Gynaecologists. *National Heavy Menstrual Bleeding Audit: A national audit to assess patient outcomes and experiences of care for women with heavy menstrual bleeding in England and Wales*. 2011. Available at: [www.rcog.org.uk/globalassets/documents/guidelines/research-audit/nationalhmbaudit\\_1stannualreport\\_may2011\\_generalpublicsummary.pdf](http://www.rcog.org.uk/globalassets/documents/guidelines/research-audit/nationalhmbaudit_1stannualreport_may2011_generalpublicsummary.pdf).

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1 Fergusson RJ, Lethaby A, Shepperd S, Farquhar C. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. Cochrane Database of Systematic Reviews. 2013; Issue 11.