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ORIGINAL ARTICLE

Office hysteroscopy: A report of 2402 cases

Hystéroscopie diagnostique en consultation : une série consécutive de 2402 cas

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KEYWORDS
Office hysteroscopy;
Vaginoscopy;
Failure rate;
Pain;
Postmenopausal bleeding

Summary
Introduction. — Hysteroscopy is the gold standard for evaluation of uterine cavity. It can be performed either as office setting or as day care procedure under general anaesthesia. Objective of this study is to assess feasibility and acceptability of office hysteroscopy without anaesthesia.
Materials and methods. — This retrospective observational study took place in the gynaecologic unit of a teaching hospital. Women who had had an office hysteroscopy from 2010 to 2013 were included.
Results. — Two thousand four hundred and two office hysteroscopies were carried out. Indications were menorrhagia (32.2%), postoperative evaluation (20.8%), infertility (15.8%), postmenopausal bleeding (10.9%) and other indications (20.3%). Women's mean age was 39.4 [39.0—39.9] and significantly higher among women with a failure of the office hysteroscopy (47.3 vs. 38.6, $P < 0.01$). The failure rate was 9.5%, significantly higher in women with postmenopausal bleeding and lower in women for a postoperative evaluation. Assessment of an abnormal uterine cavity was done in 56.0% of cases with 28.7% of myomas, 27.2% of polyps, 17.7% of synechiaes, 14.7% of endometrial hypertrophies, 9.0% of trophoblastic retentions and 7.7% of uterine malformation. The complication rate of office hysteroscopy was 0.05%. Mean pain score during the examination was 3.57 out of 10 [3.48—3.66] and 0.89 [0.83—0.95] five minutes later.
Conclusion. — Office hysteroscopy is safe and feasible with little pain. A failure rate of 9.5% is reported, mainly for older women with postmenopausal bleeding.

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MOTS CLÉS
Hystéroscopie diagnostique, Vaginoscopie, Douleur, Échec, Consultation

Résumé
Introduction. — L'hysteroscopie est la méthode de référence pour l'évaluation de la cavité utérine. Elle peut être réalisée en consultation ou en chirurgie ambulatoire sous anesthésie générale, locorégionale ou locale. L'objectif de cette étude est de montrer la faisabilité et l'acceptabilité de l'hystéroscopie diagnostique en consultation en l'absence d'anesthésie.
Matériel et méthodes. — Étude retrospective observationnelle dans l'unité de chirurgie gynécologique d'un centre hospitalo-universitaire. Lés patientes ayant bénéficiées d'une hystéroscopie en consultation entre 2010 et 2013 ont été incluses.
Résultats. — Deux mille quatre cent deux hystéroscopies diagnostiques ont été réalisées. Les indications étaient des ménorragies (32,2 %), un contrôle postopératoire (20,8 %), une infertilité (15,8 %), des saignements postménopausiques (10,9 %) ou une autre indication (20,8 %). L'âge moyen des patientes étaient de 39,4 ans [39,0—39,9] et significativement plus élevé chez les patientes avec un échec de l'hystéroscopie en consultation (47,3 versus 38,6 ans, $p < 0,01$). Le taux d'échec était de 9,5 %, significativement plus important chez les patientes avec des métrorragies postménopausiques et significativement moindre lors des contrôles postopératoires. Une anomalie de la cavité utérine a été constatée dans 56,0 % des cas avec un myome dans 28,7 %, un polype dans 27,2 % des cas, des synéchies dans 17,7 %, un épaississement de l'endomètre dans 14,7 %, une rétention de trophoblaste dans 9,0 % des cas et une malformation utérine dans 7,7 % des cas. Le taux de complications était de 0,05 % et le score moyen de douleur par une échelle verbale simple pendant l'examen était de 3,57 sur 10 [3,48—3,66] et de 0,89 [0,83—0,95] à 5 minutes.
Conclusion. — L'hystéroscopie diagnostique est un examen sûre et faisable avec une faible douleur. Un taux d'échec de 9,5 % est rapporté, principalement chez les patientes plus âgées avec des métrorragies postménopausiques.

Introduction

Hysteroscopy is the gold standard for evaluation of uterine cavity in cases of abnormal uterine bleeding, infertility, recurrent pregnancy loss, and suspected intrauterine malformation [1,2]. Hysteroscopy may be performed either as office setting (office hysteroscopy) or as day care procedure under general anaesthesia. Office hysteroscopy appeared to be as accurate as hysteroscopy under anaesthesia and presents many benefits: no anaesthetic risks, time saving, lower costs and women preference [3—5].

Need for anaesthesia or analgesia during office hysteroscopy is still being debated; this argument about benefit of anaesthesia and analgesia is due to disparity in pain perception also depending on the technique and equipment used and on women characteristics.

According to the Cochrane data base publication, para-cervical block anaesthesia can decrease pain during procedure and 30 minutes after [6], whereas French guidelines [8] did not recommend using either analgesia or anaesthesia to achieve office hysteroscopy, while in England analgesia is administered in 62.5% of the medical centres performing office diagnostic hysteroscopy [9].

Recent improvements, such as introduction of small-diameter rigid and flexible hysteroscopes, development of no touch-approach (vaginoscopy), have led tolerance of office hysteroscopy without anaesthesia or analgesia [7,10].

Aim of this study is to report a large series of consecutive office hysteroscopy without analgesia or anaesthesia in order to evaluate feasibility and acceptability.

Materials and methods

A retrospective observational study of women who underwent office hysteroscopy was conducted from January 2010 to November 2013 in the Gynaecologic unit of a teaching hospital.

Office hysteroscopy were performed by experienced practitioners and nurses during a specific appointment without any premedication (analgesia, misoprostol or mifepristone), anaesthesia, vulvar or vaginal antisepsis or prophylactic antibiotics. Nitrogen oxide (MEOPA) was used in case of anxiety or pain experienced by the women. The cost is 66.48 euros in outpatient or in operative room.

Before hysteroscopy they were asked about age, menopausal status, parity, number of caesarean section, date of last menstruation, symptoms, use of contraceptives, and any others examinations such as trans-vaginal ultrasound and their results. Office hysteroscopy was delayed in case of a pregnancy suspicion (urinary test available before the procedure), ongoing menstruation or pelvic infection.

Hysteroscopy was performed with a 3.5 mm outside diameter rigid hysteroscope with a 30-degree lens (Endoskope; Karl Storz GmbH and Co., Tuttlingen, Germany). Saline solution 0.9% was used as a distention medium with a fluid management system or by gravity (a saline solution 150 cm over women allows an adequate distension) without any evacuation system. The vaginoscopic approach was systematically tried without speculum and tenaculum [11].

A systematic examination of uterine cavity was then performed: fundus and tubal ostia, cavity and possible

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