



## Review article

## Tips and tricks in office hysteroscopy

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## ABSTRACT

Office hysteroscopy is a minimally invasive procedure that has been shown to be highly accurate in diagnosing abnormalities of the endometrial cavity and the endocervical canal. It allows the direct visualizing of uterine pathology without the need for general anesthesia and the use of an operating room, generating cost savings and greater compliance among patients. The advent of small-diameter hysteroscopes, the use of saline solution as a distension media, as well as the vaginoscopic technique have widely contributed to the diffusion of this technique worldwide, and currently it can be considered the gold standard for the examination of the uterine cavity. The improved technology has also enabled surgeons to perform many operative procedures in an ambulatory setting without significant patient discomfort. With the development of miniaturized operative hysteroscopes and mechanical/electrified instruments, many surgical interventions on the uterine cavity can be actually performed safely and effectively in the office-based setting, introducing the concept of "see and treat hysteroscopy." This review provides several tips and tricks to maximize the chance of success of an office hysteroscopy, either diagnostic or operative.

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## Introduction

Technical and technological advances are continuously revolutionizing our everyday life, at times forcing us to race ahead just to keep up with the times. This is nowhere more true than in the field of surgery, which in recent decades has been all but reborn through modern technologies, leading to results that are both thrilling and astonishing, even in the eyes of the most skeptical.

Referring to gynecology, the most significant reflection of this frenetic and burgeoning progress is without doubt that seen in gynecologic endoscopy, and particularly in the field of hysteroscopy.

Hysteroscopy (from the Greek terms *hysteros* meaning uterus and *scopy* meaning to look) can be considered a real Copernican revolution of modern gynecology, because whereas laparoscopy simply modified the access to the abdominal cavity, hysteroscopy by contrast "enlightened" for the first time a cramped and dark

space, which was never directly explored until the mid-19<sup>th</sup> century.

Hysteroscopy, in its early days, was considered the "Cinderella" subspecialty of gynecologic endoscopy, a modality that was both laborious and difficult to master because of its considerable technical challenges and deficiencies in terms of instrumentation. Indeed, it was rarely used in routine clinical practice, which has relied almost exclusively on "dilatation and curettage" (D&C) for the purposes of diagnosis and treatment of intrauterine pathologies.

Although some scientific societies and authors continue to emphasize the diagnostic and therapeutic role of D&C,<sup>1–8</sup> a large number of papers have extensively shown throughout the years the significant limits of this technique: (1) need for in-patient admission and general or locoregional anesthesia; (2) high risk of complications (i.e., perforation, adhesions, infections); (3) poor diagnostic accuracy.<sup>3,4,9</sup> Indeed, many studies have shown that D&C is characterized by a high number of focal lesions missed and consequently by an extremely high number of false negative uterine cavities.<sup>10</sup> Furthermore, D&C has no therapeutic role, with most endometrial disorders still present in the uterus after it is performed and with a high recurrence rate of bleeding symptoms.<sup>9</sup>

Over the past 40 years, the higher diagnostic accuracy related to the possibility of direct endoscopic vision of the distended uterine

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cavity together with continuous and rapid advances in technologies and techniques, have opened up new horizons for hysteroscopic modalities, which today are considered the gold standard of diagnostic and therapeutic options in the management of intrauterine pathologies, and, more recently, of those seen in the cervix and vagina.<sup>11–13</sup>

During the 1970–1980s, hysteroscopy was routinely performed using the so-called “traditional technique.” This approach involved the use of a speculum and cervical forceps while viewing and examining the cervix under distension using CO<sub>2</sub> as the preferred gaseous medium. Owing to the large diameter of the hysteroscope, preparatory cervical dilatation was mandatory, using local or general anesthesia, followed by hospitalization during recovery (inpatient hysteroscopy).<sup>14</sup>

In the early 1990s, advances in technology and techniques made hysteroscopy less painful and invasive. While gaining an increasingly widespread acceptance in clinical practice, the method helped to reduce the number of procedures performed in the operating room. At the same time, the number of ambulatory procedures (office hysteroscopy) was seen to rise, which may also be attributed to the fact that office hysteroscopy has the inherent benefit of obviating the need for anesthesia and dilatation of the cervical canal.<sup>15–17</sup>

In subsequent years, numerous studies have indicated that office hysteroscopy has definite advantages in comparison with the blind techniques (D&C, Vabra, curette) and a diagnostic accuracy comparable to that of hysteroscopy in the operating room. In addition, the method provides added advantages, in that the risks associated with anesthesia are reduced, it generates cost savings, and has a greater compliance rate among patients.<sup>9,18,19</sup>

Currently, office hysteroscopy can be considered, in every respect, the gold standard for the examination of the uterine cavity, overcoming, in fact, the significant limitations of D&C and other blind techniques.

However, several tips and tricks are needed to maximize the chance of success of an office hysteroscopy, either diagnostic or operative.

### Comfortable setting

Office hysteroscopy should be conducted outside of the formal operating theater setting in an appropriately sized, equipped, and staffed treatment room with adjoining, private changing facilities and toilet. As the patient is aware of everything that is going on, it is advisable to organize a relaxed setting, using a protected space with a comfortable seat (Fig. 1) and, if possible, create a family environment.<sup>20,21</sup>

The nurse should set up the room where the procedure takes place in order to ensure that all the necessary equipment and instruments are in proper working conditions and readily available.

It has been speculated that women who are anxious while undergoing a hysteroscopy usually experience more discomfort during the procedure. Therefore, if the doctor or a nurse is able to develop a plan of care that will help minimize the patient's anxiety, a more positive outcome and increased patient satisfaction can be expected.

During the procedure, the nurse or a resident should provide emotional support to the patient (“vocal local”) and in order to further reduce the patient's anxiety the physician may also get the patient more involved into the procedure by inviting her to look at



**Fig. 1.** Setup of ambulatory hysteroscopy at the Department of Obstetrics and Gynecology of University “Federico II” of Naples: an ergonomic, electronically activated examination chair may facilitate in putting the patient in the proper position for the hysteroscopy, even in women with limited mobility at the knee.

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