

Outpatient hysteroscopy

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Abstract

The face of gynaecology is changing, and as it develops into a mainly ambulatory speciality. Surgical procedures previously carried out as day case surgery or as in patient are now increasingly performed in the outpatient setting. This is true of hysteroscopic procedures that were traditionally theatre based in hospital, but are now performed in the outpatient setting as first line in many centres. Crucially this has been shown to be both cost effective and acceptable to patients. This review will provide an overview of the indications, current guidelines and best practice techniques for clinicians performing both diagnostic and therapeutic outpatient hysteroscopies.

Keywords ambulatory; diagnostic; hysteroscopy; outpatient; therapeutic

Hysteroscopy is a common procedure used in gynaecology to assess the uterine cavity for suspected endometrial pathology. A specialised endoscope is passed transcervically into the uterine cavity to visualise and assess the endometrium. The hysteroscopic approach is suitable for a range of surgical techniques including endometrial biopsies, polypectomies, fibroid resection, endometrial ablation and sterilisation. Hysteroscopy was traditionally performed under a general anaesthetic (GA) in a theatre setting (inpatient or day surgery). However with the advent of smaller, flexible hysteroscopes and technological advances in surgical equipment, it is being performed more frequently in the outpatient (OP) setting with little or no analgesia. This avoids the need for a general anaesthetic, shortens appointment times, is acceptable to patients and additionally saves money.

A diagnostic hysteroscopy is usually performed for investigation of abnormal uterine bleeding (AUB), where endometrial pathology cannot be excluded or is suspected via transvaginal ultrasound scan (TVUSS), speculum, smear, swabs and pipelle (Table 1). AUB includes intermenstrual bleeding (IMB), post coital bleeding (PCB), menorrhagia, irregular bleeding or postmenopausal bleeding (PMB). Much pathology will be excluded at the gynaecology outpatient appointment with hysteroscopy only being necessary in a small proportion of cases.

Contraindications

There are relatively few contraindications to OP hysteroscopy; these include pregnancy or inability to exclude pregnancy and patient preference. If a patient finds the technique unacceptable

in the OP setting or if a procedure has previously failed in the outpatient setting they may require a GA. Women should not be excluded if they are nulliparous or have had previous treatment to their cervix.

The service

The Royal College of Obstetricians and Gynaecologists(RCOG) now recommend that all services should have a dedicated outpatient hysteroscopy service away from the operating theatre with an appropriately sized and staffed treatment room with adjoining private changing facilities and toilet. Written patient information should be provided before the appointment and consent for the procedure should be taken. A chaperone should be present regardless of the sex of the clinician, they should act as an advocate for the woman undergoing the procedure with so called 'verbal anaesthesia' reassuring and relaying any anxieties the patient may have.

Procedure for diagnostic hysteroscopy

Patient selection

Patient selection is crucial for successful OP hysteroscopy (and all ambulatory procedures). The patient has to fully understand the procedure and be positively motivated to undertake it. Additionally if the patient has found a speculum or pipelle biopsy in clinic too uncomfortable, it may not be appropriate to manage them in the OP setting. Other exclusions are patients who have not been able to tolerate a procedure previously or where pregnancy cannot be excluded. Previous treatment on the cervix such as a large loop excision of the transformation zone (LLETZ), being nulliparous, or previous myomectomies are not contraindications for OP hysteroscopy.

Patient preparation

Prior to the procedure verbal and written information should be provided to the patient, explaining what to expect and advising them to eat, drink and take simple analgesia (preferably non-steroidal anti-inflammatory drugs(NSAIDs) if no contraindications) 1 hour before the appointment. Written consent should be obtained, and if indicated a pregnancy test performed, as it is crucial to exclude pregnancy before entering the uterus. Last menstrual period, or the date of the menopause should be documented, together with the use of any hormonal contraception or HRT. There is no evidence that the prior use of cervical preparation make the procedure easier and less painful.

The patient should be introduced to the team members, usually a doctor and assisting nurse prior to undressing. She should also be reassured that she is in control of the procedure and if at any time she would like the procedure to stop then this will occur and she will be supported in her decision. The patient should remove their lower garments, empty their bladder and wear a gown tied at the back. They should be positioned in lithotomy on a surgical couch and covered appropriately to respect their dignity.

The equipment

There are many different types of hysteroscope available and the RCOG recommend using the smallest available for diagnostic

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Indications for a diagnostic hysteroscopy

Presenting problem	Indications for hysteroscopy
Pre-menopausal: Intermenstrual bleeding Post coital bleeding Menorrhagia Irregular menstrual bleeding Oligo-amenorrhoea Tamoxifen and irregular bleeding	Endometrial polyp/submucosal fibroid suspected at TVUSS Inappropriately thickened endometrium
Post-menopausal bleeding	TVUSS endometrial thickness >5 mm Or Endometrium cannot be clearly seen Pipelle endometrial sampling inadequate
Subfertility and recurrent miscarriage	Only if uterine abnormality suspected on TVUSS

Table 1

hysteroscopy. These have a diameter of 2.7 mm with a 3–3.5 mm sheath which reduce the need for cervical dilation resulting in less discomfort for the woman. The hysteroscopes come with a variety of angle options ranging from 0 to 70 degrees. The 0 degree scope provides a panoramic view of the uterus whereas the angled scopes allow for improved views of the ostia or abnormal shaped cavity. Scopes also come as flexible or rigid. Flexible are associated with less discomfort but an increased procedure time and failure rate. The type and angle of the scope should therefore be left at the discretion of the operator. The equipment should remain sterile and be assembled with the help of the nurse assisting at the patient's side.

Distension media

Carbon dioxide and normal saline can both be used as distention medium and should be left up to the discretion of the operator, however normal saline has been shown to facilitate faster procedure times, less vasovagal reactions, better image quality and can be used for operative procedures.

The procedure

The patient should be cleaned and draped in lithotomy to maintain a sterile field as in a theatre setting, reducing the risk of infection. Vaginoscopy has been shown to cause the least discomfort for the patient and the lack of a speculum allows for greater manoeuvrability; however, it may be useful to inspect the vagina and cervix and therefore in some cases, a speculum may be used prior to hysteroscopy. The hysteroscope should be placed into the vagina, guided along the operators finger and the fluid turned on to distend the vagina and identify the cervix. The external os should be slowly entered and the cervix dilated by the fluid. The images will appear on the screen and the black area should be followed to find the internal os and uterus. Careful attention should be paid to the patient to ensure that they are not in too much discomfort.

Once inside the uterus the ostia should be identified for confirmation of the correct positioning within the uterus and images (preferably digital) taken and stored. The anterior and posterior walls of the uterus should be examined and biopsies taken under direct vision from any abnormal looking area or from two separate sites if the endometrium looks normal. The biopsy sites should be checked to ensure that the bleeding has seized.

The hysteroscope should then be slowly removed, being careful to consider all aspects of the endometrium on the way out.

Post procedure

Following the procedure the patient should be given a few minutes to recover, helped to sit up and there should be a waiting area for her to recover in if necessary. Most women will dress and feel well enough to leave immediately, following a discussion on the procedure and its findings. The patient should be given written information about what to expect post procedure and contact details in case of late occurring complications.

Operative hysteroscopy

All of the techniques outlined below for operative hysteroscopy have been shown to be acceptable to patients in the OP setting but often require local anaesthesia, dilatation of the cervix and sometimes opiate analgesia (particularly for endometrial ablation) (Table 2).

Endometrial biopsies and polypectomies

Many diagnostic hysteroscopes have an operative channel or sheath through which specially designed forceps, scissors or graspers can be inserted in order to take biopsies or remove polyps under direct visualization. This reduces the risk of injury or incomplete removal compared to when performed blindly. These are suitable for small polyps which can be removed through the narrow sheath (Figure 1). This technique would not be suitable for larger polyps or fibroids due to their size or more fibrous tissue.

Indications for operative hysteroscopy

Device	Indications
Diagnostic hysteroscope with operative sheath – forceps, polyps, scissors	Endometrial biopsies Small polypectomies Intrauterine adhesions
Resectoscopes and Morcellators	Large polypectomies Submucosal fibroid resection Intrauterine adhesions Intrauterine septum resection
ESSURE sterilisation	Permanent sterilization
Endometrial ablation: Bipolar frequency Thermal balloon Microwave energy	Heavy menstrual bleeding

Table 2

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