



Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Full length article

Hysteroscopy in the Netherlands and Flanders: A survey amongst practicing gynaecologists

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ARTICLE INFO

Article history:

Received 25 November 2017

Received in revised form 5 February 2018

Accepted 14 February 2018

Available online xxx

Keywords:

Implementation

Hysteroscopy

Minimally invasive techniques

Intrauterine pathology

ABSTRACT

Objective: To gain insight in the current ideas on, and implementation of hysteroscopy amongst practicing gynaecologists in the Netherlands and Flanders.

Study design: In August 2016 an electronic questionnaire was sent to practising gynaecologist members of the Dutch (N = 591) and Flemish (N = 586) Society of Obstetrics and Gynaecology.

Results: The response rate for the Netherlands was 15.4% (91/591), and for Flanders 27.0% (158/586). Responding gynaecologists have a preference for hysteroscopy for diagnosing and treating most intrauterine pathology. Flemish respondents are more hesitant in opting for hysteroscopy instead of curettage for treatment of polyps and placental remnants. There appears to be a wide diffusion of diagnostic and basic operative hysteroscopy. In contrast to Flanders, responding hysteroscopists from the Netherlands more often perform office hysteroscopic procedures. Hysteroscopic procedures, and office procedures in particular, are now educated during residency. Therefore, recently graduated gynaecologists have a preference for this technique.

Conclusion: Our survey confirms that nowadays the focus of treating intrauterine pathology is on less invasive techniques and preserving the uterus. Dutch responding hysteroscopists have more expertise concerning office hysteroscopy than their Flemish colleagues. Future research on the cost-effectiveness of and optimisation of patient comfort during office hysteroscopy is needed to support its further implementation.

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Introduction

Hysteroscopy is the gold standard for treatment of intrauterine pathology [1,2]. Numerous innovations have resulted in techniques suitable for the office setting [1,3]. Furthermore, the 'see and treat' option is supported by the use of bipolar energy, a continuous flow system and an electronic fluid pump.

The innovations in hysteroscopic procedures only started in the mid-'90s [1,3,4]. The slow evolution was due to the small number of therapeutic applications, the specific difficulties encountered during hysteroscopy, the reluctance of (onco)gynaecologists to accept new developments entailing a learning curve, and the lack of financial incentive [1,4].

In the Netherlands, five questionnaires were conducted to investigate the degree of diffusion and the practice of hysteroscopy [5–9]. Van Dongen et al. reported on increasing performance of

hysteroscopic procedures in 2002, compared with 1997, while the number per gynaecologist was limited [6,9]. Timmermans et al. showed in 2003 that office hysteroscopic polypectomy was not a common procedure, and that teaching hospitals performed significantly more office procedures [7]. In 2013, Janse et al. assessed the opinion of residents and recently graduated gynaecologists on their hysteroscopic training and current practice [5]. The implementation of hysteroscopic procedures trained during residency appeared to have improved compared to a similar survey in 2003, and training during residency was judged as sufficient [8]. Furthermore, the expertise of young gynaecologists was enhanced compared to 2003.

In Flanders, the rollout of hysteroscopic procedures remains unclear.

We aimed to gain insight on the current ideas on hysteroscopy and the hysteroscopic practices in the Netherlands and Flanders.

Materials and methods

An electronic survey (Lime Survey GmbH, Hamburg, Germany) in Dutch was pretested on 5 gynaecologists, and approved by the

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ethics committee of the Ghent University Hospital, Belgium. The study was registered at ClinicalTrials.gov (NCT02853695). In August 2016, the questionnaire was sent to all practicing gynaecologist members of the Dutch (n = 591) and Flemish (n = 586) Societies of Obstetrics and Gynaecology (NVOG and VVOG respectively). Three reminder emails were sent in Flanders, and, due to administrative constraints, only two in the Netherlands. After informed consent, all gynaecologists were asked to complete the first part of the questionnaire regarding the respondent's characteristics and preferences concerning hysteroscopy. The second part was specific for hysteroscopists. All data were registered anonymously.

Data were collected and analysed in the statistical program SPSS version 24 (IBM SPSS Statistics 24.0, IBM Corp., Armonk, NY, USA).

For symmetric distributed continuous variables, means, standard deviations, and 95% confidence intervals (CIs) are reported. For non-symmetric continuous variables median, interquartile range (IQR), minimum and maximum were computed. Categorical data are presented as frequency and percentage.

Demographical data were compared between type of clinic (teaching or non-teaching hospital) within the Netherlands and Flanders, and a comparison was also made between Flanders and the Netherlands per type of clinic. For the baseline characteristics, symmetric and non-symmetric distributed continuous data were analysed using the *t*-test and Mann-Whitney *U* test respectively and categorical data were analysed using Chi-square test.

Categorical outcome data, and non-symmetric continuous outcome variables recoded into categorical variables, were analysed by binary logistic regression analysis. The odds ratio (OR) with 95% CI was computed comparing Flanders and the Netherlands as well as teaching and non-teaching hospitals. If the interaction between country/region and type of hospital was significant, teaching and non-teaching hospitals were compared per country/region. Moreover, the OR was adjusted (aOR) for unbalanced baseline variables found to be clinically significant. Symmetric continuous outcome variables were analysed by linear regression, analogous to the logistic regression.

Clinical experience is a computed variable taking into account respondent's age and year of graduation. Day clinic means that the patient is admitted to the hospital but discharged the same day. Office hysteroscopy is a hysteroscopic procedure being performed in an outpatient setting.

For all analyses, a *p*-value <.05 indicated statistical significance.

Results

The total response rate was 21.2% (249/1177). The Dutch response rate was 15.4% (91/591) (Fig. 1), and in Flanders 27.0% (158/586) (Fig. 2).

The respondent's demographical data are presented in Table 1.

Hysteroscopy for diagnosis and treatment of intrauterine pathology and abnormal uterine bleeding (AUB)

Respondent's preferences are presented in Table 2, and the logistic regression analysis results in Table S1.

The odds for the performance of saline infusion sonohysterography (SIS) in addition to ultrasound (US) in diagnosing intrauterine pathology were significantly higher in the Netherlands (aOR 17.7 [95% CI 7.7–48.3], *p* < .01).

The odds for hysteroscopy as preferred technique for polypectomy were significantly higher in the Netherlands (aOR 12.5 [95% CI 2.5–229.1], *p* < .01).

The odds for performing or referring patients for hysteroscopic resection of type II myomas, were significantly higher in teaching

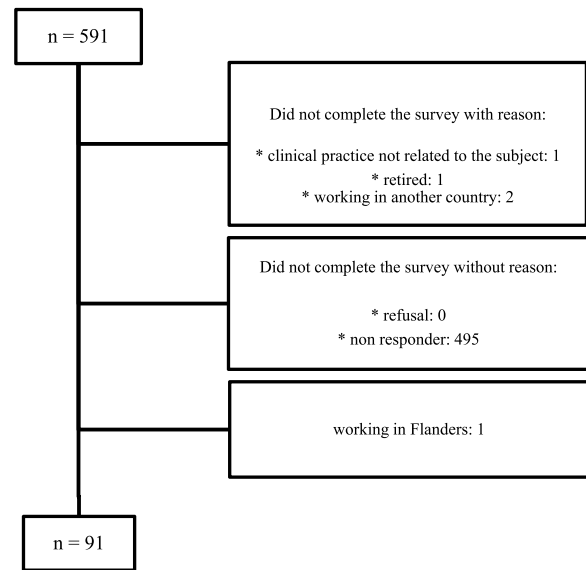


Fig. 1. Response data in the Netherlands.

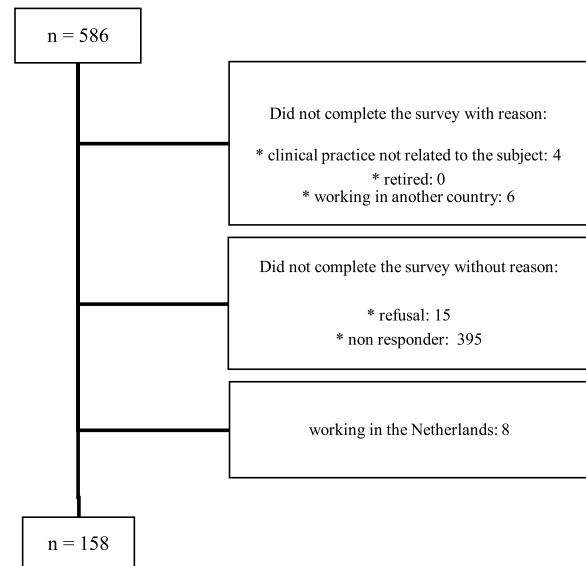


Fig. 2. Response data in Flanders.

hospitals (aOR 3.0 [95% CI 1.6–5.6], *p* < .01), and significantly lower if the respondent did not perform hysteroscopy (aOR 0.3 [95% CI 0.1–1.0], *p* < .01).

The odds for hysterectomy as the preferred treatment for a type II myoma in women without reproductive desire were significantly lower in teaching hospitals (aOR 0.5 [95% CI 0.3–0.9], *p* = .02), and for gynaecologists with less clinical experience (aOR 0.44 [95% CI 0.24–0.81] and aOR 0.34 [95% CI 0.15–0.72], *p* = .01, compared to gynaecologists with mean and long experience, respectively).

The odds for hysteroscopy as the preferred technique for removal of placental remnants were significantly higher in the Netherlands (aOR 16.8 [95% CI 4.9–105.9], *p* < .01), and for gynaecologists with less (aOR 3.3 [95% CI 1.3–9.0], *p* = .01) and mean (aOR 3.0 [95% CI 1.3–6.9], *p* = .01) experience. The odds for no minimum time interval or a minimum of less than 6 weeks after end of pregnancy for removal of placental remnants by curettage were significantly lower in the Netherlands (aOR 0.4 [95% CI 0.2–

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