Outpatient hysteroscopy: best practice and well accepted

M Sharma.NNSWLHD
Email:meenu.sharma@ncahs.health.nsw.gov.au

Abstract

Outpatient diagnostic and operative procedures, including outpatient hysteroscopy are considered the best practice in modern medicine[1]. There still appears to be non uniform uptake of this service in gynaecology, mostly citing reluctance by women due to fear of pain/anxiety. Results of this audit confirm the high quality service provided by one stop clinic, by providing comprehensive investigation/treatment cycle within a single appointment.

Methods

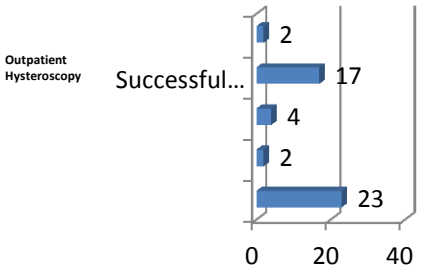
This was a retrospective audit of women referred to a one stop postmenopausal bleeding/high suspicion of cancer clinic led by a consultant gynaecologist in a teaching hospital in the United Kingdom.

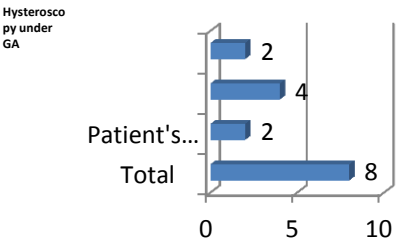
More than 1000 women were referred over a period of 4 years to this clinic, with approximately 45% requiring diagnostic hysteroscopy and endometrial biopsy after ultrasound scan led triage. Most women accepted and tolerated the procedure well in outpatient setting.
Miniature outpatient diagnostic hysteroscopes with operating channel were used, without the need of vaginal instrumentation (vaginoscopic technique) or anaesthesia. Directed biopsies and polypectomies (using bipolar twizzle) were undertaken in suitable patients.
Paracervical block was used in small number of women with severe cervical stenosis. No pre procedure analgesia was offered routinely.

7 clinics were chosen randomly, with 51 women referred in total ranging from 29 years old to 85 years old.
Postmenopausal bleeding was the most common cause of referral in postmenopausal women (n=29), with irregular vaginal bleeding[2] being predominant symptom in menstrual women. All suitable women had a transvaginal ultrasound scan before being reviewed by the consultant. Endometrial thickness ranged from 1 mm to 25 mm.

Results

Results: 16 (55%) women with postmenopausal bleeding had normal endometrial thickness on ultrasound scan with cut off endometrial thickness of 4 mm. 2 women declined outpatient hysteroscopy due to fear of pain, while 17 women accepted, underwent and tolerated the procedure well.
4 women were found to have endometrial polyps and 2 of those underwent outpatient hysteroscopy and polypectomy with bipolar twizzle, while in the other 2, it was deemed not suitable to carry out the procedure in outpatient setting.
In 4 women, an attempt to carry out outpatient hysteroscopy failed due to severe cervical stenosis.
Histology was benign in most women, however endometrial cancer was diagnosed in 3 (5.8%) women with further 2 diagnosed with complex hyperplasia.





Conclusion

Most women accept (and tolerate well) diagnostic and operative hysteroscopy in the outpatient setting. One stop clinics led by trained staff are the way forward for women globally, to alleviate anxiety associated with long waiting times for GA procedures and to reduce pressure on waiting lists, in addition to providing a cost-effective high quality care.

References

1. RCOG/BSGE Joint Guideline. Best Practice in Outpatient Hysteroscopy. Green-top guideline No. 59. Mar 2011
2. RCOG/BSGE Joint Guideline. Endometrial hyperplasia, Management of Endometrial Hyperplasia (Green-top Guideline No. 67). Feb 2016