Outpatient Hysteroscopy
One-Stop Protocol - CG601

Approval

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<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
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Change History

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1.0 Purpose
The aim of this protocol is to provide high quality, efficient service and care for the patients referred to the Outpatient Hysteroscopy service. The Trust is committed to the provision that is fair, accessible and meets the needs of all individuals.

2.0 Scope
For all staff, medical, nursing and clerical to fulfil the criteria of best service and best clinical practice which is evidence based and according to RCOG recommendations of outpatient hysteroscopy.

3.0 Roles and Responsibilities
The team consists of:

Consultant
The health care professional should have the necessary skills and expertise to carry out hysteroscopy in an outpatient setting. (Accredited with RCOG/BSGE)

Nursing Staff:
Registered Nurse:
- Act as a scrub nurse, competent in aseptic techniques.
- Assist and support the Consultant and support the patient.
- Ensure the smooth running of the clinics
- Maintain all stock levels
- Ensure equipment is in good working order

Healthcare Assistant
- Act as the patient’s advocate during the procedure to provide reassurance, explanation and support. This will alleviate anxiety and divert the patient’s attention, thereby minimising pain and embarrassment

4.0 Definitions
Outpatient hysteroscopy is a well-established diagnostic test that is in widespread use across the UK. The procedure involves the use of miniaturised endoscopic equipment to directly visualize and examine the uterine cavity, without the need for formal theatre facilities or general or regional anaesthesia.

Outpatient Hysteroscopy is indicated primarily in the assessment of women with abnormal uterine bleeding but is also employed in the diagnostic work-up of reproductive problems. Recent advances in endoscopic technology and ancillary instrumentation have facilitated the development of operative hysteroscopic procedures in an outpatient setting with or without the use of local anaesthesia.
Outpatient hysteroscopy, whether diagnostic or operative, is successful, safe and well tolerated. Outpatient hysteroscopy also offers a convenient and cost effective means of diagnosing and treating abnormal uterine bleeding as well as aiding the management of other benign gynaecological conditions. However, as with any procedure requiring instrumentation of the uterus, outpatient hysteroscopy can be associated with significant pain, anxiety and embarrassment. This not only impacts upon women’s satisfaction with their experience, but also limits the feasibility and possibility the safety, accuracy and effectiveness of the procedure. To minimize pain and discomfort, variations in hysteroscopic equipment, adaptations to the technique and use of pharmacological agents have been advocated. (1)

5.0 Management of Referrals and Patients

IT IS THE HYSTEROSCOPISTS RESPONSIBILITY TO CONFIRM THE PATIENT’S LMP AND ENSURE SHE IS NOT PREGNANT BEFORE OPH. Outpatient Hysteroscopy may be diagnostic or therapeutic.

Indications for referral:

- Postmenopausal bleeding
- Abnormal uterine bleeding (AUB)
  - >3/12 Irregular bleeding >40 years.
  - >3/12 Heavy periods >40 years.
- Persistent IMB / persistent irregular bleeding
- Heavy infrequent periods in women who have PCOS or BMI>30
- AUB on tamoxifen
- Endometrial pathology identified on USS (polyps <2cm, fibroids <2cm).
- Asymptomatic women found to have a thickened endometrium on scan
- In general endometrial thickness >10mm or polyps should be referred.
- Women referred for lost intrauterine coil threads
  - Lost strings - USS confirmation that IUD is in situ is essential prior to referral.

Suitable patients:

- Poor anaesthetic candidates are ideal for OPH.
- Doctor assessment: Cervix is visible / accessible with speculum. Possible to grasp cervix (i.e. not flush with vaginal vault).
- Patient accepts OPH concept.
- Patient weight <160kg
Unsuitable patients:
- Patients who do not accept the Outpatient Hysteroscopy concept after counselling
- Patients requesting endometrial ablation
- Large endometrial / submucous lesions (polyps >3cm, fibroids >3cm).
- Coexisting pelvic pathology (large ovarian cysts etc.).
- Hyperplasia suggested on USS
- Thin endometrium (<3mm) seen on USS.
- Patients with presumed or confirmed Pelvic Inflammatory Disease (PID)
- Patient weight >160kg

### OUTPATIENT HYSTEROSCOPY CLINIC TIME-TABLE

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<th>MONDAY</th>
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5.1 Consent

As this is an invasive procedure that carries a small risk of bleeding, perforation and failure, a consent form should be completed. Prior to their appointment, all patients receive the OPH information leaflet. This will be sent with their appointment confirmation letter, or given to them when a referral is made by GOPD clinic, GP etc. It is the legal and ethical responsibility of the hysteroscopist to ensure the patient understands the small but significant risk of complications during this procedure. All patients must have read, and signed the consent document.

5.2 Patient data sheet, coding and service performance

All clinical data from OPH patients (including images and video) will be submitted to the patient data sheet that is to be kept in the patient notes. This data should (and images) also be submitted to the clinic database for coding, regular audit and ongoing research. Patient satisfaction, numbers scoped and follow-ups, will also be audited for future modifications to the service.

Hysteroscopist to complete all parts of patient data sheet and Viewpoint database.

Patient to rate her Pain Score using visual analogue score.
Patient to complete satisfaction questionnaire on the way out from the clinic (NB not in front of staff).

Questionnaire is given and collected by Sonning receptionist.

Patient should be given the 602 contact card in case of complication.

Coding is exceptionally important for correct payment to the service. Please enter all procedures onto EPR.

5.3 OPH clinic appointments and follow-up:

Five or six 40 minute slots are set aside for OPH and one to two 20 minute slots are available for follow-up appointments.

Only 19% of OPH patients require follow-up\(^2\). Most patients should be discharged and sent back to the GP with further treatment recommendations. **GOPD follow-up should occur in a minority of patients and even fewer should return for OPH follow-up.** Any plan for follow-up at GOPD or OPH clinic should be documented (on the patient information sheet and database) with the indication clearly stated.

**IT IS THE HYSTEROSCOPIST’S RESPONSIBILITY TO BOOK PATIENTS WHO FAILED HYSTEROSCOPY FOR GA UNDER 2WW RULE IF THEY ARE SEEN IN ONE STOP CLINIC.**

**DNA**

As per the Trust policy, patients who fail to attend their appointment will not routine be offered another appointment: it will be at the clinician’s discretion. Any patients referred under the 2 week rule will be made a further appointment.

**Indications for follow up after OPH, in general gynae clinic**

- Complications occurring at OPH.
- When endometrial cancer is diagnosed, patients should be directly referred to Gynae-oncology MDT.
- No results should be given over the phone or written to the patient without prior review at the MDT.
- Cancer diagnosis should be given only by appropriately trained staff with the clinical nurse specialist present for support and ongoing care

5.3.1 Ultra Sound Scans (USS)

USS results should assist triage for the next mode of management, i.e. OPH, DSU hysteroscopy, Pipelle Biopsy or no further investigation.

TV USS is associated with improved identification of endometrial disease compared with hysteroscopy alone\(^3\). Therefore all patients attending OPH should have TV USS report prior to clinic including patients directly referred by GP referral system (One-stop OPH).
5.3.2 Post-Menopausal Bleeding (PMB)

The OPH clinics will investigate all suitable PMB patients (Algorithm in Appendix 1).

5.4 Management of PMB patients in Outpatient Setting

Most patients are seen in the One-Stop service

- The proforma for rapid referral clinic should be filled out with explanation of the need for hysteroscopy and endometrial biopsy.
- A history to elicit risk factors for endometrial cancer should be taken.
- Written consent must be obtained and documented.
- The BMI should be calculated and a pelvic ultrasound performed.
- All patients need a bimanual examination, if the USS does not record the uterine position, if dilatation of the cervix is required prior to insertion of the hysteroscope.
- Hysteroscopy and an endometrial aspirate should be performed in women with suspicious history, ultrasound markers of irregular/fluid filled cavity and Doppler flow.
- Any large lesion on hysteroscopy warrants booking of day case hysteroscopy under general anaesthesia, or for Myosure in the outpatients, if suitable. Many small lesions can be removed at the time of diagnostic hysteroscopy, or assess as to whether there is any benefit to a further attempt, with or without local anaesthetic, in the OPH is appropriate or if it requires removal under general anaesthetic.
- Women with negative hysteroscopy in whom sample could not be obtained can be discharged from the clinic.
- Patients with multiple episodes of PMB should have OPH despite endometrial thickness less than 4 mm.
- Any unscheduled bleeding on sequential HRT, PMB not on HRT or on continuous combined HRT with regular endometrial of 4mm or less can be discharged from the clinic following examination. In these scenarios if the endometrial thickness is regular and more than 4mm then an endometrial aspirate should be attempted.
- In cases where pipelle is considered to be scanty, a hysteroscopy should be performed if not done already.
- The histology result should be awaited when a good endometrial sample is obtained.
5.4.1 Hysteroscopy in premenopausal women:

- The suitability of hysteroscopy in women referred to the clinic should be assessed by the attending clinician.
- Premenopausal women who are referred for abnormal bleeding, LMP should be established and a non-pregnancy status should be confirmed by pregnancy test if necessary.
- A written consent should be obtained for women undergoing operative hysteroscopy.
- The procedure should be avoided in women with suspicion of pelvic infection and cervical cancer.
- Women having a hysteroscopy for a lost intrauterine device should have taken extra contraceptive precautions 7 days prior to the attendance in the clinic.

5.4.2 Anaesthesia/technique:

- Routine use of local anaesthetic is not required for diagnostic hysteroscopy.
- In situations where the patient is unable to tolerate the examination or dilatation of the cervix is required such as during operative hysteroscopy, a paracervical or intracervical local anaesthesia should be used.
- Topical application of local anaesthetic to the ectocervix should be considered where application of a cervical tenaculum is necessary.\(^1\)
- Vaginoscopy should be the standard technique for outpatient hysteroscopy, especially where successful insertion of a vaginal speculum is anticipated to be difficult and where blind endometrial biopsy is not required.\(^1\)

5.4.3 Cervical Preparation

Patients do not routinely require cervical preparation but may be considered in:

- Patients with a pinpoint cervical os
- Patients with a history of multiple caesarean sections
- Patients who have had a cone biopsy

5.5 Communication and results to the referring GP

The patient should be given the 602 contact details in case of delayed complication. The GP should be sent a copy of this report along with the clinic letter in the post; this letter should also be copied to the patient.

All laboratory sample request forms should have the patient’s GP and practice address written for automatic delivery of results. Patients should be instructed to retrieve the results from the practice approximately 3 weeks after OPH unless malignancy is suspected. Patients with suspicious findings should be seen and given the results directly in OPH or GOPD within 2 weeks.
5.6 After care

Post operatively women can wait in the recovery area before leaving and should be provided with analgesia if required. They can resume normal activities after the procedure. They should be made aware of light bleeding for few days and possibility of infection and to contact the GP if develop fever, foul discharge, heavy bleeding, or persistent pain.

6.0 Potential complications / Risk Management

6.1 Post-operative pain:

About 78% of patients consider the pain from outpatient hysteroscopy less than that usually experienced during menstruation. Furthermore a significant reduction in the mean pain score can be achieved with the use of analgesia during and within 30 minutes after outpatient hysteroscopy.

**Bleeding**: Potential sources of intraoperative bleeding include lacerations due to cervical manipulation and intrauterine instrumentation which usually settles without any intervention and very few cases of persistent bleeding would require management according to the cause of bleeding with exclusion of perforation of the uterus.

**Infection**: The risk of infection after operative hysteroscopy is low (0.85% risk of endometritis and 0.57% that of UTI), thus prophylactic antibiotics are not routinely administered.

**Uterine perforation**: The rate of uterine perforation is about 0.002-1.7% in diagnostic hysteroscopy with slightly higher incidence in operative hysteroscopy which is about 0.7-3% and is one of its most common complications. Therefore women should be informed of this potential complication and possible requirement of concurrent laparoscopy in rare situations.
6.2 **Vasovagal Syndrome:**

Cervical manipulation or dilatation can result in vagal stimulation of the parasympathetic system. This results in bradycardia and vasodilatation causing profound drops in blood pressure and fainting. Vasovagal rates are approx. 1 - 1.7% during outpatient hysteroscopy.\(^7\)

**Management:**

- Remove scope immediately. Check BP, pulse, RR and oxygen saturation.
- Lower head and raise legs (head down on electronic couch).
- Most cases will recover soon.
- If recovery not immediate give oxygen, get IV access and consider giving atropine 500mcg IV stat if pulse is less than 40 and systolic BP is less than 90mmHg and start IV fluids.
- In rare cases where effects of vasovagal are profound or prolonged call resuscitation team.

7.0 **Dissemination/Circulation/Archiving**

The protocol will be reviewed by the gynaecology clinical governance team and any amendment will be made.

8.0 **Training**

There is no mandatory training associated with this procedure. If staff have queries about its operation, they should contact their lead consultant the first instance.

9.0 **Audit**

**Audit Indicators as per RCOG guidelines**

- Patient satisfaction with elements of the outpatient hysteroscopy service.
- Complications (e.g. infection, vasovagal reactions, uterine trauma) of diagnostic and operative outpatient hysteroscopy.
- Failure rate of diagnostic and operative outpatient hysteroscopy and reasons for failures.
- Rates of cervical dilatation in outpatient hysteroscopy stratified by parity and menopausal status.
- Standards of documentation.
- Use of analgesia post-procedure.
- Percentage of women provided with written information and asked for written consent.
10. References


4. Patient satisfaction with outpatient hysteroscopy versus day case hysteroscopy: randomised controlled trial: BMJ 2000; 320:279 Obstetrics & Gynaecology, Pennine Acute NHS Trust, Manchester, UK


6. Richard S Guido, MD Dale W Stovall. Hysteroscopy, The international society for gynaecological endoscopy,

Appendix 1 – Algorithm for PMB management

An ultrasound will be performed at the beginning of clinic to image the endometrium, uterus and adnexae.

A history to elicit risk factors for endometrial cancer should be taken. Including direct questioning for the following risk factors: Obesity, diabetes, recurrent or prolonged PMB, unopposed oestrogen therapy, early menarche, late menopause and nulliparity. Patients with a suspicious history should have a hysteroscopy and pipelle regardless of the ultrasound findings.

Patients with PMB will require a general examination as well as a pelvic examination to exclude local causes of bleeding, and ascertain the size/shape/mobility of the uterus.

**Algorithm for PMB management**

- All patients EE <4mm
  - Examine
  - No biopsy
  - Discharge

- All other patients EE >4mm & <5mm
  - Examine and endometrial biopsy; If OPH normal no sample obtained can be discharged
  - Discharge Pipelle / No sample

- All patients EE >5mm
  - Unable to obtain biopsy
  - GA

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