Out Patient Hysteroscopy Protocol

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
Approval Group	Integrated Business, Obstetrics, Gynaecology, Sexual Health & Quality And Safety Group
Distribution	Midwifery, Medical and Neonatal staff within Cwm Taf Morgannwg University Health Board (via email)
Archiving	Directorate secretary will be responsible for archiving all versions
Document Location	Health Board intranet Hard copy in Hysteroscopy Unit PCH and Womens Health Unit RGH
Freedom of Information	Open

CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
1.2	24.10.24	Sr Ceri Williams Hysteroscopy ANP	In line with updated RCOG / BSGE guidelines 2024

AUTHORSHIP, RESPONSIBILITY AND REVIEW

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BACKGROUND

Guideline Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Purpose and scope

The aim of this guideline is to provide clinicians with up-to-date, evidence-based information regarding

Outpatient hysteroscopy, with particular reference to optimising the woman's experience.

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a

serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

Outpatient Hysteroscopy Protocol

Definition and Background

Outpatient or ambulatory Hysteroscopy clinics provide a means for delivering both diagnostic and therapeutic procedures for gynaecological cases in a safe, appropriate and cost-effective environment without the need for formal theatre facilities or general or regional anaesthesia

The aim of the service is to decrease waiting times and provide a fast track outpatient service for the investigation of abnormal uterine bleeding and / or management of endometrial pathology within Cwm Taf Morgannwg University Health Board.

Outpatient hysteroscopy (OPH) is an established diagnostic test that is in widespread use across the UK. OPH involves systematic inspection of the uterine cavity via miniature hysteroscope facilitating the diagnosis of intrauterine pathology such as endometrial polyps, submucosal fibroids, uterine anomalies, endometrial hyperplasia or endometrial cancer and may be used as a method of intervention or collecting a sample for histological examination e.g., Endometrial biopsy, without the need for formal theatre facilities or general or regional anaesthesia.

OPH is indicated primarily in the assessment of women with abnormal uterine bleeding, but is also employed in the diagnostic work-up of reproductive problems. (RCOG 2011) (Updated RCOG 2024).

Outpatient hysteroscopy, whether diagnostic or operative, is successful, safe and well tolerated.

However, as with any procedure requiring instrumentation of the uterus, outpatient hysteroscopy can be associated with significant pain, anxiety and embarrassment.

Outpatient hysteroscopy can be associated with substantial anxiety and so the treatment room should be private and patient friendly, with a separate, and ideally adjoining, changing area with a toilet. The procedure should be carried out in a well-equipped treatment room with adequate resuscitation equipment and a recovery area (RCOG 2011) (updated RCOG 2024) by a trained and competent person.

It is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex recorded at birth.

Management of patients and Referral Criteria

IT IS THE HYSTEROSCOPISTS RESPONSIBILITY TO CONFIRM THE PATIENT'S LMP, DATE OF LAST UNPROTED INTERCOURSE (IF RELEVANT) AND ENSURE SHE IS NOT PREGNANT BEFORE OPH.

Pre-menopausal

- Heavy bleeding after >3/12 of failed medical management.
- Persistent IMB / persistent irregular bleeding.
- Heavy infrequent periods in women who have PCOS or BMI>30.
- Recurrent miscarriage/ Failed assisted conception with suspected uterine anomalies.
- Complicated IUCD removal and replacement.
- Abnormal uterine bleeding on tamoxifen
- Cavity assessment in the context of endometrial ablation in OPH

Referral criteria for post-menopausal women

1. Post -menopausal bleeding (PMB) with ET > / =4mm
2. Recurrent PMB with any ET
3. Incidental finding of ET >10 mm
4. PMB on Tamoxifen

For the full 'Gynaecology Rapid Access Service for Suspected Endometrial Cancer' (GRAS) guideline, please see the link

https://wisdom.nhs.wales/a-z-guidelines/g/gynaecology-rapid-access-service-gras-for-suspected-endometrial-cancer-guidelinepdf/

- PMB to be referred directly to GRAS as USC
- PMB on Tamoxifen is regarded as a risk factor for endometrial polyps, hyperplasia and cancer- refer to GRAS as USC
- Endometrial ablation with amenorrhoea and <50 years old should be considered as pre-menopausal if bleeding recommences and should be seen in as 'urgent' in GOPD.

Additional criteria:

- Suspected Retained products of Conception (RPOC)
- Incidental findings of suspected pathology on Ultra-Sound Scan
- Follow up of Endometrial Hyperplasia
- Lost IUD threads
- Endometrial Polypectomy
- Endometrial Ablation

Patient Suitability

Suitable patients:

- Poor anaesthetic candidates are ideal for OPH.
- Clinician's assessment: Cervix is visible / accessible with speculum. Possible to grasp cervix (i.e., not flush with vaginal vault).
- Patient accepts OPH concept.
- Maximum weight of 250kg in PCH or 200kg in RGH due to bed weight limits.

Unsuitable patients:

- Patients who do not accept the Outpatient Hysteroscopy concept after counselling.
- Large sub mucous fibroids (> 5cm).
- A woman breaching the weight limit of the bed
- Hypertensive pre procedure. Clinician's discretion with Systolic 180-200 mmHg and Diastolic 100-110 mmHg, and to NOT proceed with BP =/> 200/110 mmHg. To be referred to the on-call medical team if symptomatic, or urgent G.P appointment.

Women or people should be made aware of other settings and modes of anaesthesia for hysteroscopy (e.g. procedure under general or regional anaesthesia, intravenous sedation) as an alternative to outpatient hysteroscopy (RCOG 2024)

Patient Referral Procedure

- Referral forms from Secondary care should be completed thoroughly and emailed to the OPH booking team office (Appendix A).
- Referrals from Primary Care will be accepted via their electronic referral letter.
- Women assessed within the GOPD / GAU can be referred internally for either routine, urgent or USC OPH.

- Internal referral forms should be completed and signed by the referring clinician with documentation when to be seen:
- Referral to state, when to be seen:

  URGENT SUSPECTED CANCER: (USC) within 10 days

  URGENT: Within 4/6 weeks

  ROUTINE: In accordance with RTT standards (currently 52 weeks)
- All referrals will be triaged by Consultants and co-ordinated by trained secretaries or administrative team; liaising with Consultants/Medical staff/Lead Nurse Hysteroscopist as necessary
- Appointment to be made in accordance to the above criteria
- Patient will be notified of the appointment date directly by the Hysteroscopy Service.
- Where possible, appointment to be agreed via telephone before sending an appointment letter

Consent

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.

Outpatient Hysteroscopy is an invasive procedure that carries a small risk of bleeding, uterine perforation, infection and failure of procedure; therefore a consent form should be completed prior to the patients' procedure.

All patients should receive the OPH information leaflet, (Appendix B) this should be sent with their appointment confirmation letter or can be provided to woman when referral is made by GOPD / GAU departments, GP etc.

Administration role

All referrals will have been triaged for the appropriate clinic / lists.

- All patients to receive information leaflet with the appointment. The information leaflet has a contact number, and also informs that pre procedure advice is available with clinic Nurses prior to procedure if needed.
- The information leaflet will need to be relative to the planned procedure i.e. Diagnostic Hysteroscopy/Mirena insertion/Polypectomy etc.

- Ensure the telephone conversation includes why the patient has been referred, where the clinic is held, what appropriate pre-medication to take and any additional pre-procedure advice
- Make the appropriate appointment on Welsh PAS.
- Take responsibility for ensuring the appointment letter is sent in a timely fashion
- Responsible for requesting notes and filing the appropriate documentation and results
- The Secretary is responsible for ensuring all patients waiting to be seen or having an appointment are appropriately reported on WPAS and ensure the dictated letters are typed and sent to the referrer.

Nursing role

- Ensure the patient fully understands and has read the pre procedure leaflet in order for the Hysteroscopist to obtain valid consent.
- Ensure patient has taken adequate analgesia prior to the procedure e.g. Ibuprofen 400 mg +/- Paracetamol 100mg one hour prior to OP Hysteroscopy – depending on healthcare professionals requirement)
- The patient to be accompanied / supported throughout procedure by a nurse/nursing assistant (local vocal)
- Any specimens taken will be labelled by the nurse in clinic
- A relative can be present (with the permission of the lead clinician and dependent on the up to date clinic risk assessment)
- Prior to leaving the department, ensure that the patient understands future management of her condition, provide a post-procedure leaflet (Appendix C)
- Ensure the patient has adequate analgesia post procedure
- If the patient requires an overnight stay (which is very unlikely), the patient could be admitted to female surgical ward for necessary observation and review.
- To care for the unwell patient which may include vaso-vagal reaction, cardiac arrest, severe bradycardia, anxiety etc.
- Support the lead Nurse Hysteroscopist in managing patient notes and clinic preparation
- Clinic nurse are responsible for setting up the clinic and clearing away, following infection control policies
- Staff will ensure that all equipment is tested and checked prior to procedures, any defects must be reported accordingly

- Qualified staff need to be adequately trained in supporting the specific procedures e.g. Diagnostic Hysteroscopy/Myosure Polypectomy/Nova sure Endometrial Ablation
- Post operatively, women can wait in the recovery area before leaving and should be provided with analgesia if required.
- Inform the patient that 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

Staffing Levels

There will be a complement of a minimum of 4 staff in the OP Hysteroscopy clinic:

- 1 Hysteroscopist
- 1 Registered nurse
- Nurse (Registered or HCSW) to support the patient throughout the procedure
- 1 Health care assistant with Welsh PAS access to 'meet and greet' , book in the patient, advise them pre-procedure, perform pregnancy tests, support the unwell patient and assist in operative procedures if required.
- The health care professional carrying out the procedure must have the relevant qualifications and skills to undertake the task
- All qualified staff will be appropriately trained in anaphylaxis and ILS with HCSW's having up to date BLS training

Potential Complications/Risk Management

Pain: significant reduction in the mean pain score can be achieved with the use of analgesia pre-procedure, 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 complication. Therefore women should be informed of this potential complication and possible requirement of concurrent laparoscopy in rare situations.

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.

Post-operative 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

Management of Vasovagal Syndrome:

- 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 is not immediate give oxygen, obtain 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 (BLEEP 2222).

Confirmed or suspected uterine perforation, bowel, bladder or blood vessel injury

- If uterine perforation is suspected the procedure will be abandoned, a full assessment undertaken and set of observations and consideration will be given to the need for admission for observation/further investigation
- If there was no evidence of bowel, bladder or blood vessel injury at the time of the perforation, the patient is well and reasonably comfortable, she needs oral broad spectrum antibiotics and analgesia as required
- Where visceral damage is suspected or confirmed – admit for observation and discuss further management with the on call general surgical or urological team.

- Where vascular damage is suspected or confirmed – admit for resuscitation, observation and treatment as required, liaising with the vascular or interventional radiology team if necessary.

Operative/Therapeutic Hysteroscopy

Where appropriate, the following may be performed in the clinic setting:

- Cervical polypectomy
- Mirena insertion
- Endometrial polypectomy / Myomectomy
- Endometrial ablation

MANAGING RESULTS

Confirmed Endometrial Cancer

Follow Cancer services protocol to include:

Merthyr & Cynon / Rhondda Taff Ely

- Informing the Cancer Nurse Specialist and Gynaecology Cancer lead(Appendix D)
- An urgent follow up appointment for results and MRI request with a Gynaecology Cancer Specialist
- Include on the next available multi-disciplinary team meeting (MDT)

Bridgend

- Hysteroscopist requests MRI and MDT listing and informs the CNS and Gynaecology Cancer lead of the results (Appendix D)
- Patient is informed of the MDT outcome in USC Gynaecology clinic by the Gynaecology Cancer lead or Hysteroscopy lead.

Benign Histology

A result letter is to be sent to the woman and G.P and she will have the opportunity to discuss these results if desired. Standard result letter (Appendix E)

Endometrial Hyperplasia

Follow the Royal College of Obstetrics and Gynaecology Guidance;

https://www.rcog.org.uk/globalassets/documents/guidelines/green-top guidelines/gtg_67_endometrial_hyperplasia.pdf

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Appendix A

Hysteroscopy Referral Form

REFERRAL FAX NUMBER: 01685 728342 (PCH)
01443 443094 (RGH)

Date:-.....

Patient's Name: …… DOB: …….

Address: ……..

……

Telephone Number / Contact Number ……..

Indication:

Referral priority (circle)
USC (within 10 days)
Urgent (4-6 weeks)
Routine (within 26 weeks)

Significant Medical /Surgical History:

Medication (*particularly anti-coagulants):

Allergies:

Any other significant information e.g. ^BMI / Hoist required / interpreter required/specific needs:

Date of Last Smear:

USS Arranged? YES NO

USS Results Attached? YES NO

Name and Status of Referrer: ……

Appendix B – Pre procedure leaflet

http://ctuhb-intranet/dir/Maternity/Hysteroscopy%20Documents/Pre%20Hysteroscopy%20leaflet%20-English%205180.pub

Appendix C – Post procedure leaflet

http://ctuhb-intranet/dir/Maternity/Hysteroscopy%20Documents/Post%20Hysteroscopybiopsy%20leaflet%20(English)%20-%203161.docx?d=w71bd660f8ff041e480219e415530130a

Appendix D

GYNAECOLOGY CANCER – KEY WORKER DETAILS

All patients diagnosed with cancer in Wales are allocated a key worker. Often the key worker is a Clinical Nurse Specialist. You may be allocated more than one key worker if you are cared for at more than one hospital. This information sheet provides you with the information you may need should you wish to contact your key worker.

What is a Clinical Nurse Specialist?

There are many different kinds of nurses involved in cancer care. Some of these nurses are called clinical nurse specialists (CNS). These nurses have undertaken specialist training and have particular areas of expertise in cancer. They work mainly in hospitals and they may specialise in a specific cancer or a particular treatment.

Your key worker is a Gynaecology Oncology Nurse Specialist:
RGH / PCH Andrea May - 07768055438
RGH / PCH Bethan Henderson – 07584542039
POW Carol Grant - 07976707642 / 01656-755538

Secretary Contact numbers:

PCH Miss Sivasuriam – 01685 728369
RGH Mr Khalifa – 01443 443526
POW Ms Margarit - 01656-752970
Working hours Monday – Friday (excluding Bank Holidays) 09.00 – 17.00

If your Nurse is unable to answer your telephone call – please leave your name and number and a brief message on the answerphone.

For emergencies or outside these hours:
Please contact your GP during working hours or GP on-call service by telephoning your GP surgery
If you are receiving chemotherapy/radiotherapy treatment and are feeling unwell:
please contact Velindre cancer centre on 02920-615888 and ask for the chemotherapy pager.

If you wish to speak to a professional for support and your key worker is not available, you may find these numbers helpful:
Rowan Tree – 01443 479369
Cancer Aid – 01685 379633
Macmillan Cancer Support – 0808 808 0000 Monday – Friday 9am – 8pm
Tenovus Support Line – 0808 808 1010 open 08.00 – 20.00 everyday
Maggie Centre – Whitchurch Cardiff – 02922408024

Appendix E

Our Ref/ein cyf: CW/

Clinic Date/dyddiad:

Tel/ffon: 01685 721721 ext 23491

Fax/ffacs: 01685 728342

Dept/Adran: Obstetrics & Gynaecology, Prince Charles Hospital, Merthyr Tydfil, CF47 9DT

SISTER C WILLIAMS

ADVANCED NURSE PRACTITIONER IN HYSTEROSCOPY

PRINCE CHARLES HOSPITAL

PRIVATE & CONFIDENTIAL

Dear

I am now in receipt of the results of your biopsy which I took during your recent hysteroscopy clinic appointment. I am pleased to tell you that your results have been reported as normal and I hope this is reassuring to you.

Yours sincerely

SISTER C WILLIAMS

ADVANCED NURSE PRACTITIONER IN HYSTEROSCOPY

Copy to:

Denise Dummett

Medical Secretary to Miss. Sivasuriam & Miss. Janoowala

Prince Charles Hospital

Merthyr Tydfil

CF47 9DT

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(F) 01685 728302