

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."*

HYSTEROSCOPY

Definition

Hystero = of or denoting the womb (uterus)

Scopy = examination with an instrument for improved viewing, often with magnification and directed lighting

Hysteroscopy is an outpatient surgical procedure performed by your gynecologist to permit direct visualization of the uterine (womb) cavity using a long, thin, lighted telescope inserted through the vagina (birth canal) and cervix (neck of the womb). Hysteroscopy is used as a diagnostic tool, an operative device, or both, depending on the specific condition.

Diagnostic hysteroscopy can be thought of as a way of "seeing" the inside of the uterine cavity. During diagnostic hysteroscopy, your gynecologist will be examining the lining of the uterus, looking for polyps, fibroids, scar tissue/scar bands, blockages of the fallopian tubes, and abnormal partitions. Operative hysteroscopy can be thought of as *operating* while "seeing" with the hysteroscope. In many cases, with the use of operative hysteroscopy, your gynecologist will be able to surgically treat or remove many of the abnormalities seen with diagnostic hysteroscopy. Hysteroscopy can also be used as a method to collect a sample of tissue (biopsy) for examination or to remove an object, such as an intrauterine device (IUD). Hysteroscopic endometrial resection and ablation are discussed in detail in the *Endometrial Ablation Procedure Education Literature*.

Other methods of determining the contour of the uterine cavity include x-ray (hysterosalpingography) and ultrasound (sonohysterogram). Both involve injection of fluid into the uterine cavity during imaging to "inflate" the cavity. These methods are often used in place of a diagnostic hysteroscopy but may lead to a recommendation for operative hysteroscopy.

Diagnostic hysteroscopy and straightforward operative hysteroscopy are often done in your doctor's office. More complicated operative hysteroscopy is performed in an operating room setting. The procedure can be completed in as little as two minutes or take longer than an hour, depending on the procedure being performed. Hysteroscopy, both diagnostic and operative, is an outpatient procedure. Most women recover very rapidly and resume normal activity at home or work the day after the surgery.

Preparation

In-office procedure: Preparation for an in-office hysteroscopy will depend on the method of pain control used by your doctor. The procedure can be comfortably performed with administration of oral or intravenous medications, usually along with injection of local anesthetic. Intravenous medications are given to produce a "conscious sedation" and often require an empty stomach. Your doctor will give you instructions based on the planned procedure and anesthetic choice.

Outpatient hospital procedure: As with all procedures in which general anesthesia is administered, you will be asked not to eat or drink anything after a certain time, typically midnight, on the evening prior to your surgery. You may brush your teeth in the morning but not swallow the water. If you are on medications that must be taken, you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. ***Please refer to the attached list and tell us if you took any of these within the past 10 days.*** If your new medication is not on the list, alert us immediately so that we may ensure optimal procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure

You will be lying on your back with your legs elevated in stirrups, much like you would for a pelvic examination. The procedure usually takes between five minutes and one hour depending on the type of anesthesia used and if diagnostic or operative hysteroscopy is to be performed.

The procedure begins by gently cleaning the vagina and then placing a speculum in the vagina to hold it open. Injection of local anesthetic is usually given at this point. The cervix is grasped with an instrument to hold it still, while the opening is gradually dilated with surgical instruments until the hysteroscope can be inserted without force.

The cavity of the uterus is much like a balloon: when empty it is flat but when inflated space is created inside the balloon where there was none. Performing hysteroscopy involves "inflating" the cavity of the uterus with a liquid or gas (flowing in and out through grooves along the hysteroscope) so that each surface can be seen. Miniaturized instruments can then be placed along side of the operative hysteroscope to correct many of the abnormalities within the cavity.

Once sufficient visualization, biopsy, and surgical corrections have been completed, the procedure is complete. The instruments are removed from the uterus and vagina and you will begin your recovery.

In most cases, any tissue removed is sent to the laboratory for microscopic examination by the pathologist. The results of this examination are usually not available for one to several days.

Post Procedure

Recovery from hysteroscopy is rapid and most women will go home within one or two hours of the procedure. Though you may have some discomfort and cramping following the procedure, it is not necessary for you to plan time off from work or your normal activities beyond the day of surgery. It is normal to have some bleeding and discharge for one- or two-days following hysteroscopy. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching, and tampon use until told you may resume by your doctor (usually two to three days after diagnostic hysteroscopy and two to three weeks after operative hysteroscopy).

Medications, such as ibuprofen or naproxen, are usually all that is needed for the cramping you might have after your surgery. Ask your doctor what is recommended or if a prescription for pain medicine will be given. An antibiotic prescription may also be given and should be taken until completion. If any side effects occur, contact our office immediately.

Expectations of Outcome

Hysteroscopy and hysteroscopic surgery are performed as outpatient procedures, without any surgical incisions, and with minimal discomfort and rapid recovery. With the use of these techniques, structural abnormalities within the uterine cavity can be demonstrated and, in many cases, corrected.

Hysteroscopy is superior to hysterosalpingogram in diagnosing intrauterine pathology. Sonohysterography may be better tolerated and equally effective in diagnosing intrauterine polyps, scarring, fibroids, and foreign bodies when compared to diagnostic hysteroscopy. Both hysterosalpingogram and sonohysterography have only diagnostic capabilities.

Many women who have experienced heavy or irregular uterine bleeding will return to a regular menstrual cycle following removal of endometrial polyps and fibroids from within the cavity. Maintenance of regular cycles may be assisted with hormones or birth control pills.

If your surgery was part of an investigation into infertility, your doctor will explain what was found and accomplished by the surgery and will help you understand the impact of these findings on your future fertility

Possible Complications of the Procedure

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- J) **Perforation of the Uterus**: The most serious complication of the procedure is the creation of a perforation, or hole, in the wall of the uterus. This occurs when the dilator or hysteroscope is pushed too far or with too much force. Perforation of the uterus may lead to injury of other structures and organs within the abdomen (blood vessels, nerves, intestines, and bladder), bleeding or infection. Perforation is not common, however, may require another operation to be treated appropriately.
- J) **Pelvic Infection**: Hysteroscopy involves placing an instrument through the vagina and cervix into the uterus. Because of this, it is possible to introduce a microorganism (such as bacteria or yeast) from the vagina into the uterine or abdominal cavity. Many microorganisms are normally present in the vagina and cause no infection or other symptoms. However, when these same microorganisms are present within the pelvis or cavity of the uterus, a more serious infection can be the result. Signs of infection

that you should be watchful of are: foul-smelling vaginal discharge, tenderness, or pain in the vagina and pelvis for more than two days, bleeding lasting more than two days, fevers, shaking chills, nausea, vomiting, weakness, and feeling ill.

****If you have symptoms suggesting any of the above after your discharge from the hospital, you must contact us immediately or go to the nearest emergency room.***

-) **Bleeding**: Most women will have a small amount of bleeding following this procedure. If your bleeding is heavier than your normal period or lasts longer than two days, please call your doctor.
-) **Fluid Imbalance**: In addition to water, fluids used to "inflate" the cavity of the uterus for hysteroscopy contain dissolved sugars, starches, and salts. These substances give the fluids certain desirable properties for visualization of the uterine cavity. When too much fluid flows from the uterus and enters the abdominal cavity or blood stream, an "imbalance" in the water content of the blood may result. Careful choice of fluid and monitoring of fluid delivery make this an uncommon complication.
-) **Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE)**: In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. ***If you notice these signs, you should go directly to an emergency room and also call our office.*** Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.
-) **Lower Extremity Weakness/Numbness**: This, too, is a rare event that may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline

Patient Signature

Date

Account #

Patient Name (Print)

Physician

Date

Witness

Date

The information contained in this Medical Informed Consent Form ("Consent Form") is intended to solely inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional. Please call your doctor if you have any questions.