Trust Guideline		Worcestershire Acute Hospitals NHS Trust

Outpatient Hysteroscopy (OPH) and Postmenopausal Bleeding (PMB) Service Guideline

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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Outpatients Hysteroscopy Service, Gynaecology
Target staff categories	Gynaecology medical & nursing staff, Outpatients staff

Guideline Overview:

This Guideline sets out

- the process of referral for OPH Clinic and PMB One-Stop Clinic (2 week wait (2ww) pathway), either external or internal referral
- Pathway for routine and 2ww referrals.
- OPH procedure and managing complications

NB. Hard copies of this policy are not permitted as they **cannot guarantee** and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust Intranet Clinical Guidelines and Policies tab on the front page

Latest Amendments to this policy:

10/01/2020 following OPH/PMB Team Meeting:
Section 5.1.1.2 PMB Referral Criteria - Changed to reflect new 2ww referral form as agreed with Gynaecology oncology team
14/02/2020 agreement at OPH Team Meeting to add Section 5.8.1 Cervical Stenosis/Failed OPH and Section 5.8.2 Previous Endometrial Ablation

18/09/2020 Change to order of guideline sections
Section 5.1.2 Changed to reflect new internal referral form via ICE
09/10/20 Following Gynae. Ambulatory Care Team Meeting, Updated Section 5.1.1.3.2 Anticoagulants General Information and Section 5.6.2 Criteria for proceeding to OPH**,** 5.6.2.2.1 With PMB taking HRT or not Endometrial thickness >5mm
31/03/2021 Addition of the 'Management of Shock' flow chart
29/12/2023 Document extended for 6 months whilst under review (Alex Blackwell)
20/08/2024 Document extended for 6 months whilst under review (Alex Blackwell)

Contents page:

Appendices

Supporting Documents

Supporting Document 1	Equality Impact Assessment
Supporting Document 2	Financial Risk Assessment

1. Introduction

Outpatient Hysteroscopy also known as office-based hysteroscopy or ambulatory hysteroscopy, is a safe, convenient, effective environment and method to investigate causes of abnormal uterine bleeding; intermenstrual bleeding, post coital bleeding and post-menopausal bleeding or as a part of fertility/recurrent miscarriage investigations. When carried out by medical or nursing staff with good technical skill, it is acceptable to most women although between 3-10% will experience severe pain and are not able to tolerate the procedure and will require a general anaesthetic to undergo hysteroscopy[1].

The aim of this guideline is to provide staff with information to facilitate delivery of a high quality, efficient and evidence based service through dedicated diagnostic, “see and treat” and operative outpatient clinics for women requiring diagnostic, treatments and operative gynaecological procedures.

In this Trust, OPH is undertaken at the Women’s Health Unit at The Alexandra Hospital, Redditch.

This document covers:

- The process of referral for Outpatient Hysteroscopy Clinic and for PMB One-Stop Clinic (2ww), either external or internal referral.

- OPH procedure and responsibility of medical and nursing staff own competence in:

    - The correct identification of the woman and suitability for OPH
    - Carrying out the procedure in accordance with the RCOG Best Practice for OPH recommendations[2]
    - Obtaining endometrial biopsy
    - Management of complications
    - Follow up and management of results
    - Reporting any rejected samples and incidents

2. Scope of this document

This policy is relevant to all medical and nursing staff who carry out diagnostic and operative OPH and to the staff who assist in the procedure.

3. Definitions

OPH involves the systematic inspection of the uterine cavity via miniature hysteroscope (2-4mm)[3]. It enables diagnosis of intrauterine pathology such as endometrial polyps, submucosal fibroids (types 0-2), 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

4. Responsibility and Duties

It is the responsibility of the medical and nursing staff carrying out OPH and of those assisting, to ensure they are familiar with the contents of this guideline.

5. Guideline Detail

5.1 Referral to OPH or PMB One-Stop Clinics

5.1.1 Referral Citeria

5.1.1.1 Pre-menopausal

- Women with heavy menstrual bleeding (HMB)[4] or intermenstrual bleeding (IMB)
- Recurrent miscarriage/ Failed assisted conception
- Suspected uterine anomalies
- Complicated IUCD removal and replacement

5.1.1.2 PMB

- **PMB not on Hormone Replacement Therapy (HRT)** - direct referral as 2 week wait (2ww) to the PMB One-Stop Clinic (ultrasound scan included as part of One-Stop pathway)
- **PMB on HRT >6 months** - refer as 2ww to PMB One-Stop clinic for assessment +/- endometrial pipelle (ultrasound scan included as part of One-Stop pathway).
- **PMB on Tamoxifen** is regarded as a risk factor for endometrial polyps, hyperplasia and cancer[11] - refer as a 2ww to OPH PMB One-Stop Clinic. Ultrasound scan is included as part of One-Stop pathway with advantage of visualising adnexa in these cases.
- **Endometrial ablation with amenorrhoea and <50y** should be presumed to be pre-menopausal if bleeding recommences and should be seen in as **'urgent' in GOPD.**
- **Premature ovarian failure or women <50y** but referred as 2ww PMB clinic should be seen as '**urgent' in GOPD** as likelihood of endometrial cancer is so low.
- **Post coital bleeding** with no other symptoms should be seen as **'urgent' in GOPD** rather than PMB 2ww clinic

Exception:

- PMB and previous hysterectomy, refer as 2ww to GOPD, not PMB One-Stop Clinic. No ultrasound scan initially but following assessment, clinician may later request this

5.1.1.3 Considerations on referral to OPH or PMB One-Stop Clinics

5.1.1.3.1 Vaginal Pessaries and Intra-Uterine Devices (IUD)

- Vaginal Shelf Pessaries must be removed before ultrasound scan. These patients should be put on the list last or later to attend the unit to allow removal of the shelf pessary prior to scan and possible OPH
- IUD *should* be removed at the GP practice prior to endometrial assessment on pelvic ultrasound scan if due for replacement and out of date. Contraceptive cover should be discussed with the GP if necessary
- IUD *can remain in situ* if being used for HRT, contraception or to control symptoms of heavy menstrual bleeding. In patients with IUD in situ, endometrial thickness measured on ultrasound scan may not be relied on when making a decision to proceed with hysteroscopy

5.1.1.3.2 Anticoagulants General Information[5,22]

- Procedures that require anticoagulation to be stopped will vary in their bleeding risk and the consequences of bleeding
- The ultimate risk of bleeding for a patient on anticoagulants should be individually assessed by the clinician.
- Any anticoagulant therapy changes should be clearly documented in the patient's medical notes
- Anti-Coagulants Standard: low risk procedures which includes diagnostic hysteroscopy and biopsy do not require interruption of Warfarin as long as the INR is within target range >1.5 and <3
- Direct Oral Anticoagulant's (DOAC) provide a similar level of anticoagulation to Warfarin with a target INR of 2.5 but produce more peaks and troughs
- Taking a biopsy/treatment and bleeding risk is based on clinician discretion at the time of procedure
- Patients with artificial heart valves or high risk coronary conditions should be discussed with Cardiology before stopping anticoagulation
- Patients who have had a recent thrombosis (within the last 6 weeks) should be discussed with Clinical Haematology
- The decision to stop Warfarin should be made only when operative hysteroscopy is being planned eg. removal of large polyps/fibroids etc.

It is the clinician responsibility to provide clear instructions for the patient regarding the stopping of anticoagulation and bridging therapy

Table 1: Medical procedures and their associated bleeding risk[23]

Bleeding risk	Type of procedure
No bleeding risk	Pelvic examination Smear test
Low bleeding risk	Cervical biopsy Large loop excision of transformation zone Diagnostic hysteroscopy Pipelle biopsy Hysteroscopy and resection of polyp, including type 1 fibroid polyps <3cm MyoSure polypectomy Vulval biopsy Labial/Bartholin's abscess NovaSure ablation
High bleeding risk	All day case and inpatient surgery

Interruption of Oral Anticoagulants for Outpatient Hysteroscopy +/- Biopsy +/- treatment with low risk bleeding[5,22] (see Table 1)

Warfarin

- Warfarin should not be interrupted for diagnostic procedures (+/- endometrial biopsy, at the discretion of the clinician) as long as the INR is within target range of >1.5 and <3

DOAC's eg Rivaroxaban, Edoxaban, Apixaban

- AM procedure: Withhold morning dose of DOAC. Take missed dose 2 hours after procedure as long as haemostasis is secure
- Procedure after 2pm: Take morning dose of DOAC before 7am and restart when next dose is due as long as haemostasis is secure and 2 hours has elapsed from end of procedure

Clopidogrel, Prasugrel, Ticagrelor

- There is currently no requirement to stop Clopidogrel, Prasugrel or Ticagrelor prior to diagnostic procedures or diagnostic biopsies

Interruption of Anticoagulation for Outpatient Operative Hysteroscopy with high risk of bleeding[5,22] (See Table 1)

Warfarin

- If considering temporary discontinuation of Warfarin, refer to Pre-op Assessment Key Documents WAHT-KD-017 WARFARIN & OTHER ORAL ANTICOAGULANTS GUIDELINES AND PROCEDURES via the Trust Key Documents page on the intranet and provide clear instruction for the patient based on individualised assessment for temporary discontinuation of Warfarin and bridging therapy

DOAC's eg Rivaroxaban, Edoxaban, Apixaban[7,22]

- AM procedure: Withhold morning dose of DOAC. Take missed dose 2 hours after procedure as long as haemostasis is secure
- Procedure after 2pm: Take morning dose of DOAC before 7am and restart when next dose is due as long as haemostasis is secure and 2 hours has elapsed from end of procedure

Clopidogrel, Prasugrel, Ticagrelor[7,22]

- Stop Clopidogrel, Prasugrel or Ticagrelor 5 days before endoscopy. Continue aspirin if already prescribed

5.1.2 Referral process

- Women assessed in Primary Care who meet the criteria for referral, can be referred into the service via the referral form ratified by the Clinical Commissioning Group for OPH or to the PMB One-Stop Clinic as a 2ww referral if endometrial cancer is suspected.
- Referral forms should be completed thoroughly and emailed to the OPH booking team office
- Women assessed within the WAHT GOPD or at the WAHT Gynaecology Assessment Unit can be referred internally for either routine, urgent or 2WW OPH
- Internal referrals for OPH should be made via ICE
- The One-Stop Office booking team / routine booking teams are responsible for booking appropriate appointments following referral.
- Referrals are triaged by one of the OPH consultants/nursing team working in Oncology/OPH

5.2 Documentation

- Women will receive an appointment via letter that contains instructions either for routine OPH clinic or OPH PMB One-Stop Clinic (2ww). They will also receive a copy of the Outpatient Hysteroscopy – Information For You[8] patient information leaflet which is endorsed by the OPH team, the RCOG and the BSGE
- Attempts should be made to email the information leaflet to patients who are attending at short notice
- The OPH patient information leaflet is also available as an audio version[9] for patients who require this. The link to this can be found by accessing the RCOG website. Attempts should be made to send this to patients who require it by the One-Stop Office booking team
- Generic OPH paperwork will be found within PMB/Hysteroscopy/One-Stop Office Key Documents found within the Trust Intranet Clinical Guidelines and Policies under Gynaecology
- Documents that should have a header and barcode for scanning onto patient health records on eZnotes, will populate patient identification details automatically e.g. history sheet/procedure record, operative waiting list forms. It is therefore good practice to print these documents from eZnotes
- Documentation should be printed contemporaneously with the procedure where possible or as a clinic print when preparing clinic notes

5.3 Staffing

5.3.1 OPH / PMB One-Stop Clinician Responsibilities

It is responsibility of the medical or nursing staff carrying out the procedure to ensure:

- They are currently registered with their professional body i.e. General Medical Council or Nursing and Midwifery Council
- Preferably, they will be members of the British Society of Gynaecological Endoscopy (BSGE)
- They have undergone the appropriate training as part of their special skills (medical staff) or PG Cert in OPH at Bradford University (nursing staff) and are deemed competent
- They maintain competency by carrying out a minimum of 100 hysteroscopy per year (equivalent of 1 clinic alternate weeks)
- Keep up to date with developments in OPH – membership of the BSGE will enable this and attempts must be made to attend the BSGE Annual Scientific Meeting or equivalent at least once within a 3 year period
- Be involved with service audit and are proactive in seeking advice/engaging in remedial activity if any issues are identified

5.3.2 Staff numbers and roles

The level of staffing for clinics depends on the clinic session taking place. The minimum staffing levels are outlined below. It is the responsibility of the Unit Manager / Nursing Sister to ensure staffing requirements are met and highlight deficits to the Matron for Gynaecology.

The clinic requires:

- a clerk to book-in women as they attend for appointments onto the hospital computer system
- a health care assistant to welcome the woman and carry out baseline observations (see below)

In the procedure room there should be:

- A qualified and competent medical or nursing staff member carrying out the procedure
- A registered nurse (RN) assisting the procedure
- A health care assistant (HCA) acting as 'vocal local' for the patient (RCOG, 2011)
- A second RN for assistance, acting as 'runner' during a procedure, setting up machines when needed, setting up working trolley between cases and administering analgesia where required, is advantageous

5.4 Environment

5.4.1 Equipment

Area for clerking
Procedure room with access to changing and toilet facilities for women
Recovery room with couch
Computer workstation
Handwashing facilites
Examination light
Examination couch and stool
Equipment Trolley
Stack system
Versapoint Machine
Emergency Trolley
Medicine Cupboard with appropriate range of analgesia
Prescription Charts (inpatient and outpatient)
Sterile gauze swabs
Needles for dental syringes
Dental syringes – long and standard
Smear taking brush and pot
Gallipots
Sterile cleaning solution sachets
Vaginal examination pack form HSDU
Polyp forceps

Vulsellum Forceps
Range of different sized specula, Cusco and Sims
Range of different sized Hegar dilators
Disposable Os finder
Disposable sound dilator
Range of IUS/IUD – Mirena, Jaydess, Copper
Instillagel & Quill
Sterile swabs & Chlamydia swabs
Sterile scissors
Formalin pots
Specimen bags
Sterile Coil Retriever
Sponge holders
Pipelle endometrial biopsy device
Syringe endometrial biopsy device
Hysteroscopy Packs from HSSU
Versapoint sheaths
Light lead covers
Disposable gloves
Disposable aprons
Sterile gloves
Sharps Box
Lubricating jelly
Foleys catheter
Silver Nitrate
Blood taking equipment
Range of cannulas

Medications: Range of appropriate analgesia and local anaesthetic

Fluids:

IV Stand
Normal Saline
Pressure bag
IV Giving Set
3 Way Tap
50ml syringe
Disposable kidney dish

5.4.2 Setting up for a Clinic Session

- Before every clinic session, it is essential that all equipment is checked and in sound working order in the interest of health and safety, patient comfort and the smooth running of the clinic session
- All clinical areas and equipment should be cleaned as per Trust Decontamination Policy[10]

- Set up working trolley:
  Diagnostic Hysteroscopy Sterile pack from HSDU
  Dressing pack x1
  Sterile Gauze Swabs x 1 pack
  Vaginal Examination pack from HSDU
  Sponge holders x 1
  Vulsellum x 1
  Polyp forceps x 1
  Disposable Versapoint Sheath x 1
  Disposable Kidney dish

5.5 Arrival at clinic

- Women should be greeted and 'arrived' on the Trust computerised system Oasis checking identity, asking the woman to state her name, date of birth and first line of address
- On arrival at the clinic, women who are attending PMB One-Stop Clinic should have already had a pelvic ultrasound scan (as instructed on appointment letter)
- They will then be clerked in by a registered nurse or health care assistant who will
  - Re-check identity, asking the woman to state her name, date of birth and first line of address
  - check for any allergies and put an identity band onto the women – red if there are any allergies, white if not
  - assist the woman in completing the medical history on the nursing record
  - take baseline observations (blood pressure, pulse, temperature and O2 saturations), their BMI and urinalysis and document these on the nursing record
  - Women with the potential for pregnancy, pre and peri-menopausal, should have a pregnancy test completed
  - It will be explained that friends and relatives will be asked to wait in the waiting area or go off the unit whilst the procedure is carried out. Patients will be reassured that nursing staff will be there for them. In exceptional circumstances, this may be overruled eg. patient with learning difficulty

5.6 The Consultation

5.6.1 Pre-procedure

- In preparation, the clinician carrying out the consultation will read through the referral letter and nursing record to familiarise themselves with the past medical history
- A history sheet should be printed contemporaneously with the appointment.
  - OPH procedure record is available via the OPH pathway on the Trust intranet.

  - PMB procedure record is available via eZnotes and should be printed from here as it will be a headed sheet which self-populates the patient identity details
- A full medical history will be taken by the clinician and the indication for proceeding to OPH identified / alternative investigation
- Ensure negative pregnancy test and no unprotected sexual intercourse (UPSI) since the last period in women of reproductive age or trying to conceive
- The results of any previous scan will be discussed along with any proposed investigation / treatment / management plans
- Where there is concern regarding a patient's suitability for hysteroscopy or scheduled procedure e.g. active infection, the procedure may be deferred if necessary
- Valid, informed consent will be obtained (see below Section 5.6.3)
- If a biopsy is likely to be needed, ensuring that the woman is contactable is the responsibility of the person taking the biopsy. This should be checked at this stage so that she can be advised on any further tests or investigations that may be required based on the results

- Concurrently, patient details will be entered on the stack system by the nursing staff
- Following the Trust aseptic technique policy[13] the assisting RN will prepare the treatment trolley
- Open sterile vaginal examination pack on top shelf of trolley
- Open the following items and place within the sterile field provided by the opened hysteroscopy pack. Sponge holder, vulsellum, 1 pack sterile gause swabs and gallipot and pour sterile cleaning solution into it, appropriate speculum and lubricating jelly
- During the procedure they will assist the clinician by opening packs as requested

5.6.2 Criteria for proceeding to OPH

5.6.2.1 Pre-menopausal

- Consider starting pharmacological treatment for HMB without investigating the cause if the woman's history and/or examination suggests a low risk of fibroids, uterine cavity abnormality, histological abnormality. This group of patients do not require outpatient hysteroscopy unless they fail to respond to conservative management in 3 months or 6 months of LNG-IUS insertion
- Refer women with intermenstrual and irregular bleeding to rule out polyps and submucosal fibroids.
- Patients with intermenstrual bleeding and breakthrough bleeding must be screened for chlamydia, rule out progesterone only contraception as a cause and must be treated for ectropion and lower genital tract lesions before referral.

- Women with infrequent heavy bleeding who are obese or have polycystic ovary syndrome
- Women on tamoxifen
- Failed response to initial conservative management

5.6.2.2 Post-Menopausal

5.6.2.2.1 With PMB taking HRT or not[11]

- > 5 mm endometrium
- Persistent vaginal bleeding irrespective of endometrial thickness
- Pelvic ultrasound scan findings suggestive of focal uterine cavity pathology
- Minimal intra-uterine fluid if suspicious and associated with thickened or irregular, indistinct or ill-defined endometrium - in cases where a reliable measurement could not be obtained

5.6.2.2.2 Without PMB

- Incidentally thickened endometrium of >8mm[12]
- Fluid in the cavity with irregular or ill-defined endometrium and/or >5mm
- Incidental polyps and focal lesions should be treated based on clinical judgements as overall risk of malignancy is very small <1% unless other abnormal features noted. Majority of patients are found to have inactive benign polyps

5.6.3 Obtaining consent

- Informed, valid consent must be obtained for any investigation / treatment. This should include:
  - Benefits and risks
  - Alternative options for investigation / treatment
  - Encouragement to ask for the procedure to stop if it becomes too painful
- Documented verbal consent is adequate for any vaginal / speculum examinations / genital swabs.
- If hysteroscopy +/- biopsy / treatment / insertion of intra-uterine device is required, written consent is essential.
  - It is best practice to create an E-Consent form via eZ-notes, where this is not possible, a Trust written consent form will be completed.
- Following the Trust Policy for Consent to Examination or Treatment[14] options of investigation or management will be discussed and an opportunity for queries, before asking the woman to sign a consent form as evidence of her informed, valid consent

- The pathway for patients that lack capacity to give or withhold consent is within the Trust Policy for Consent to Examination or Treatment[14] and this will be followed

5.6.4 The procedure

Below is a brief outline of a hysteroscopy procedure. Other procedures may be added to the diagnostic hysteroscopy procedure.

- The woman will be shown to the changing area and asked to remove the lower half of her clothing and put on a theatre gown or draw sheet, maintaining her dignity
- The woman will be shown to the examination couch and into the lithotomy position. Staff will ensure she is made as comfortable as possible. A HCA or RN will attend the woman throughout the procedure providing distraction as the 'vocal local', assessing the patient's tolerance and communicating to the team[15]
- Before commencing the procedure, patient identity details will be checked on the stack system by asking the patient to state their name, DOB and first line of address
- The first-line method of approach to OPH should be vaginoscopy although traditional approach with Cusco's speculum insertion and vulsellum forceps may be necessary if there is difficulty in locating the cervical os or cervical stenosis requiring dilatation and local anaesthetic (LA) or treatment necessitates it[15]
- Examination of the lower genital tract will be carried out for all patients
- A cervical smear will be taken if indicated, following Local Trust Policy
- Lower genital tract swabs will be taken when infection is suspected from the history or examination (evidence of cervicitis, heavy or coloured or malodorous discharge). The OPH procedure will be deferred until the infection has been treated if necessary
- During vaginoscopy approach, the hysteroscope is inserted into the vagina and allowed to fill with the distention fluid (normal saline). The external cervical os is located and the endocervix traversed, through the internal os into the uterine cavity
- Where the cervix is stenosed, the hysteroscope may be withdrawn and Cusco's speculum inserted into the vagina ready for cervical dilatation +/- local anaesthetic (see below Section 5.6.4.1)
- Insertion of intracervical local anaesthetic gel (Instillagel 6ml) with the Instillaquill may be considered when Vulsellum forceps are required to stabilise the cervix. This is not required where cervical block is to be used[15]
- Dilatation with os finder or Hegar dilators can be carried out
- Instruments may then be removed and vaginoscopy approach can be attempted again – this is likely to improve patient comfort **or**
- The hysteroscope is then introduced to the cervical os using normal saline as a distension medium
- The whole procedure is performed under direct vision. A panoramic view of the uterine cavity is revealed. Once inside the cavity the tubal ostia are identified, the size, shape, contour of the cavity and the endometrium are inspected. If no

pathology i.e. polyps or submucous fibroids are found then the hysteroscope is withdrawn, inspecting the cervical canal on the way out. During hysteroscopic examination digital images of the uterine cavity will be obtained and any abnormalities seen will be documented

- An endometrial biopsy may be taken to sample the endometrium where indicated. All women being investigated for postmenopausal bleeding will have an endometrial biopsy although it is at the clinician's discretion where the endometrium is atrophic
- If any pathology has been identified and is technically possible to treat, depending on the expertise of the clinician, in addition to the tolerance of the woman, she may be offered the opportunity of treatment for avulsion polypectomy using appropriate technique for outpatient setting. Where the clinician is not trained to perform such procedures, the woman will be issued with an appointment for an alternative clinic
- All staff are responsible for safe disposal of sharps used, and consumables, decontamination of the equipment and surroundings as per Trust decontamination policy[18]
- Endoscopes will be sent for decontamination as per Trust Decontamination of Endoscopes Policy[19]

- If Versapoint is required:
  - Plug in machine to main electricity supply on wall
  - Switch on Versapoint Machine
  - Attach paddle cable to machine
  - Place paddle on floor maintaining safety of staff and patients
  - Place electrode on Versapoint Machine

- If the LNG-IUS / Copper IUD has been agreed as a method of treatment with the woman, the device may be fitted
- Cervical polypectomy can be carried out for any patient found to have a cervical polyp at time of hysteroscopy if tolerable for the patient
- All specimens/biopsies will be sent to histology for analysis
- The clinician will debrief the patient following hysteroscopic investigation and discuss findings; management required and schedule further appointments where necessary
- If abnormal uterine pathology is suspected the clinician will advise the patient and agree firm arrangements with the patient as to how the results will be received i.e. via letter / telephone followed by GOPD appointment or by clinic appointment only
- If, at any time, for any reason the clinician undertaking hysteroscopy is unsure or concerned about the patient, then the procedure will be stopped and appropriate actions taken
- A Consultant clinician must be contactable (eg. On-call consultant) at all times when an OPH is running with a junior medical staff member or the nurse hysteroscopist

- The clinician / clinic staff will check that the patient has recovered from the procedure sufficiently and that it is safe for her to go to the waiting area for refreshments
- Women that are high risk for development of post-procedural infection, consideration should be given to prescribing a course of oral, broad spectrum antibiotics Eg. Augmentin 625mg TDS for 5 days
    - Eg. Uncontrolled diabetes
    - Immuno-supressed eg. Patients on long term steroids, anti retro-virals
    - Definite/possible hydrosalpinx on pelvic ultrasound scan

5.6.4.1 Local Anaesthetic

Use of local anaesthetic cervical block is likely to be necessary if cervical dilatation is carried out[15]. Given as intracervical block at 12,2,10 and 6,4,8 o'clock (avoiding 3 and 9 o'clock positions). The lowest concentration and smallest dose producing the required effect should be given:

Maximum doses[16]:

Lignocaine plain 3- 4mg/kg/ 4hrs
Lignocaine with adrenaline 7mg/kg/4hrs
Bupivacaine 2mg/kg/4hrs
Citanest 6mg/kg/4hrs

Drug	Maximum dose for infiltration	* Maximum dose for plexus anaesthesia
Lignocaine	3mg/kg	5mg/kg
Lignocaine with adrenaline (Lignospan Special)	7mg/kg	7mg/kg
Bupivacaine	2mg/kg	2mg/kg
Bupivacaine with adrenaline	3mg/kg	3mg/kg
Prilocaine (Citanest)	6mg/kg	7mg/kg
Prilocaine with adrenaline / octapressin	8mg/kg	8mg/kg
Mepivacaine Scandonest	7mg/kg	

5.7 Management of Pain

It is common for hysteroscopic procedures to cause some degree of pain, and effective pain management is essential. All members of the team play a role in assessing patient tolerance levels and reassuring patients during the procedure to ensure effective pain management is achieved

Pre-procedure

- Obtain written consent
- Ensure choice of treatment setting and anaesthesia offered
- Ensure that the patient is aware that some discomfort is likely and although temporary, they may stop the procedure at any point
- Ensure all patient's aware of the possibility of 'see & treat' interventions e.g. endometrial biopsy, polypectomy, LNG-IUS insertion where appropriate

During Procedure

- Vaginoscopic approach preferred[20]
- Intra-cervical instillagel via quill is recommended[20]
- Intra-cervical local anaesthetic is advised where cervical dilatation is required[20]
- All staff to be vigilant in monitoring and responding to patient pain and tolerance of the procedure
- The clinician carrying out the procedure must stop immediately if the patient requests or patient in substantial pain. Local anaesthesia and general anaesthesia should be discussed before proceeding.

Recovery

- If required, patients should be offered simple analgesia, maintaining awareness of which analgesia, if any, has been taken pre-procedure
- All patients to be recuperated and offered refreshments in designated recovery room
- Patients with significant post-operative pain can be admitted under Gynaecology for a period of observation and opiate analgesia if necessary
- Follow up or rescheduling of procedures under regional / general anaesthesia to be discussed and arranged by the surgeon

5.7.1 Entonox Gas

- Routine use is not advocated as it does not give and any pain relief advantage over local anaesthetic[17]
- Entonox gas when inhaled provides rapid, short lasting pain relief and is suitable for use for women undergoing minor outpatient procedures, including those undertaken in the Outpatient Hysteroscopy clinic. It can be used-on its own or in addition to a local anesthetic

5.8 Management of Other Findings

5.8.1 Cervical Stenosis/Failed OPH

- Be aware of the axis of the uterine cavity retroversion of anteversion

- Do not use blind dilatation of the uterine cavity this will obliterate cues to the uterine opening and create false passage
- Use a narrow hysteroscope
- Consider high pressure fluid irrigation and hydro- distension
- Narrow operating hysteroscopes (alphascopes can be used for hysteroscopic dilalation using micrograpers and biopsy cups which can also be used for removing polyps under vision)
- In difficult cases consider ultrasound guided dilatation
- Pipelle endometrial sampler and the inside plunger can be used as a guide to access the cavity

5.8.2 OPH following Endometrial Ablation

- Care should be individualized
- Attempt can be made to perform OPH based on clinicians discretion
- It should be explained that there is a high risk of failure and perforation
- In cases of failed OPH, consideration should be given to risk factors and likelihood of pathology before referral for inpatient diagnostic hysteroscopy

5.8.3 Pyometra

Pyometra is a collection of pus within the uterine cavity. It is not a common finding but can be found incidentally at hysteroscopy. Rarely, patients can develop septicaemia and therefore immediate action is required to treat the patient.

Known/ Highly Suspected Pyometra:

- Insert Cusco's speculum and take triple swabs
- Stabilise the cervix with vulsellum forceps if necessary and cervical dilator/pipelle biopsy instrument to open stenosed cervix
- Drain fluid and send sample for histological assessment
- Take endometrial pipelle biopsy for histological assessment
- Prescribe course of oral, broad spectrum antibiotic
- Rebook for OPH in 2 weeks

Pyometra found during OPH:

- Stop the procedure immediately to minimise any backflow of infection due to saline distention media in use
- Drain the fluid and send sample for histological assessment
- Take endometrial pipelle sample for histological assessment
- Prescribe a course of oral, broad spectrum antibiotics
- Rebook for OPH in 2 weeks

5.8.4 Ovarian cysts

Follow Local Trust guideline for management of pre / postmenopausal ovarian cysts

5.9 Management of Complications

5.9.1 Vasovagal Attack

During hysteroscopic procedures a vasovagal episode is caused by stimulation/manipulation of the cervix which can affect the vagus nerve. This results in bradycardia (slow heart rate) reducing the oxygenated blood flow to the brain causing a faint in the patient.

Signs

Woman reports feeling sick and faint. Clinical signs are evident: Pale, sweating, bradycardia, hypotension and reduced conscious state.

Action

- Immediately stop the procedure and remove instruments
- Reassure patient and calmly try to rouse them by talking to them
- Put the patient into a feet-up, head-down position - elevate the foot end of the examination couch higher than the head end of couch
- Ensure fan is on and facing patient
- Monitor pulse rate and blood pressure and record on observation chart
- If appropriate, offer oral analgesia
- Consider IM Buscopan 20mg
- It is highly likely that recovery will follow within 10 minutes to half an hour, a warm drink and biscuits can be offered and the patient discharged when recovered
- If the patient's pulse rate and blood pressure continues to remain low or the condition is deteriorating, IV access and fluids may be required
- At Redditch site, call the Medical Emergencies Team on 2222 if necessary
- At the Kidderminster site, call the Resident Medical Officer via switchboard
- Bring the Emergency Trolley to the procedure room – Atropine may be required, kept in the Emergency Drugs Box
- Give oxygen if necessary and prescribed
- In these cases, when the patient is stable, consideration of transfer to Gynae Ward for observation can be given until recovered and appropriate treatment given .

5.9.2 Cervical Trauma

Application or removal of instruments can result in bleeding from traumatised cervical tissue.

Signs

Steady trickle of bleeding from puncture site.

Action

Pressure is applied to the puncture site with cotton wool balls attached to sponge holders and held in place until the flow subsides. Silver nitrate sticks may be used for cauterisation.

5.9.3 Uterine Perforation

Perforation of the uterine cavity occurs where there has been penetration of the serosal uterine surface.

Signs

Perforation is diagnosed when the contents of the peritoneal cavity are seen and the hysteroscopy can be advanced beyond the distance of the uterine cavity. The patient may complain of increased pain and become faint.

Action

- Immediately stop the procedure and remove instrumentation
- If suspected cancer, attempts should be made to take a pipelle biopsy to send for histological examination, at the discretion of the clinician carrying out the procedure
- Reassure the patient and if faint, implement procedure for vasovagal episode
- Observe in recovery area of clinic and review by consultant
- Regular observations
- A course of oral, broad spectrum antibiotics will be prescribed
- Consultant review must include an explanation of what happened to the patient, preferably with the clinician who carried out the procedure present), assessment to determine further management i.e. antibiotic cover and surveillance or surgical intervention of diagnostic laparoscopy
- If patient is unwell and/or deteriorating, the woman will be transferred to a Gynae Ward for observation and review by consultant
- It is more likely that the patient will recover, they will then be allowed home with the contact number for Gynaecology Assessment Unit and appropriate safety-net advice
- Rebook for hysteroscopy as OPH or under GA in 8-12 weeks

5.9.4 Haemorrhage

Although rare, this complication can be associated with operative procedures involving deep myometrial penetration (resection of uterine septaea and adhesions), false passage and accidental contact with uterine wall in addition to abnormal endometrial pathology (highly vascular).

Signs

Excessive blood loss.

Action

- Immediately stop the procedure and remove instrumentation
- Reassure the woman
- Prescribe and administer IV infusion of Normal Saline 1l
- Administer oxygen if prescribed
- If faint treat as for vasovagal episode
- Insert Foley catheter into the uterine cavity facilitate intrauterine tamponade if necessary
- Transfer to Gynae Ward on a bed for further observation and management
- Consultant review

5.9.5 Severe Bronchospasm or Other Severe Allergic Reaction:

May occur rarely in response to injection of local anaesthetic.

- Stop Procedure and administer prescribed oxygen if appropriate
- At Redditch site, call the Medical Emergencies Team on 2222 if necessary
- At the Kidderminster site, call the Resident Medical Officer via switchboard. Attempts should be made to get anaesthetic help from the main theatre department
- Bring Medical Emergency Trolley to procedure room

5.10 Post procedure

- Dictation for correspondence to the General Practitioner (GP) and patient will take place either during or at the end of a clinic session. Dictated letters should be uploaded to Bluespier ready for typing, at the end of clinic.
- Written documentation will be sent for scanning into the electronic patient record on eZnotes
- Patient Pathway Decisions for Patients on 2ww PMB OPH Clinic sheets will be sent to the PMB OPH secretary (to inform whether patient can be taken off the 2ww pathway or not)
- Patients MUST NOT be taken off the 2ww pathway until histology results have been received and appropriately.
- Generic outpatient clinic outcome sheets will be actioned by the ward clerk or consultant secretary dependent on staffing at the time of clinic

5.11 Samples

- Expiry dates on sample pots containing Formalin should be checked by two members of staff before use
- The request form for the sample should be created by the clinician who took the sample on ICE computer system with as much relevant information as possible for lab staff to process and report the sample accordingly
- Information on the sample pot should match that on the request form
- Patient and sample identification on samples should be checked by two members of staff and any samples sent during a clinic should be listed in a record book

5.12 Follow up and Results

- Following clinic the case notes and Dictaphone must be returned by the clinician to the appropriate secretary in order for letters to be written to the patient and G.P and for collation of results
- It is the responsibility of the clinician for each clinic to review histology reports from samples they have taken as soon as possible, preferably within 2 weeks of the clinic, initiate any further treatment or appointments based on this report and dictate correspondence to the GP and patient

- A letter will be sent to the patient (copy to the GP) with results which should also state whether the patient can be taken of the 2WW pathway
- Samples that are reported as 'inadequate' should be actioned appropriately – the clinician taking the sample should record in the medical records at the time of taking the sample whether a repeat would be necessary if it were to be reported as 'inadequate'
- Clinicians should ensure that there is a failsafe system in place where they can assure themselves that a result comes back for every sample they send to histology, that the woman is informed of her result and that the appropriate action is taken when necessary
- Clinicians are responsible for communicating events leading to rejection or loss of a sample to the woman concerned in an honest and sensitive manner following the Duty of Candour guidance and Local Trust Policy. They should also advise women when/if another sample should be taken
- Where appropriate junior staff / nurse hysteroscopist will discuss findings with the consultant prior to initiating further management
- The GP, referring clinician and patient will be informed in writing of all findings and further management in line with Trust policy for clinic correspondence
- If required, referral to the Gynae MDT[21] will be completed by the clinician performing OPH at the time of the procedure if results are immediately suspicious or on receipt of histology results
- If required a follow up appointment will be requested in GOPD via the Outcome Form by the clinician
- The Clinic Outcome Form will be completed and returned to the OPH PMB secretary for actioning

6. Implementation of Key Document

6.1 Plan for implementation

- This guideline will be available on the Trust Intranet under Clinical Policies and Guidelines for anyone to refer to
- It can also be found by the OPH/PMB Team on the Trust Shared Drive following the pathway…
  M:Drive, Acute, WomenandChildren, Women&Children, Outpatient Hysteroscopy Team

6.2 Dissemination

Gynaecology staff will be made aware via Gynaecology Governance Meetings of the OPH Service Guideline and information disseminated to team members

6.3 Training and Awareness

It remains the responsibility of clinicians involved with OPH to maintain competency, keep up to date with national developments in OPH and local guidelines and service pathway

7. Monitoring and Compliance

Any incidents are recorded on Datix and investigated by an appropriate senior member of team for the department involved

8. Policy Review

Once approved the policy will be reviewed following any changes to recommendations / guidelines on a national or local level or every 3 years

9. References

1,3 Bakour, S. H. Jones, S. E. Khan, K.S. (2006). Ambulatory Hysteroscopy: An Evidence-Based Guide to Diagnosis and Therapy in the Outpatient Setting. London: Royal Society of Medicine Press Limited

2,15, 17,20 Royal College of Obstetricians and Gynaecologists. (2011) Best Practice in Outpatient Hysteroscopy. *Greentop Guideline No.59*. London: Royal College of Obstetricians and Gynaecologists and British Society for Gynaecological Endoscopy

4 National Institute of Clinical Excellence. (2018) Heavy Menstrual Bleeding: Assessment and Management. *NICE Guidance 88*. London: National Institute of Clinical Excellence

5, 7 WHAT-HAE-002A, Endoscopy Standard Operating Procedure: Prescribing/omission of oral anticoagulants for elective endoscopy

WAHT-TP-132 Reducing Venous Thromboembolism in Adult Patients Pathway

8 RCOG/BSGE. (2018) Outpatient Hysteroscopy – Information for You. RCOG/BSGE

9 https://soundcloud.com/rcobsgyn/outpatient-hysteroscopy

10,18 WAHT-INF-037 Decontaminating Policy

11, 21 Sundar, S., Balega, J., Crosbie, E., Drake, A., Edmondson, R., Fotopoulou, C., Gallos, I., Ganesan, R., Gupta, J., Johnson, N., Kitson, S., Mackintosh, M., Martin-Hirsch, P., Miles, T., Rafii, S., Reed, N., Rolland, P., Singh, K., Sivalingam, V. and Walther, A. (2017). **BGCS uterine cancer guidelines**: Recommendations for practice. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 213, 71-97.

12 Smith Bindman, R., Weiss, E, and Feldstein, V. (2004). How thick is too thick? When endometrial thickness should prompt biopsy in postmenopausal women without vaginal bleeding. Ultrasound Obstetrics and Gynaecology, 24 (5), 558-565.

13 WAHT-INF-025 Aseptic Technique Policy

14 WAHT-CG-075 Policy for Consent to Examination or Treatment

16 eMedicines Compendium
https://www.medicines.org.uk/emc/product/870/smpc

19 WAHT-INF-026 Decontamination of Endoscopes Policy

20 Kolhe, S. (2015) Setting up of ambulatory hysteroscopy service. *Best Practice and Research Clinical Obstetrics & Gynaecology* 29(7), 966-981.

22 WAHT-KD-017 Warfarin and Other Anticoagulants Guidelines and Procedures

23 Goh, E. et al (2020) Perioperative management of women on oral anticoagulants and antiplatelet agents undergoing gynaecological procedures. *The Obstetrician and Gynaecologist* 22(2), 131-136

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

12 Background

10.1 Equality requirements
The content of this policy has no adverse effect on equality and diversity.

10.2 Financial risk assessment
The content of this policy has no adverse effect on finance

10.3 Consultation
Circulated to the following for comments

Nursing staff involved with OPH Service
Consultants who carry out OPH

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Gynaecology Clinical Governance
Key Documents Approval Group

10.4 Approval Process
Complete as above once approved

10.5 Version Control
This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Appendix 1

Management of Cervical Shock

Symptoms and Signs
*Feeling dizzy/lightheaded
*Low BP, slow HR. Bradycardia is defined as HR <60 but most people do not get symptoms unless HR <40
* Pallor and sweating
* N&V
* Loss of consciousness
* Patient may have a transient seizure

Assess using ABCDE approach
- Call for help/emergency buzzer if needed
- Lay patient flat, raising legs if possible
- Stop cervical stimulation
- Consider possibility of anaphylaxis

A
- Check responsiveness – talk to the patient, listen for sounds of obstruction
- Open airway if necessary – head tilt/chin lift/jaw thrust

B
- Check patient is breathing, listen for breath sounds
- Apply oxygen (10-15L/min)
- Attach pulse oximeter
- Loosen any tight clothing around the neck
- Remove face mask

C
- Look for signs of shock – pallor/sweating/feeling faint
- Check BP/HR

Remember to call 2222 and ask for emergency medical team/cardiac arrest team at anytime if required

Patient starts to feel better

- Lay flat until fully better
- Administer analgesia if required
- Observe for usual time period unless longer required
- Allow home

Patient continues to show signs of shock, has reduced level of consciousness or HR <60bpm (most patients will not manifest persistent, significant signs unless HR <40)

Call 2222 and ask for emergency medical response team

- Gain IV access if possible and administer 300mcg Atropine followed by saline flush
- (For those in whom IV access is not possible 300mcg Atropine may be given IM , mid- thigh, although this is not recommended by the Resuscitation Council UK)

Patient starts to feel better

Remain symptomatic or unwell

- Give further dose of IV Atropine 300mcg after 3-5min followed by a saline flush

Remain symptomatic or unwell

Continue Resus as per BLS and assess D and E

Supporting Document 1 - Equality Impact Assessment Tool
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy / guidance affect one group less or more favourably than another on the basis of:**		
	Age	No	
	Disability	No	
	Gender reassignment	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
	Race	No	
	Religion or belief	No	
	Sex	No	
	Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and / or justifiable?**	N/A	
4.	**Is the impact of the policy / guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy / guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

NB:
Where an inappropriate, negative or discriminatory impact has been identified please proceed to conduct a Full Equality Impact Assessment and refer to Equality and Diversity Committee, together with any suggestions as to the action required to avoid / reduce this impact.

Advice can be obtained from the Equality and Diversity Leads in HR and Nursing Directorates (details available on the Trust intranet).

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval