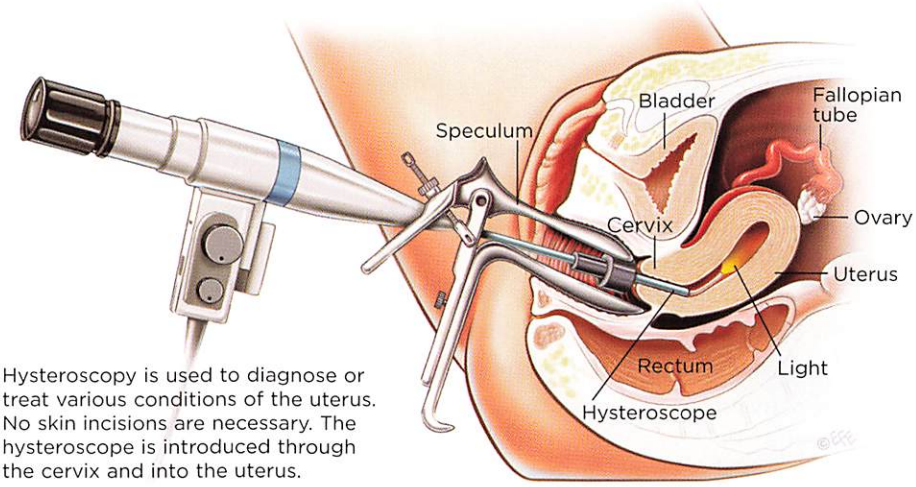
HYSTEROSCOPY

Patient information to assist informed consent

Hysteroscopy is a procedure to examine the inside of the uterus. The doctor uses a thin telescope called a hysteroscope. It is passed through the cervix, as shown in the illustration. The hysteroscope allows the gynaecologist to inspect the lining of the uterus and the openings of the fallopian tubes, and to look for any abnormalities. This minimally invasive procedure helps to diagnose uterine problems and can be used to treat some conditions.



Hysteroscopy is used to diagnose or treat various conditions of the uterus. No skin incisions are necessary. The hysteroscope is introduced through the cervix and into the uterus.

Diagnostic hysteroscopy

Diagnostic hysteroscopy examines the uterus for abnormalities and signs of disease. A small sample (biopsy) of the uterine lining (endometrium) is usually taken. The biopsy is often sent to a pathologist for examination.

Your doctor may recommend a diagnostic hysteroscopy if a test (such as pelvic ultrasound) or pelvic examination indicates a problem, or if you have abnormal uterine symptoms or signs. It may be used to investigate:

- abnormal bleeding from the uterus (such as heavy, long or scanty periods), absence of periods, adhesions in the uterus, or bleeding between periods
- uterine bleeding after menopause
- painful or irregular periods
- pelvic pain and discomfort
- infertility
- recurrent miscarriages.

Operative hysteroscopy

Operative hysteroscopy (also called therapeutic hysteroscopy) is used to treat certain uterine problems. Tiny surgical instruments are inserted through the hysteroscope and into the uterus. Depending on the diagnosis, this procedure can sometimes replace the need for major surgery. Operative hysteroscopy is most often used to:

- treat abnormally heavy menstrual flow by ablation of the endometrium
- remove some polyps (non-cancerous growths of the endometrium)
- remove some fibroids (non-cancerous growths of the uterine muscle wall)
- remove adhesions (scar tissue)
- correct some defects of the uterus, such as uterine septum (a wall of tissue that divides the inside of the uterus)
- remove an intrauterine contraceptive device (IUD)
- insert a special type of contraceptive device into the uterus.

Diagnostic hysteroscopy and operative hysteroscopy can be performed separately or during the same procedure.

Operative hysteroscopy in conjunction with laparoscopy: Once the hysteroscope is inserted and the inside of the uterus is visible, the gynaecologist may sometimes decide that a laparoscopy is necessary.

Laparoscopy can assist with the diagnosis and treatment of a range of gynaecological conditions. The patient education pamphlet "Laparoscopy" is available from your gynaecologist.

Talk to your gynaecologist

The aim of this pamphlet is to provide general information. It is not a substitute for advice from your gynaecologist and does not contain all the known facts on hysteroscopy. Read this pamphlet carefully, and save it for reference. This information will change with time, due to clinical research and new therapies. Terms are used that may require explanation by your gynaecologist. Write down questions you wish to ask. Your gynaecologist will be pleased to answer them. If you have concerns, discuss them with your gynaecologist. Use this pamphlet only in consultation with your gynaecologist. Seek the opinion of another gynaecologist if you are uncertain about the advice you are given.

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER BELOW

DEAR DOCTOR: When you discuss this pamphlet with your patient, remove this sticker, and put it on the patient's medical history or card. This will remind you and the patient that this pamphlet has been provided. Some doctors ask their patients to sign the sticker to confirm receipt of the pamphlet.

YOUR DOCTOR

"Hysteroscopy" has been reviewed by obstetricians and gynaecologists in Australia and New Zealand

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YOUR COMPLETE MEDICAL HISTORY

The gynaecologist and anaesthetist need to know your medical history. Tell them about any health problems you may have had, as some problems may interfere with the surgery, anaesthesia or recovery. This information is confidential. Tell your gynaecologist if you have or have had:

- an allergy or bad reaction to antibiotics, anaesthetic drugs or any other medicines
- prolonged bleeding or excessive bruising when injured
- recent or current infection; recent or long-term illness
- any previous surgery.

Tell the gynaecologist if you are, could be, or plan to become pregnant. You may need to take a pregnancy test. Hysteroscopy is not done during pregnancy.

Give the gynaecologist and anaesthetist a list of ALL medicines you are taking or have recently taken, including:

- medicines prescribed by your family doctor
- over-the-counter medicines bought without prescription
- herbal medicines, naturopathic preparations or vitamins
- long-term treatments such as anti-coagulants (blood thinners), aspirin (including that contained in cough syrups), arthritis medication or insulin.

The gynaecologist may ask you to stop taking some medications for a week or more before your procedure, or give you an alternative dose. Discuss this carefully with your gynaecologist.

BEFORE SURGERY

Before a hysteroscopy, some patients need an X-ray examination called a hysterosalpingogram (HSG). An HSG is used to check for abnormalities of the uterus and fallopian tubes. The uterus is filled with a special dye that shows up on X-ray examination. The passage of dye shows, for example, if the fallopian tubes are open or blocked. An HSG and other tests help the gynaecologist with diagnosis and planning of the procedure. In some patients, an ultrasound examination may be helpful.

Your doctor may prefer to do the hysteroscopy in the first week after your period. If performed at other times of your menstrual cycle, menstrual fluid or a thickened endometrium could interfere with the gynaecologist's view of the inside of the uterus. If you have regular periods, give the gynaecologist an estimate of when your next period is due.

The day before surgery, the gynaecologist may insert a medicated pessary high inside the vagina to help soften or dilate the cervix. This can cause mild cramping overnight that may require pain relief. Some women have cramp pains during a hysteroscopy. On the day of surgery, the gynaecologist may give you medication to help reduce any uterine cramping.

Stop smoking several weeks before and after the procedure. Smoking interferes with healing and increases anaesthetic risks. It is best to quit.

Remember, the decision whether to undergo a hysteroscopy is always yours and should not be made in a rush. Make a decision only when you are satisfied with the information you have received and believe you have been well informed.

The gynaecologist cannot guarantee that your symptoms will improve following operative hysteroscopy. A successful hysteroscopy does not rule out the possibility of repeat surgery. However, most patients can expect good results.

Consent form: If you need to have hysteroscopy, the gynaecologist will ask you to sign a consent form. Read it carefully. If you have any questions about the consent form, surgery, risks, benefits or related matters, ask your gynaecologist.

ANAESTHESIA

Depending on the patient's medical history, general health and the recommended procedure, hysteroscopy may be done with the patient having general, epidural or local anaesthesia.

Some women who have had children may not need local anaesthesia of the cervix.

Your gynaecologist or anaesthetist can explain which type of anaesthesia is best for you. Follow all preoperative instructions. Modern anaesthetic drugs are safe with few risks. However, a few people may have a serious reaction to them.

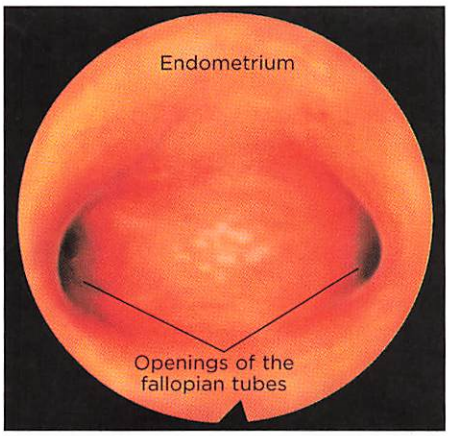
Rarely, a side effect from anaesthesia can be life threatening. Ask your anaesthetist or gynaecologist for more information.

DIAGNOSTIC HYSTEROSCOPY

The woman lies on her back with her legs apart. A frame or stirrups support her feet and knees. A urinary catheter may be inserted into the urethra to drain urine.

The gynaecologist introduces an instrument called a speculum into the vagina to keep the vaginal walls apart. This allows a clear view of the cervix. The cervical canal is gently opened (dilated) to allow passage of the hysteroscope. In some cases, the hysteroscope can be comfortably inserted without the need for cervical dilation.

The hysteroscope is passed through the cervix and into the uterus. The uterus has a narrow cavity inside. Fluid (such as saline) or carbon dioxide gas is passed through the hysteroscope to gently separate the walls of the uterus and allow the doctor to view the uterine walls and shape of the uterus.



The view of the inside of the uterus through the hysteroscope

Any abnormalities can be seen, as well as the internal openings of the fallopian tubes. This photograph (left) shows the inside of a normal uterus through a hysteroscope.

Infertility evaluation

In the evaluation of infertility, hysteroscopy can be useful because it allows the gynaecologist a clear view of the inside of the uterus. Problems such as disease or damage to the uterus can be diagnosed and sometimes treated during the procedure.

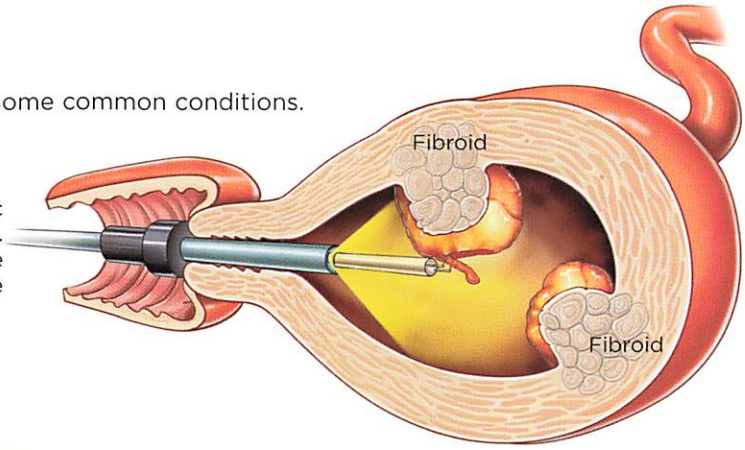
Operative hysteroscopy is rarely used in the treatment of blocked fallopian tubes, a known cause of female infertility. On visual inspection, the openings to the fallopian tubes may appear to be closed or collapsed. This may be due to permanent scarring or to temporary muscular spasm of the fallopian tubes.

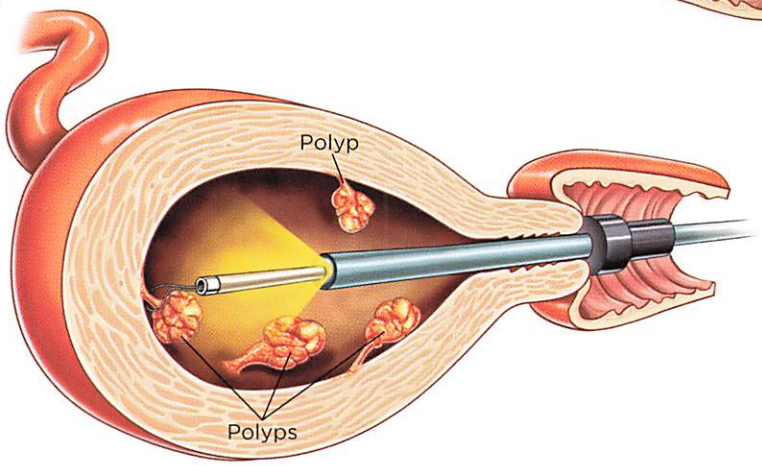
OPERATIVE HYSTEROSCOPY

These illustrations show the techniques used to treat some common conditions.

REMOVAL OF A UTERINE FIBROID

Fibroids are the most common type of non-cancerous pelvic tumour in women and can cause heavy or irregular bleeding. A hysteroscopy can remove fibroids that have grown in the cavity of the uterus but not those in the muscle wall of the uterus.





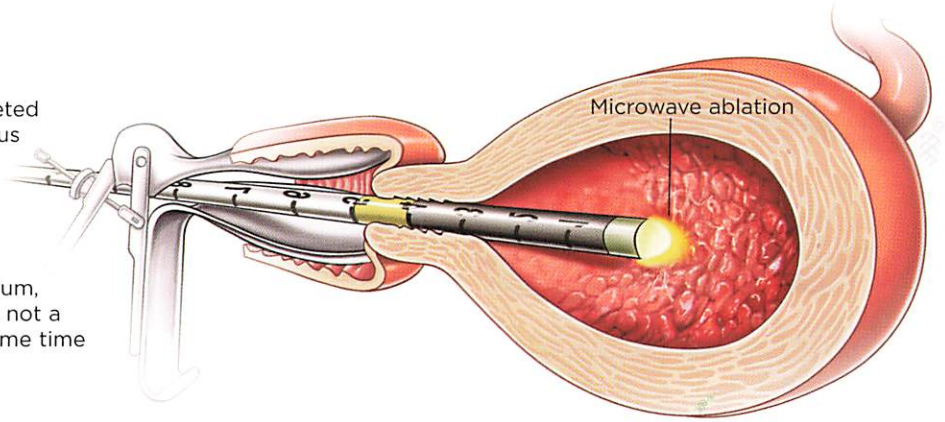
REMOVAL OF UTERINE POLYPS

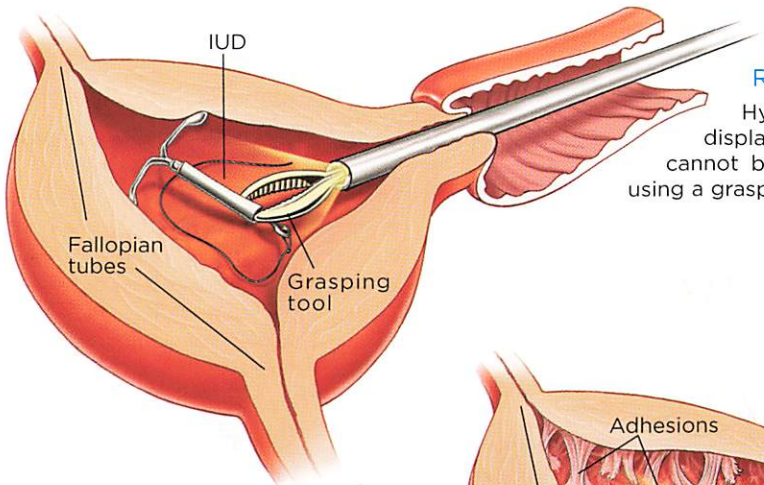
Polyps are abnormal fleshy lumps that grow in the endometrium. They often cause irregular bleeding. They are usually benign (non-cancerous) but can rarely become cancerous.

ENDOMETRIAL ABLATION

Some women with heavy bleeding and a completed family may choose to have the lining of the uterus (endometrium) destroyed. This is called endometrial ablation. Different ablation techniques can be used, including rollerball, microwave, loop resection, thermal balloon and laser, among others.

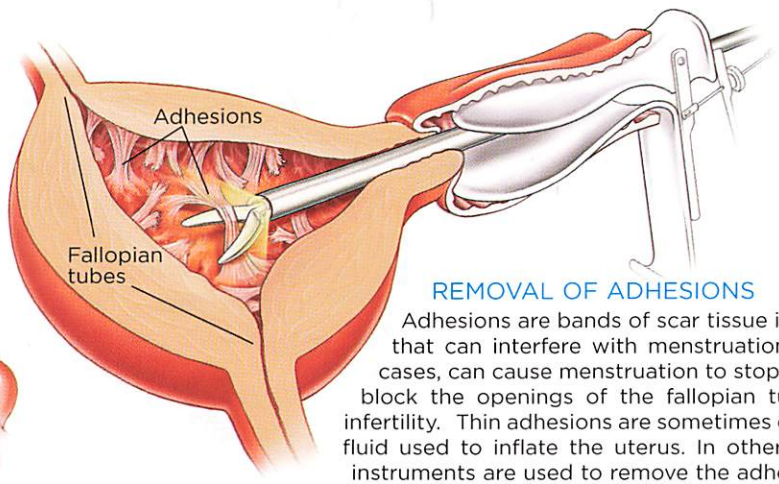
Endometrial ablation destroys the endometrium, so pregnancy becomes unlikely. However, this is not a form of contraception, and sterilisation at the same time may be an option for some women.





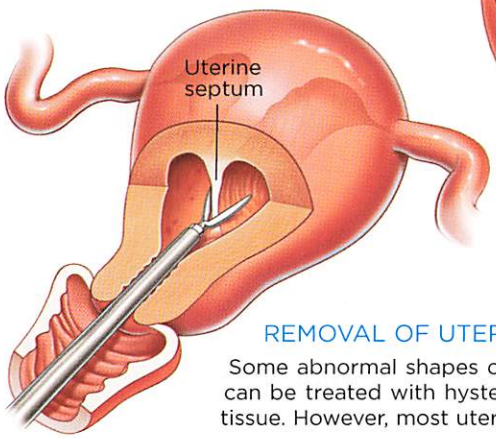
RETRIEVAL OF DISPLACED IUD

Hysteroscopy is usually recommended if an IUD has become displaced from its normal position in the cervix and uterus, and cannot be removed or found. The gynaecologist removes the IUD using a grasping tool.



REMOVAL OF ADHESIONS

Adhesions are bands of scar tissue inside the uterus that can interfere with menstruation and, in severe cases, can cause menstruation to stop. Adhesions that block the openings of the fallopian tubes can cause infertility. Thin adhesions are sometimes disrupted by the fluid used to inflate the uterus. In other cases, surgical instruments are used to remove the adhesions.



REMOVAL OF UTERINE SEPTUM

Some abnormal shapes of the uterus can increase the risk of infertility and miscarriage. Some of these defects can be treated with hysteroscopy. For example, treatment of uterine septum involves removing the thin wall of tissue. However, most uterine defects can only be diagnosed or confirmed with hysteroscopy, not treated.

RECOVERY AFTER HYSTEROSCOPY

Most women are able to go home after two to four hours, or longer after a general anaesthetic. Arrange for a relative or friend to drive you home. If you had a general anaesthetic, do not drive for at least 24 hours, and avoid making important decisions for two days. Do not undertake strenuous activities. You may need to take a few days off work.

Shower as normal, but avoid baths, spas and swimming as there is a small risk of infection. Do not use tampons as they can increase the risk of infection. Wear sanitary napkins unless advised otherwise by the gynaecologist.

Mild cramping can be managed with over-the-counter pain relief. Cramping should resolve within a few days. Your gynaecologist may prescribe a short course of an NSAIDs. Take them as directed.

If adhesions or fibroids were treated, the gynaecologist may prescribe a short course of female hormones. This discourages scar-tissue growth in the uterus.

Blood-stained fluid may drain from the vagina. The fluid may contain small clots or pieces of tissue. A little of vaginal bleeding for a few days is normal, but no more than a normal period. It should stop within 14 days.

If carbon dioxide gas is used to inflate the uterus, some may escape into the abdominal cavity. This can cause discomfort and pain in the shoulder area.

To reduce the risk of infection, do not have sex for at least seven days following the procure. Normal physical and sexual activity can be resumed when any bleeding and discomfort have stopped completely, and you are feeling well enough.

POSSIBLE COMPLICATIONS OF HYSTEROSCOPY AND HYSTEROSCOPIC SURGERY

As with all procedures, hysteroscopy does have risks, despite the highest standards of practice. While your gynaecologist makes every attempt to minimise risks, complications can occur that may have permanent effects.

It is not usual for a doctor to outline every possible side effect or rare complication of a procedure. However, it is important that you have enough information about possible complications to fully weigh up the benefits and risks of the procedure.

Any discussion of frequency of risks or benefits (for example, one patient in 100, or "rare" and so on) can only be estimates as the outcomes of clinical research can vary widely. Such outcomes can depend on many factors, such as the surgical methods, equipment, surgeons' experience and data collection, among others.

The following possible complications are listed to inform you, not to alarm you. There may be other complications that are not listed. Smoking, obesity and other significant medical problems can cause greater risks of complications.

General surgical risks

- Rarely, excessive bleeding may be life threatening, requiring a blood transfusion.
- A blood clot can develop in a deep leg vein (DVT), which can be life threatening if it moves to the heart or lungs. However, this is not common and can be treated.
- Risks of general anaesthesia include a chest infection, short-term nausea, a sore throat due to the breathing tube, or cardiovascular problems such as heart attack or stroke, which are uncommon.

Specific risks of hysteroscopy

About two to four women out of every 100 who undergo hysteroscopy have a complication of some kind.

- Trauma to the cervix during dilatation.
- Perforation of the uterus with the hysteroscope or other surgical instrument. Although uncommon, this risk is slightly greater in postmenopausal women and in women who have recently been pregnant. The gynaecologist may decide to postpone the hysteroscopy until the uterus has healed. A perforation usually heals quickly. Rarely, further surgery may be required.
- Postoperative infection, such as infection of the bladder (cystitis) or uterine lining (endometritis); treatment with antibiotics is usually needed.
- Cuts or puncture damage to nearby organs (such as the bladder, bowel or blood vessels) if perforation of the uterus has occurred. Laparoscopy or open surgery to repair the damage may be necessary.
- Heat damage to nearby organs (such as the bladder, bowel or blood vessels) caused by electrical or laser instruments during cautery to stop bleeding, or during resection or ablation of tissue.
- Heavy postoperative bleeding. Treatment may include medication to constrict the blood vessels or, uncommonly, blood transfusion. In severe and rare cases, a hysterectomy may be needed if the bleeding cannot be stopped.
- Fluid imbalance. Hysteroscopic surgery is sometimes performed with the uterus distended with fluid. Pressure within the uterus may force fluid into the bloodstream, and cause a fluid imbalance in the body. Complications can include a build up of fluid in the brain (cerebral oedema) or lungs (pulmonary oedema). In rare cases, it can be life threatening. Treatment includes special fluids delivered through a vein or by mouth. Further observation in hospital may be needed for a few days until the problem resolves.
- gas embolism. If carbon dioxide gas is used to distend the uterus, a gas bubble may rarely enter the bloodstream. This can be life threatening but can usually be quickly treated by the anaesthetist and surgeon.

Report to your gynaecologist

Notify your gynaecologist at once if you notice any of the following:

- fever greater than 38°C or chills
- increasing nausea and vomiting
- increasing or persisting pain
- bad-smelling discharge or bleeding from the vagina
- persistent bleeding from the vagina that becomes heavier than a normal period and is bright red
- dizziness, shortness of breath, feeling faint or chest pain
- pain or burning on passing urine or the need to pass urine frequently (this may indicate a urinary tract infection).

If you cannot contact your gynaecologist, go to your family doctor or Accident and Emergency at your nearest hospital.

COSTS OF TREATMENT

Ask your gynaecologist for an estimate that lists the likely costs. As the actual treatment may differ from the proposed treatment, the final account may vary from the estimate. It is best to discuss costs before treatment rather than afterwards.

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