Outpatient Hysteroscopy - Full Clinical Guideline

Reference No.: Gynae/07:23/H3

Contents

1. Introduction

Outpatient or ambulatory hysteroscopy clinics provide a means for delivering both diagnostic and therapeutic procedures for common gynaecological conditions in a safe, convenient and cost effective environment. Advances in endoscopic technology have facilitated the movement of gynaecological interventions from an expensive inpatient experience requiring general anaesthesia and theatre facilities to a convenient office based setting.

2. Objectives

The aim of this guideline is to provide clinicians with up-to-date, evidence-based information regarding outpatient hysteroscopy, with particular reference to minimising pain and optimising the woman's experience. 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.

3. Policy Scope

This policy applies to all Trust employees, irrespective of grade, level, location or staff group, including locum and agency staff, students and staff employed on honorary contracts who are involved with delivery of care in the Outpatient Hysteroscopy Department.

4. Definitions

Hysteroscopy is the inspection of the uterine cavity by endoscopy with access through the cervix. It allows for the diagnosis of intrauterine pathology and serves as a method for surgical intervention (operative hysteroscopy).

5. Abbreviations

ACN	-	Ambulatory Care Network
ANTT	-	Aseptic Non Touch Technique
BBV	-	Blood Borne Virus
BMI	-	Body Mass Index
BSGE	-	British Society for Gynaecological Endoscopy
DNA	-	Did Not Attend
GOPD	-	Gynaecology Outpatient Dept.
GP	-	General Practitioner
HCA	-	Health Care Assistant
HRT	-	Hormone Replacement Therapy
HTRS	-	Hysteroscopic Tissue Retrieval System
IUCD	-	Intra Uterine Contraceptive Device
IUS	-	Intra Uterine System
OPH	-	Outpatient Hysteroscopy
RN	-	Registered Nurse
RCOG	-	Royal College of Obstetricians & Gynaecologists
PMB	-	Post Menopausal Bleeding
PPE	-	Personal Protective Equipmenrt
PT	-	Pregnancy Test
RPOCs	-	Retained Products of Conception
TCU	-	Thermal Control Unit
TV USS	-	Transvaginal Ultra Sound Scan

6. Indications Guideline Detail

6.1 Referral to OPH or PMB One-Stop Clinics and Menstrual Disorder Clinics

6.1.1. Pre and peri-menopausal

- Persistent Inter-menstrual bleeding/irregular periods (≥3 months duration) in women
- Heavy Menstrual Bleeding failing to respond to 6 months medical treatment
- Recurrent miscarriage/ Suspected uterine anomalies
- Assess cavity for outpatient endometrial ablation
- To perform outpatient endometrial ablation
- Lost IUCD threads for hysteroscopic retrieval
- Fertility Investigation
- Persistent RPOCs

6.1.2. Post Menopausal

- PMB not on Hormone Replacement Therapy (HRT) - direct referral as 2 week wait (2ww)
- 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 - refer as a 2ww to OPH PMB One-Stop Clinic.
- Incidental scan finding of abnormally thickened endometrium or polyp in asymptomatic women
- TVUS shows endometrial thickness >/=4mm where pipelle is not possible or yields an inadequate sample
- TVUS indicating presence of polyp, cystic spaces or heterogenous endometrium or unclear/ill defined endometrium.

6.1.3. Other Indications for referral (any age group)

- High risk with any Endometrial Thickness
- Recurrent postmenopausal bleeding
- On Tamoxifen/ Oestrogen only HRT
- Previous endometrial hyperplasia with atypia.
- Post coital bleeding with no other symptoms should be seen as ‘urgent’ in GOPD or colposcopy, unless they have abnormal endometrial thickness.

6.1.3 Anticoagulants General Information

- Please refer to supplementary flow chart in attached appendix

7. Absolute Contra-indications

- Non-consent in person with mental capacity
- Pregnancy or suspected pregnancy
- Acute genital tract infection, either suspected or known
  Relative Contraindication:
- Virgin

NOTE* Those patients with severe comorbidities and those who are particularly high risk for general or regional anaesthetic should be offered OPH as a first line investigation.

*Whether or not to proceed with diagnostic or therapeutic OPH is a clinical decision between the Clinician and the individual patient.

8. Referral guidelines (if booking from any Gynae clinic)

- Arrange TV USS as required (unless patient coming to one-stop clinic with an attached scan slot).
- Counsel patient for outpatient procedure and give information leaflet.
- Consent form to be signed by referring doctor and patient, if possible.
- If Mirena IUS an option, give Mirena Leaflet.
- Fill out internal referral form as required. (It is essential to highlight any specific concerns eg: very high BMI (over 40), extreme patient anxiety, need for hoist or interpreter or very difficult examination).
- If requesting outpatient endometrial ablation, to give appropriate leaflets and follow the guidance, ensure all the pre-requisites for ablation are fulfilled eg prescribe the pre-procedure analgesics as per ablation protocol; ensure recent endometrial biopsy in last 6-12 months +/- diagnostic OPH/ normal ultrasound scan.

9. Duties and Responsibilities

9.1 Clinician Responsibilities

It is the 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.
- 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 (Ambulatory Care Network ACN) 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.

9.2 Staff Number 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 and document it on the outpatient hysteroscopy record. A wristband needs to be checked and applied at this point.

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 HCA/ RN for assistance, acting as 'runner' during a procedure, setting up machines when needed, setting up working trolley between cases and administering Entonox/ oral analgesia where required.
- Please note: Individual learning package for nursing staff is a requirement prior to working in the hysteroscopy suite.

10. Environment

10.1 Equipment

Area for clerking Procedure room with access to changing and toilet facilities for women
Recovery room/area
Computer workstation
Hand washing facilities
Examination light
Examination couch and stool
Equipment Trolley
Camera Stack system
TruClear, Novasure, Thermablate, Machine
Emergency Trolley
Medicine Cupboard with appropriate range of analgesia
Sterile gauze swabs
Needles for dental syringes
Dental syringes – long and standard
Smear taking brush and pot
Gallipots
Sterile cleaning solution sachets
Examination/Hysteroscopy pack
Polyp forceps
Sterile Hysteroscopy Tray/Sets
Sterile and Unsterile Latex free gloves
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
Camera covers
Disposable gloves
Disposable aprons/gown

Sterile gloves
Sharps Box
Lubricating jelly
Foleys catheter
Silver Nitrate Sticks
Vaginal pack
Medications:
Range of appropriate analgesia and local anaesthetic
Fluids:
IV Stand
Normal Saline
Pressure bag
IV Giving Set

- Before every clinic session, it is essential that all equipment is checked, cleaned 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/Infection Policy.

11. Procedure

Procedure Guidelines
Below is a brief outline of a hysteroscopy procedure. From reading this you will understand the sequence of the procedure. All other procedures which take place within the Hysteroscopy Department are really an extension of this procedure.

- The clinician will have a consultation with the patient ensuring that the reason for the clinic appointment is fully understood.
- The clinician will assess the general health status of the patient and obtain a detailed medical history, based on this; possible investigatory / management / treatment plans will be discussed with the patient. Pregnancy Test (PT) if clinically indicated.
- Where there is concern regarding a patient's suitability for hysteroscopy or scheduled procedure, the advice of the consultant will be obtained and procedure deferred if necessary.
- The proposed diagnostic investigation/procedure will be explained in detail to the patient and written consent obtained.
- Maintaining the patient's dignity, she will change into a theatre gown, assisted onto the examination couch and into the lithotomy position. Staff will ensure she is made as comfortable as possible. A HCA will attend the woman throughout the procedure providing distraction techniques, assessing the patient's tolerance and communicating to the Team.
- WHO surgical checklist performed in the treatment room prior to the procedure.
- Examination of the lower genital tract will be performed on all patients. A cervical smear will be taken if indicated. 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 procedure will be deferred until the infection has been treated.
- Best practice in outpatient hysteroscopy recommends vaginoscopic approach to examine vaginal walls, cervix and enter cervical canal and uterine cavity. If not possible, then a standard approach may be utilised based on clinician's discretion using speculum. The cervix is then cleaned with sterile cleaning solution. A Vulsellum may be applied to the cervix to stabilise the cervical canal.
- The hysteroscope is then introduced to the cervical os using normal saline as a distension medium. The whole procedure is performed under direct vision. As the hysteroscope is passed through the internal os, a panoramic view of the uterine cavity is

revealed. Once inside the cavity the tubal ostia are identified and the endometrium 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 is taken to sample the endometrium where indicated. All women being investigated for postmenopausal bleeding will have an endometrial biopsy unless the uterine cavity 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 mechanical avulsion polypectomy under direct vision using hysteroscopic grasper/ scissor/ basket (depending what is available), Versapoint (bipolar) polypectomy and resection of fibroids or TruClear/hysteroscopic tissue removal systems. Where the clinician is not trained to perform such procedures, the woman will be issued with an appointment for a consultant led clinic or admitted for a day case procedure.
- If the Mirena/Levonorgestrel IUS has been agreed as a method of treatment with the woman, the device will be fitted.
- Cervical polypectomy will be performed on any patient found to have a cervical polyp at time of hysteroscopy.
- All specimens/biopsies will be sent to histology for analysis appropriately labelled.
- The Hysteroscopist/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 hysteroscopist undertaking hysteroscopy is unsure or concerned about the patient, then advice from the Consultant Clinician for that clinic will be obtained. The Consultant clinician must be contactable or alternative cover must be in place.
- 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.
- Dictation for correspondence to the General Practitioner (GP) and patient will take place either during or at the end of a clinic session and notes being taken to the appropriate secretary.
- Histology results will be returned to the secretary of the clinician for each hysteroscopy clinic. It will be the responsibility of the clinician for each clinic to review histology reports. Where appropriate junior staff or Nurse Hysteroscopist will discuss findings with a consultant prior to initiating further management.
- The GP, referring team and patient will be informed in writing of all findings and further management in line with Trust policy for clinic correspondence.

11.1 Setting up for Hysteroscopy Procedure

- Set up working trolley
- Enter patient details on the stack machine (if applicable)
- Open sterile Hysteroscopy pack on top shelf of trolley
- Open Diagnostic Hysteroscope/Operative Hysteroscope Set on separate trolley if required
- Wear appropriate PPE
- Perform Hand Hygiene according to infection control guideline
- Wear appropriate sterile gloves.
- Assemble Hysteroscopy instruments. Ensure Hysteroscope set is checked and in working condition. Replace if necessary.

- Attach light lead to hysteroscope and to light source maintaining ANTT.
- Attach camera head with camera cover applied correctly to hysteroscope maintaining ANTT. White balance with camera head with white material (gauze swab, cotton balls or sterile white paper. (Can be carried out by clinician if you are not familiar with process).
- Use 1000mls normal saline as standard distension medium with a pressure bag. Attach giving set onto Hysteroscope inflow. Allow water to run to remove air bubbles. Close inflow. Close roller ball of giving set. Maintain pressure at 100mmhg. During procedure, clinician may request to increase pressure.
- Pour sterile cleaning solution into gallipot, appropriate speculum and lubricating jelly. Cotton balls may be required.
- Open appropriate gloves for clinician.
- During a procedure assist the clinician by opening packs as requested.

Additional: upon request

Hegar dilators
Dental syringe & needles.
Coil retriever
Sims speculum
Spencer Wells Artery forcep
Winterton Speculum
Curette
Swab/Smear sampler
Hysteroscopic grasper/ scissors/ basket

11.2 Operative Procedures

Operative procedures which take place in the Outpatient Hysteroscopy Clinic include endometrial ablations, resection of uterine fibroids and endometrial polypectomy. Other minor surgical procedures can be performed in the department and to set up for these procedures, you will be guided by the clinician as to the equipment and instruments needed.

Endometrial Ablation

Thermablate and Novasure are the techniques used for endometrial ablation in the Outpatient Hysteroscopy Clinic.

Thermablate

Set up stack system and fluid trolley for distension medium as for hysteroscopy procedure.
The patients attend directly a Hysteroscopy Clinic and are instructed to eat breakfast prior to coming to the hospital. If any patient has not had breakfast, tea and toast/biscuits will be offered. All patients are visited by the consultant prior to the operative list starting and written consent is obtained. Pregnancy test result if required. Pre-medication should have been prescribed and taken by the patient. Additional medication upon admission should also be checked and administered. Do not open the cartridge until confirmed by the clinician.

Working trolley: Set up as for normal hysteroscopy procedure.

Additional:

Thermablate Machine
Disposable Cartridge (check expiry date/available from gynaecology theatre)
1000ml bag of saline with pressure bag

Trolley Preparation

- Connect Treatment control unit and power supply unit. Place on Thermal control unit (TCU) stand. Plug power cord to wall outlet.
- Put on protector sleeve.
- Insert Disposable Cartridge into heating chamber of TCU.
- Ensure "This Side Up" and the guidance markings are visible on the top side of the catheter. Re-insert if required.
- Ensure plastic balloon cover is attached to maintain sterility.
- Switch on Machine. Machine will perform initial testing procedure.

- Machine will display “Ready for Treatment” to initiate procedure.
- This takes approximately 8-12 minutes.
- Please refer to manufacturer’s operating manual for instructions.

Procedure

- The patient will be seen by Consultant in the Outpatient Hysteroscopy Clinic/Gynaecology clinic and appropriate medications should have been prescribed and self-administered. A RGN will facilitate and ensure that appropriate medications have been taken by the patient prior to procedure. Patient is checked in by the consultant, introduced to the team, consent form checked and taken to get changed.
- Patient details are recorded in the department’s patient procedure documentation.
- Patient is positioned on couch and HCA stands beside her to offer support.
- The Consultant will visualise cervix, clean and administer local anaesthetic.
- A hysteroscopy will be performed to assess the uterine cavity, a pipelle endometrial biopsy will be obtained if not already done and the cervix will be dilated if necessary.
- The Thermablate will then be inserted into the uterine cavity, procedure commenced.
- Once the correct pressure in balloon has been reached the heating cycle will begin.
- During the procedure the patient will usually experience moderate crampy, period pain (of which she will be made aware when consented). Keeping her talking / providing distraction during this time is vital. The nurse/hca will assess the patient’s ability to tolerate the discomfort and act as the patients advocate, communicating this with the consultant and team.
- After the Thermablate is removed re-look hysteroscopy will be performed to ensure cavity appears well-ablated.
- Once the procedure is completed, the balloon can be disposed of in large sharps bin.
- Bar codes stickers from all instruments used/opened including from the balloon must be stuck on to or recorded in the patients notes.
- All trays and instruments should be checked, repackaged and returned to sterile services department for reprocessing.
- Nursing/clinicians documentation is completed in patient notes and entry made in clinic patient procedure documentation of the procedure undertaken.
- The patient is cleaned up and when ready is taken back to consulting room or to Recovery Area depending how the patient feels at the time, further analgesia may be given as necessary.
- Most patients are advised to remain in the hospital for a couple of hours. They may require additional painkillers. They are offered analgesia to take home with precise instructions. They are advised to rest for the remainder of the day and that the following day may be required off work. The patient is made aware that it is normal to have a bloody discharge for up to two weeks following the procedure. They are given the ward’s contact number in case of any problems.

Novasure Endometrial Ablation System

Set up stack system and fluid trolley for distension medium as for hysteroscopy procedure.

The patients attend directly a Hysteroscopy Clinic and are instructed to eat breakfast prior to coming to the hospital. If any patient has not had breakfast, tea and toast/biscuits will be offered. All patients are visited by the consultant prior to the operative list starting and written consent is obtained. Pregnancy test result if required. Pre-medication should have been prescribed and taken by the patient. Additional medication upon admission should also be checked and administered. Do not open the device until confirmed by the clinician.

Working trolley: Set up as for normal hysteroscopy procedure.

Additional:
NovaSure Machine
NovaSure Device (check expiry date)
CO_2 gas cannisters (check expiry date)
1000ml bag of saline with pressure bag

Trolley Preparation

- Have NovaSure device at hand ready- do not open until confirmed by consultant. Please refer to manufacturer's operating manual for instructions.

Procedure

- The patient will be seen by Consultant in the Outpatient Hysteroscopy Clinic/Gynaecology clinic and appropriate medications should have been prescribed and self-administered. A RGN will facilitate and ensure that appropriate medications have been taken by the patient prior to procedure. Patient is checked in by the consultant, introduced to the team, consent form checked and taken to get changed.
- Patient details are recorded in the department's patient procedure documentation.
- Patient is positioned on couch and HCA stands beside her to offer support.
- The Consultant will visualise cervix, clean and administer local anaesthetic.
- Cervical dilatation will be done as required.
- A hysteroscopy will be performed to assess the uterine cavity, a pipelle endometrial biopsy will be obtained if not already done. If incidental polyp noted this will be removed as appropriate and send of for histology.
- Turn NovaSure machine on- input the final cavity length measurement.
- Total cavity length, uterocervical length and final cavity length measured and documented.
- The consultant will set the NovaSure array to the correct length, the NovaSure will then be inserted into the uterine cavity and seated to ensure correct positioning within the cavity. Consultant will then confirm the width of the cavity which will be inputted into the NovaSure controller. Then press the green flashing tick to continue.
- Consultant will advance the cervical collar and press the foot pedal to start the cavity integrity assessment. Once passed, Nurse/HCA will press the green flashing tick enabling the consultant to press the foot pedal to start the ablation.
- During the procedure the patient will usually experience moderate crampy, period pain (of which she will be made aware when consented). Keeping her talking / providing distraction during this time is vital. The nurse/hca will assess the patient's ability to tolerate the discomfort and act as the patients advocate, communicating this with the consultant and team.
- After the NovaSure is removed re-look hysteroscopy will be performed to ensure cavity appears well-ablated.
- Once the procedure is completed, the NovaSure can be unplugged and can be disposed of in large sharps bin.
- Bar codes stickers from all instruments used/opened including from the NovaSure must be stuck on to or recorded in the patients notes.
- All trays and instruments should be checked, repackaged and returned to sterile services department for reprocessing.
- Nursing/clinicians documentation is completed in patient notes and entry made in clinic patient procedure documentation of the procedure undertaken.
- The patient is cleaned up and when ready is taken back to consulting room or to Recovery Area depending how the patient feels at the time, further analgesia may be given as necessary.
- Most patients are advised to remain in the hospital for a couple of hours. They may require additional painkillers. They are offered analgesia to take home with precise instructions. They are advised to rest for the remainder of the day and that the following day may be required off work. The patient is made aware that it is normal to have a bloody discharge for up to two weeks following the procedure. They are given the ward's contact number in case of any problems.

Endometrial Polypectomy Procedure

Endometrial polypectomy can take place by Avulsion, Versapoint or HTRS.

<u>Avulsion Polypectomy</u>

Working Trolley: Set up as for hysteroscopy procedure.

Additional:

Hysteroscopic grasper/ scissors/basket
Gauze Swabs
Hegar dilators if requested
Dental syringe & needles if requested.

The clinician will request for any other instruments to be opened into the sterile field if they are required for the procedure.

Versapoint Polypectomy

Working Trolley: Set up as for hysteroscopy procedure and use of Operative Hysteroscope.

Additional: Versapoint machine
Versapoint Cable (Grey)
Versapoint electrode
Hysteroscopy graspers
Gauze swabs
Dental syringe & needles if requested
Hegar Dilators if requested.

Plug Versapoint machine into electricity supply. Confirm with the operator that the Versapoint machine displays the correct setting. Place the foot pedal within reach of the operator's foot.

- Open up the Versapoint electrode pack and connect it to the cable connector maintaining ANTT at all times, place on the sterile field created by setting up for hysteroscopy procedure. The clinician will request for any other instruments to be opened into the sterile field if they are required for the procedure. Dispose of electrode into sharps bin after procedure. Clean Versapoint machine and disinfect Grey cable ready for next use.

Endometrial Polypectomy or Fibroid resection using HTRS

Working Trolley: Set up as for Hysteroscopy procedure using Truclear Morcellator Hysteroscope Tray. Refer to Hysteroscopy Assembly Instructions.

Additional: **1L or** 3L bag normal saline in respective pressure bag
Suction tubing
Suction container with liner insitu
Tissue Trap
Morcellation blade (TruClear Incisor)
Small scissors

Plug Truclear machine into electricity supply. Confirm with the operator that the machine is displaying the correct setting. Place the foot paddle close to the operator's foot.

- Open the Truclear Morcellator hysteroscope set.
- Assemble scopes inner and outer sheath if required.
- Attach bung (blue) to working channel of scope
- Connect light source to both ends.
- Connect camera head with camera cover applied and white balance.
- Connect fluid.
- Open Truclear Morcellator Incisor Blade (confirm with clinician first).
- Attach blade to hand piece remove black plastic blade cover observing ANTT at all times.
- Connect working handpiece to Truclear morcellator machine.
- Attach suction tubing between working hand piece and wall suction container with tissue trap
- Hand morcellator equipment to operator when requested.
- Switch on suction unit.

- The operator must ensure that the morcellator blade lines up with the aperture using the 'window lock' function before using the morcellator.

To retrieve specimen:

- Specimen will be in tissue trap inside suction pot.
- Remove tissue trap from suction pot and cut off trap. Remove hard plastic.
- Place specimen collected including tissue trap into formalin pot.

Post Procedure Instructions:

Dispose of morcellation blade into sharps bin. Take dirty instruments into the sluice. Clean Truclear machine and Pedals, replace suction liner, tissue trap and suction tubing. Equipment documentation checklist filled in.

11.3 Management of Histology Specimens

- Ensure that the Formalin histology pots are securely closed.
- Each pot requires a large patient identification label to be attached to the pot (not lid).
- The specimen type must be hand written on the pot e.g. polyp or endometrial biopsy.
- It is the clinician's responsibility to write the histology request form.
- It is the clinic nurses responsibility to check the form has been completed fully.
- At the end of a clinic a RGN is responsible for ensuring all specimens are correctly labelled and have appropriate request form. All specimen details are recorded in the "specimen book" and signed out.
- If the patient is a referral for investigation of suspected cancer, "URGENT" is written on the histology request form. This alerts the histology department to analyse these specimens first.
- If two separate specimen pots are to be sent to histology for the same patient, they may be placed in the one bag with one histology specimen request form. Specimen pot is labelled pot 1 and 2. The specimen type is also written on the pot. The clinic nurse checks that the numbers and specimen type on the pots match the request form.
- These specimens can then be sent to Histology department.

All specimens leaving the department must be clearly labelled and packaged appropriately for transportation after each clinic session. The correct labelling of all specimens is essential in order to avoid the risk of no processing, incorrect processing and indeed most importantly the hazard of incorrect diagnosis. While it is the ultimate responsibility of the clinician to fill out all request forms correctly, it is the clinic nurses responsibility to check for errors/omissions on the request forms in addition to checking the labels on the specimen matches that on the request form. This is done before the specimens leave the clinic room. All specimens sent to the laboratories from the department are documented and signed for by a Nurse prior to being sent off.

Areas to be checked on histology form:

- Date
- Specimen type
- Clinical information
- Signature
- Label on sample matches that on request form
- Specimen type hand written on sample pot/swab
- Specimen type documented in clinic diary next to patient's name

11.4 Recovery Post Procedure

All patients will be offered a comfortable place to rest with refreshments post procedure. The patient may go home when she feels ready. Occasionally a patient may require observation on the Ward and will be allocated a bed for the duration of recovery. Any concerns about the patients' recovery should be discussed by the Ward staff with the Consultant for that hysteroscopy session.

11.5 Post-Clinic

- The clinical treatment room should be thoroughly cleaned at the end of each session, including the couch, trolley and surfaces.

- Any stock not used should be put away to its appropriate storage area.
- Any necessary re-stocking of clinical equipment and stationary should be carried out to ensure that everything is in place for the next clinic session.
- All specimens should be checked and signed off according to unit policy (please see section on management of Histology and Cytology samples)
- All equipment should be checked ready for the next session or switched off/unplugged if it is the end of the clinic day.

11.6 Management of pain associated with hysteroscopic interventions

It is common for hysteroscopic procedures to cause some degree of pain, and effective pain management is essential in order for outpatient hysteroscopic procedures to be deemed acceptable by patients. 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, the following guidelines are in place.

Pre-operative

- Obtain informed verbal/written consent
- Ensure choice of treatment setting and anaesthesia offered
- Ensure all patient's aware of the possibility of 'see & treat' interventions e.g. endometrial biopsy, polypectomy, LNG-IUS insertion where appropriate.

Peri-operative

- Vaginoscopic approach recommended as best practice.
- Direct or paracervical anaesthesia where cervical dilatation with Hegar dilators required.
- All staff to be vigilant in monitoring patient pain and tolerance of the procedure.
- All staff to respond to patient feedback regarding pain and tolerance of the procedure.
- Clinician/Hysteroscopist to stop the procedure immediately at the patient's request.
- Clinician/Hysteroscopist to continue or cease the procedure in accordance with the patient's wishes.
- The use of intravenous / inhalational conscious sedation (Penthrox) or direct hysteroscopic uterine injection of local anaesthesia at the Clinician's discretion in the absence of evidence to support such interventions.
- Entonox is offered under the UHDB Patient Group Direction (PGD ref: UHDB025).

Post-operative

- All patients to be offered simple analgesia.
- All patients to be offered recuperation and refreshments in designated Recovery area.
- All patients with significant post-operative pain to be admitted to a Gynae Ward for a period of observation and opiate analgesia where necessary.
- Follow up or rescheduling of procedures under regional / general anaesthesia to be discussed and arranged with a copy of the letter to be sent to respective consultant.

Entonox Gas

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 and is readily available for use in the Department. Please refer to UHDB Patient Group Direction for Administration of Entonox (UHDB025).

Further details can be found on the Trusts Intranet or Pain Team.

11.7 Management of complications associated with hysteroscopic procedures

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

- The clinician must Immediately STOP the procedure and remove instruments.
- Reassure patient and calmly try to rouse them by talking to them.
- Elevate the foot end of the examination couch higher than the head end of couch.
- Ensure fan is on and facing patient.
- Give oxygen as prescribed.
- Monitor pulse rate and blood pressure and record in the notes.
- If the patient's pulse rate and blood pressure continues to remain low, IV access and fluids may be required prior to the woman being transferred to the ward.
- In severe cases atropine may be administered (located in Emergency Crash Trolley)
- Call the CRASH Team on 2222/ for SRP ring 999 if requested to do so.
- Bring the CRASH Trolley to the Hysteroscopy Clinic from outside treatment room at SRP and Burton and from outside Consult Suite 14 at RDH,
- When the patient is stable transfer to Gynae Ward on a bed. The patient will remain under observation on the ward until she is well enough to go home.

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 used for cauterisation may be requested by the clinician. These are kept in the drugs cupboard. Monsels may also be requested and can be obtained from the Colposcopy treatment rooms.

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

- The clinician will abandon the procedure and remove instrumentation.
- Reassure the patient and if faint, implement procedure for vasovagal episode.
- The woman will be transferred to a Gynae Ward for observation and review by consultant.

This review will include an explanation of the complication to the patient and assessment to determine further management i.e. antibiotic cover and surveillance or surgical intervention of diagnostic laparoscopy.

Pyometra
Pyometra is a collection of pus within the uterine cavity. It is not a common finding but is usually found incidentally at hysteroscopy. Rarely, patients can develop septicaemia and therefore immediate action is required to treat the patient. Trust guidelines are in place to assist clinicians and departmental staff ensuring that patients are treated appropriately and in a timely manner.

If pyometra is found during outpatient hysteroscopy procedure, antibiotic therapy is required. Please follow Trust Antibiotic Full clinical Guideline – i.e. Sepsis of Unknown Origin (adults)

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

Signs
Excessive blood loss.

Action

- The clinician will abandon the procedure and remove instrumentation.
- Reassure the woman.
- Set up IV drip stand with Normal Saline 1L and run through giving set.
- Administer oxygen as prescribed.
- If faint treat as for vasovagal episode.
- Assist the clinician with instruments as requested. Inserting of a Foley catheter into the uterine cavity may be undertaken to facilitate intrauterine tamponade or a vaginal pack is used. The woman will be transferred to a Gynae Ward on a bed for further observation and management.
- The patient will be reviewed by the consultant.

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
- Call the CRASH TEAM on 2222, for SRP ring 999
- Bring Crash Trolley.

11.8 Record Keeping and Clinical Documentation

Patients & G.P letters

- Histology, microbiology and blood results will be returned to the secretary of the consultant for each hysteroscopy clinic. It is the responsibility of the clinician for each clinic to review reports, and initiate any further treatment or appointments based on this report.

Department Communication

- Regular OPH departmental meetings for nursing staff take place to facilitate/cascade information from the departmental, Directorate and Trust.
- Operational meetings take place biannually involving the Lead Clinician, Consultant, and Lead Nurse/Sister or Matron to plan and review the services provided by the department.

11.9 Protocol for patients requiring further investigations/procedure under general anaesthesia

- The clinician will discuss the proposed procedure with the patient.
- Any relevant patient information for the proposed procedure will be given to the patient.
- A consent form must be signed by the patient and clinician if appropriate.
- The waiting list form will be completed by the clinician, requesting the procedure. The consent form, waiting list form and patient notes should be sent with the patient to the pre-op assessment unit where the patient will be clerked and issued with a date for procedure.

11.10 DNA's (Patient did not attend)

DNA's are dealt with as per Trust policy. All patients referred for investigations of Postmenopausal bleeding (PMB) must be issued with another appointment after first DNA. If the patient is on an urgent pathway for investigations of suspected cancer a new appointment should be issued within 1 week and the patient contacted by telephone and informed of the appointment.

If there is a second DNA, then no further appointments to be made. Please inform the lead for gynaecological oncology MDT for any further actions.

11.11 Patient Cancellations

Any patient who telephones the Department to cancel their appointment must be put through to either Reception staff, or Clinic Coordinator Gynae Outpatients dept.

11.12 Patient Information Leaflets available

One Stop See and Treat Leaflet
Post One Stop Procedure Information Leaflet
Endometrial Polypectomy
Endometrial Ablation
Mirena IUS
Uterine Artery Embolisation

11.13 Sterile Services Management

Introduction

Instruments used in the Outpatient Hysteroscopy Clinic are sterilised on site or offsite. In order to assist the department to run efficiently and effectively the dispatch and receipt of instruments need to be tracked, monitored and managed appropriately. It is the responsibility of all members of nursing staff to ensure that an accurate record of instruments received, used and returned for reprocessing and sterilisation.

Recording & Management of Instruments

For every instrument used, the small sticker which contains a serial number and product code on the front packaging of every instrument must be removed and placed in the patients' notes.

- Once an instrument has been used the assisting clinical staff must place a bar code sticker on specimen log book and one on patient's notes.
- The used instrument must be placed in its original packaging with barcode intact and placed in instruments container following appropriate diagram/picture lay out.

Cleaning Schedule for hysteroscopy suite

A schedule is available in the Hysteroscopy Suite and is to be carried out as specified.

12. Review, Monitoring, and Revision Arrangements

Monitoring Compliance and Effectiveness

As per agreed Business Unit Audit forward programme

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

13. Infection control policy for Clinic/Session with known or Suspected BBV and Infected Cases.

Suspected Blood Borne Virus (BBV) and Hepatitis patient's should be done at end of list by communicating with clinician and informing patient.
Please refer to Infection Control Manual.

14. References

Best Practice in Outpatient Hysteroscopy
Royal College of Obstetrics & Gynaecology (RCOG) Green-top Guideline No. 59 March 2011 Best Practice in Outpatient Hysteroscopy RCOG/BSGE Joint Guideline

Epic guideline

Infection control manual

ANNT policy v2.1

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

LOW RISK PROCEDURE

- Diagnostic Hysteroscopy +/- biopsy +/- Mirena insertion
- Cervical Polypectomy
- Hysteroscopic Sterilisation
- Endometrial Polypectomy for small polyps (at discretion of the clinician)

Clopidogrel / Prasugrel / Ticagrelor	Continue therapy
Dabigatran / Rivaroxaban / Apixaban / Edoxaban	Take last dose of drug ≥24 hours before procedure
Warfarin: check INR during week before hysteroscopy	• If INR within therapeutic range, continue usual daily dose • If INR above therapeutic range but <5 reduce daily dose until INR returns to normal range and proceed with hysteroscopy if INR<4
Therapeutic Enoxaparin	Continue therapy

HIGH RISK PROCEDURE

- Endometrial Ablation
- Endometrial Polypectomy for large polyps filling whole cavity or multiple polyps
- Transcervical resection of fibroid

CLOPIDOGREL / PRASUGREL / TICAGRELOR

LOW RISK CONDITION	HIGH RISK CONDITION
• Ischaemic heart disease without coronary stent • Cerebrovascular disease • Peripheral disease	Coronary artery stents
Stop 5 days before hysteroscopy Continue aspirin if already prescribed	Liaise with cardiologist Consider stopping 5 days before hysteroscopy if: • >12 months after insertion of drug eluting coronary stent • >1 month after insertion of bare metal coronary stent Continue aspirin

WARFARIN

LOW RISK CONDITION	HIGH RISK CONDITION
• Prosthetic metal heart valve in aortic position and no additional risk factors (e.g. af, h/o stroke/TIA, poorly controlled hypertension, diabetes) • Xenograft heart valve • Atrial Fibrillation without valvular disease • >3 months after VTE • Low risk thrombophilia	• Mechanical heart valve patients other than those with a bileaflet aortic valve and no other risk factors (full guideline) • Atrial Fibrillation with h/o Stroke/TIA within last 3 months or with three or more additional risk factors (see full guideline) • <3 months after VTE in very high risk patients such as patients with previous VTE whilst on therapeutic anticoagulation who now have a target INR or 3.5
Stop warfarin 5 days prior to hysteroscopy Check INR prior to procedure to ensure INR<1.5 Restart evening of hysteroscopy with usual daily dose Check INR 1 week later to monitor	Consider bridging with therapeutic LMWH (see inpatient guideline) Stop warfarin 5 days before hysteroscopy, start LMWH 2 days later, last dose ≥24 hours before hysteroscopy Restart warfarin evening of hysteroscopy with usual daily dose Give thromboprophylaxis in the first 48 hours following hysteroscopy as per Trust guidelines Give first first therapeutic LMWH at least 48 hours after procedure, continue LMWH until INR therapeutic

DABIGATRAN / RIVAROXABAN / APIXABAN / EDOXABAN:
take last dose >48 hours before hysteroscopy (i.e. last dose 3 days before) For dabigatran with dGFR 35-50, take last dose 96 hours before.
Contact haematologist in case of rapidly deteriorating renal function.

THERAPEUTIC ENOXAPARIN: Give last dose >24 hours prior to procedure

April 2020 UHDB for RDH site specific

Documentation Control

Reference Number: **UHDB/Gynae/07:23/H3**	**Version:** UHDB V1		**Status: Final**	
Version / Amendment	Version	Date	Author	Reason
	1	08:09	Mr S Abdul, Miss A Fowlie, Heather Morris, Kay Thornewill, Nikki Smith Gaynor Lowe, Alison Caldwell	Supporting new service
	2	May 2014	Miss S Kolhe Consultant Gynaecologist	Review
	3	July 2019	Dennis Casayuran – Nurse Hysteroscopist	review
UHDB	1	November 2022	Dennis Casayuran - Clinical Nurse Specialist – Hysteroscopist Shilpa Kolhe – Consultant Gynaecologist RDH Dr N Pope - Obstetrocs & Gynaecology Consultant QHB	Review to ensure cross site coverage
Intended Recipients: Gynaecology Outpatient Services				
Training and Dissemination: Cascaded through lead sisters/doctors Published on Intranet, NHS.net circulation list. Article in Business Unit newsletter				
Consultation with:	Gynaecology Staff			
Business Unit sign off:	15/05/2023: Gynaecology Guidelines Group: Miss B Purwar – Chair 23/05/2023: Gynaecology Development & Governance Committee: Mr J Dasgupta			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/06/2023				
Implementation date:	04/07/2023			
Review Date:	July 2026			
Key Contact:	Joanna Harrison-Engwell			