A Prospective Audit of the Outpatient Hysteroscopy Service at Queen Alexandra Hospital, Portsmouth, UK

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BACKGROUND

An earlier review of hysteroscopy provision within our service found an increasing rate of hysteroscopies undertaken in the theatre setting over a 1 year period.

We wished to audit our outpatient hysteroscopy service against the joint British Society for Gynaecological Endoscopy (BSGE)/Royal College of Obstetricians and Gynaecologists (RCOG) guideline 'Best practice in out-patient hysteroscopy'[1] as part of the service improvement work to ascertain whether it might be possible to reduce the number of women undergoing a potentially unnecessary general anaesthetic

OBJECTIVES

- To ensure we are following evidence based best practice:
  - Vaginsocopy should be standard technique for all diagnostic hysteroscopies
  - Routine dilatation should be avoided
  - Rates of dilatation
  - Local anaesthetic should be used to the cervix where dilatation is required
  - Record failure rate and reason for failures
  - Complication rate
- To identify any areas for improvement
- To increase capacity in outpatient hysteroscopy
- To reduce hysteroscopy workload in theatres

METHOD

Prospective data collection over one month (1/4/19 to 30/4/19) from all outpatient hysteroscopy appointments in this large district general hospital within the National Health Service (NHS), UK.

Data was collected onto and analysed using Excel.

Image 1: Our outpatient hysteroscopy room

RESULTS

220 appointments in one month

21/220 (9.5%) not attended (DNA)

199/220 attended clinic

140/220 (63.6%) post menopausal bleeding (PMB) clinic

59/220 (26.8%) benign ambulatory (amb) clinic

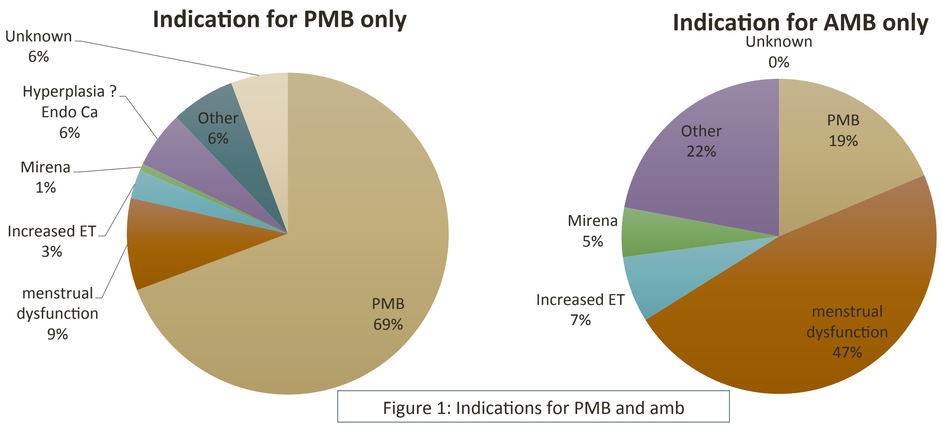

Figure 1: Indications for PMB and amb

Hysteroscopy outcomes

- 118/199 (59%) had an attempted hysteroscopy
  - Diagnostic 91/118 (77%) (85/91, 93%, success rate)
  - Operative 27/118 (23%) (27/27, 100%, success rate)
  - 112/118 (95%) were successful
- Hysteroscopy was not attempted for 75/199 (37.7%)
  - 7/199 (3.5%) not attempted as exam not tolerated
  - 57/199 (28.6%) because they were not required
  - 4/199 (2%) declined
  - 7/199 (3.5%) due to staffing [Figure 2]
- 6 data points removed due to inaccurate data entry

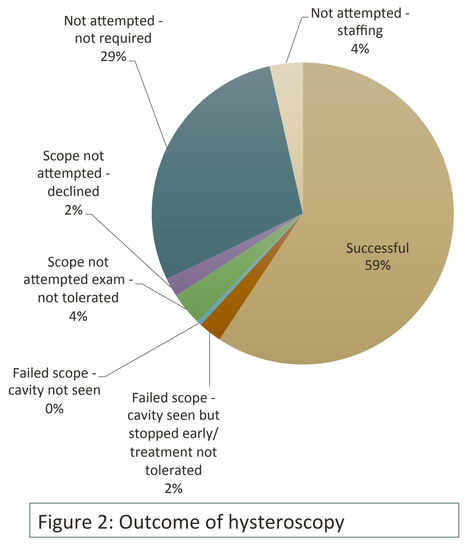

Figure 2: Outcome of hysteroscopy

Vaginoscopy

- Vaginoscopic approach in 56/91 (61.5%) of diagnostic hysteroscopies

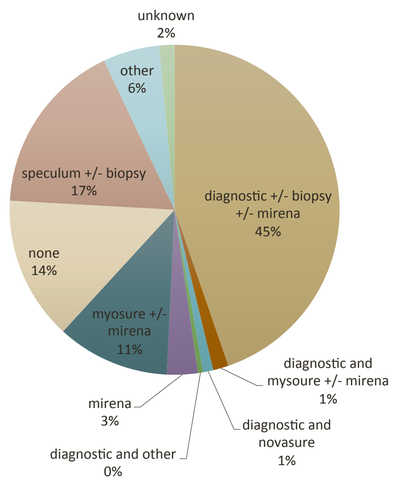

Figure 3: Procedures undertaken

Operative hysteroscopies

Operative hysteroscopies were 27/118 (23%) of all hysteroscopies

- 25 Myosure resection of polyp/fibroid
- 2 Novasure endometrial ablation

- 5/27 (19%) were 'see and treat' after initial diagnostic hysteroscopy
- 22/27 (81%) were planned operative hysteroscopies

Cervical dilatation

- Cervical dilatation rates were:
  - Diagnostic hysteroscopy 18/91 (19.8%)
  - Operative hysteroscopy 26/27 (96.2%)
- Rates of dilatation did not correlate with parity or menopausal status
- 41/44 (94%) cervical dilatations received local anaesthetic to the cervix

Outcome of clinic visit

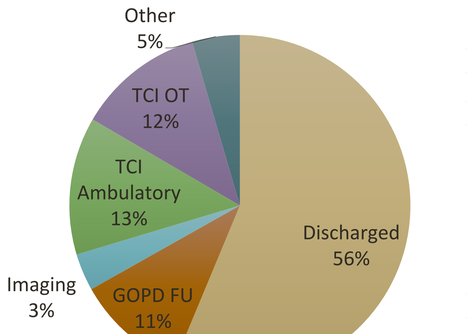

Figure 4: Clinic outcomes

- 112/199 (56.3%) discharged
- 50/199 (25.2%) further hysteroscopy appointment
  - 26/199 (13.1%) ambulatory clinic
  - 24/199 (12.1%) theatre
- 28/199 (14.1%) gynaecology out-patient follow up and/or imaging

Failure rates

- 6/91 (6.6%) diagnostic hysteroscopies failed
  - 5/12 cavity seen before the hysteroscopy was abandoned as not tolerated

Complications

There were no recorded complications

CONCLUSIONS

Our outpatient hysteroscopy success rates of 87% are comparable with published data[2], providing further evidence that it is safe and well tolerated.

Areas identified for improvement are to increase the number of vaginoscopic diagnostic hysteroscopies, and to increase the proportion of operative hysteroscopies provided as a one stop 'see and treat' service as recommended by NICE[3].

FUTURE WORK

- The findings of this audit were shared within our department and all staff encouraged to adhere to best practice guidelines
- We will be creating a business case to enable all outpatient hysteroscopy clinics to provide a 'see and treat' service
- Once this has been implemented, we will be re-auditing our service to determine whether these changes lead to an improvement in the proportion of patients receiving a 'see and treat' service and the number of diagnostic hysteroscopies performed with vaginoscopic technique

The authors have no conflict of interests to declare

REFERENCES

1. Hysteroscopy, Best Practice in Outpatient; BSGE/RCOG joint guideline No 59 [internet], https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg59/
2. Smith PP, Kolhe S, O'Connor S, Clark TJ. Vaginoscopy Against Standard Treatment: a randomised controlled trial. BJOG 2019;https://doi.org/10.1111/1471-0528.15565
3. Heavy menstrual bleeding: assessment and management, National Institue for Health and Care Excellence, Guideline NG88, March 2018 (updated Novemeber 2019)