Presentations

Introduction to the National BSGE Outpatient Hysteroscopy (OPH) Patient Satisfaction Survey

Ayesha Mahmud, Paul Smith, Justin Clark

Background

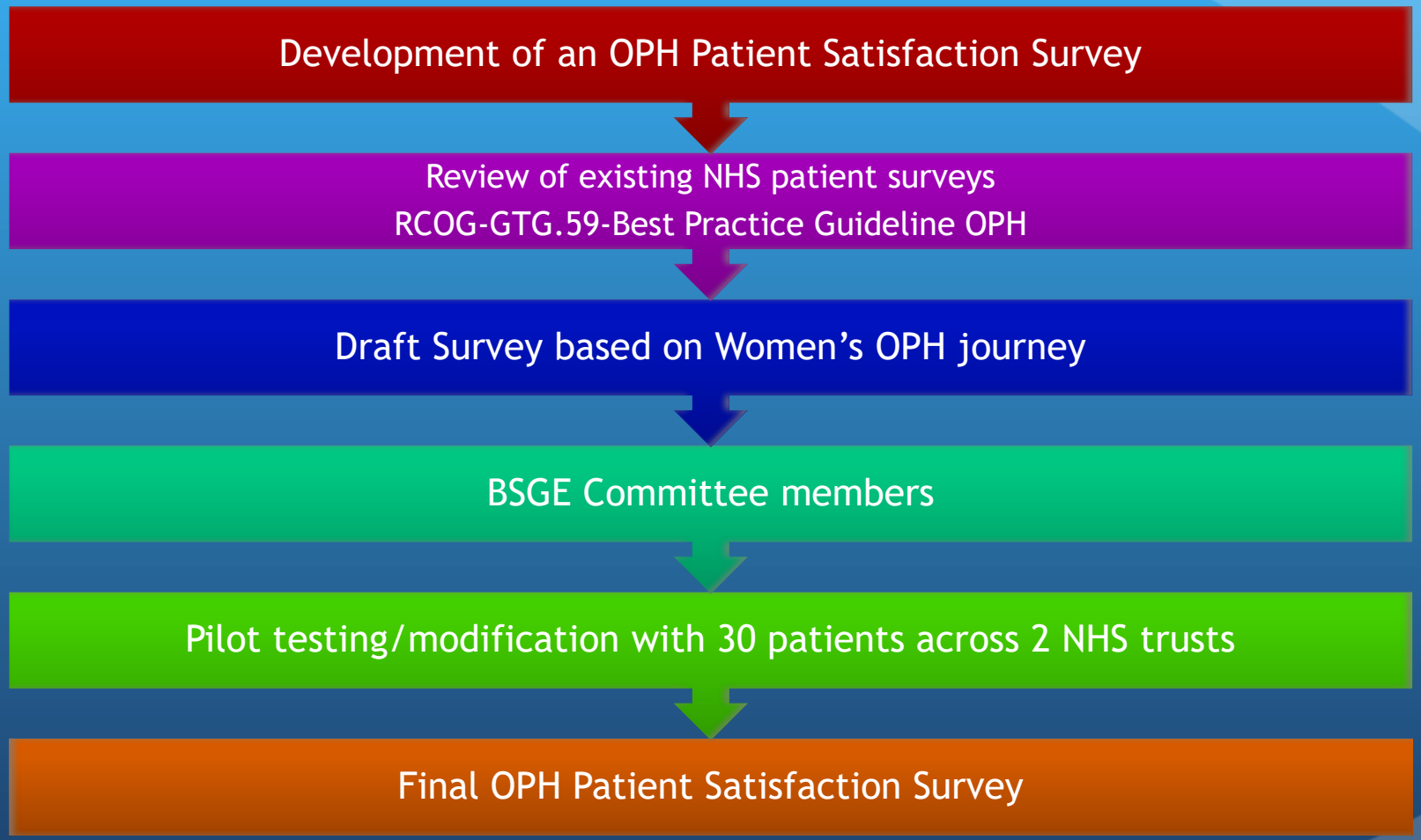
Background

- National OPH survey 2018- highlighted variation in practices- raising questions about women's experience of hysteroscopy
- Backlash from OPH hysteroscopy patient groups
- No agreed national benchmark or OPH tool
- Need for an OPH tool that is able to capture women's satisfaction with the care they receive during their hysteroscopy journey

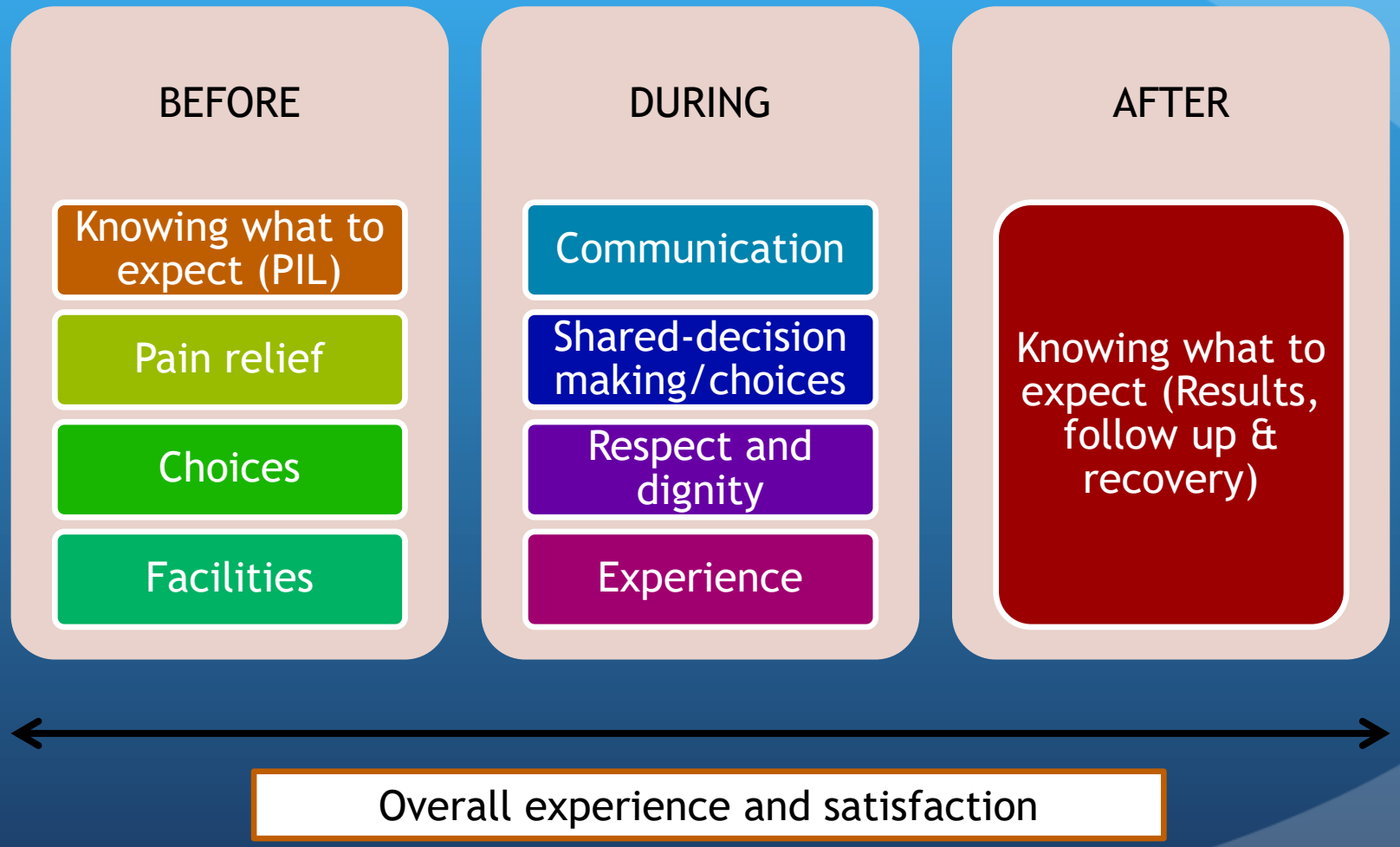
OPH Patient Satisfaction Survey

Methodology

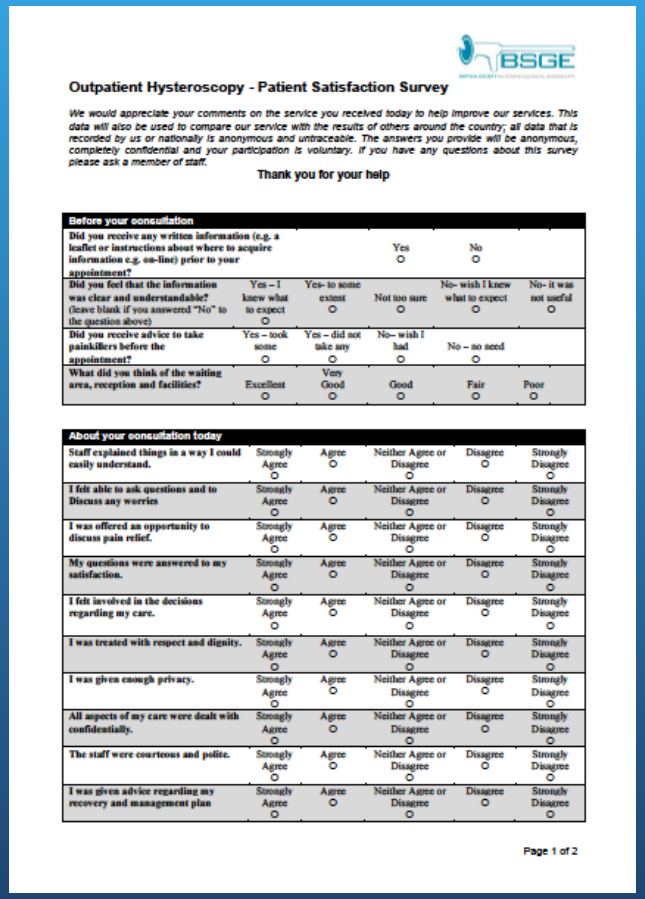
Methodology



Women's OPH journey



OPH Patient Satisfaction Survey



BSGE

Outpatient Hysteroscopy - Patient Satisfaction Survey

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Thank you for your help

Before your consultation						
Did you receive any written information (e.g. a leaflet or instructions about where to acquire information e.g. on-line) prior to your appointment?				Yes ○	No ○	
Did you feel that the information was clear and understandable? (leave blank if you answered "No" to the question above)	Yes – I knew what to expect ○	Yes- to some extent ○	Not too sure ○	No- wish I knew what to expect ○	No- it was not useful ○	
Did you receive advice to take painkillers before the appointment?	Yes – took some ○	Yes – did not take any ○	No- wish I had ○	No – no need ○		
What did you think of the waiting area, reception and facilities?	Excellent ○	Very Good ○	Good ○	Fair ○	Poor ○	

About your consultation today					
Staff explained things in a way I could easily understand.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I felt able to ask questions and to Discuss any worries	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I was offered an opportunity to discuss pain relief.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
My questions were answered to my satisfaction.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I felt involved in the decisions regarding my care.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I was treated with respect and dignity.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I was given enough privacy.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
All aspects of my care were dealt with confidentially.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
The staff were courteous and polite.	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○
I was given advice regarding my recovery and management plan	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○

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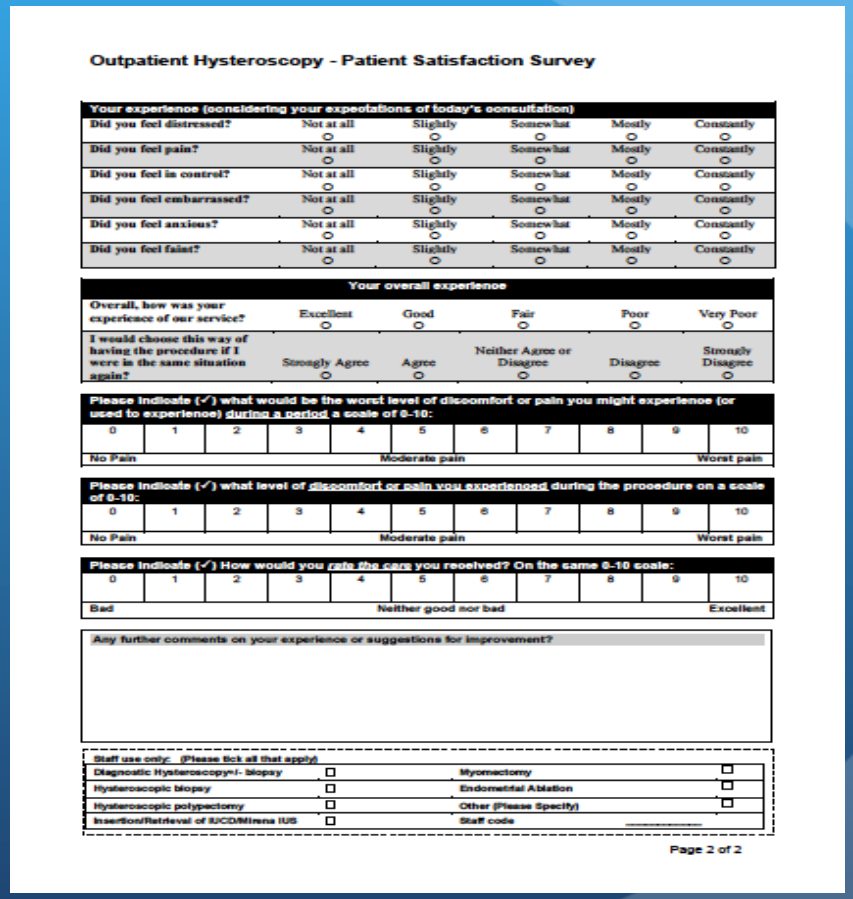

Outpatient Hysteroscopy - Patient Satisfaction Survey

Your experience (considering your expectations of today's consultation)					
Did you feel distressed?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○
Did you feel pain?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○
Did you feel in control?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○
Did you feel embarrassed?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○
Did you feel anxious?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○
Did you feel faint?	Not at all ○	Slightly ○	Somewhat ○	Mostly ○	Constantly ○

Your overall experience					
Overall, how was your experience of our service?	Excellent ○	Good ○	Fair ○	Poor ○	Very Poor ○
I would choose this way of having the procedure if I were in the same situation again?	Strongly Agree ○	Agree ○	Neither Agree or Disagree ○	Disagree ○	Strongly Disagree ○

Please indicate (✓) what would be the worst level of discomfort or pain you might experience (or used to experience) during a period a scale of 0-10:

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No Pain					Moderate pain					Worst pain

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Please indicate (✓) How would you rate the care you received? On the same 0-10 scale:

0	1	2	3	4	5	6	7	8	9	10
Bad					Neither good nor bad					Excellent

Any further comments on your experience or suggestions for improvement?

Staff use only: (Please tick all that apply)			
Diagnostic Hysteroscopy+/- biopsy	☐	Myomectomy	☐
Hysteroscopic biopsy	☐	Endometrial Ablation	☐
Hysteroscopic polypectomy	☐	Other (Please Specify)	☐
Insertion/Retrieval of IUCD/Mirena IUS	☐	Staff code	_____

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Instructions

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Outpatient Hysteroscopy - Patient Satisfaction Survey

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Thank you for your help

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Hysteroscopic biopsy	☐	Endometrial Ablation	☐
Hysteroscopic polypectomy	☐	Other (Please Specify)	☐
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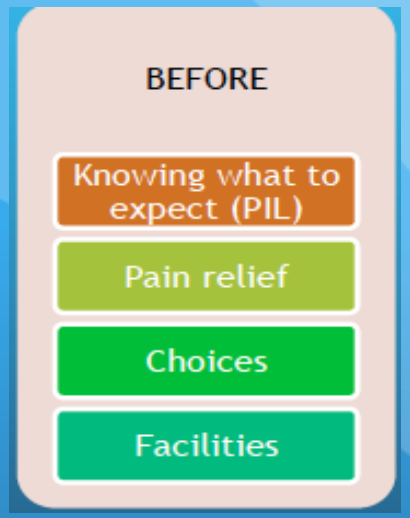
Before your visit



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DURING

- Communication
- Shared-decision making/choices
- Respect and dignity
- Experience

Your experience

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DURING

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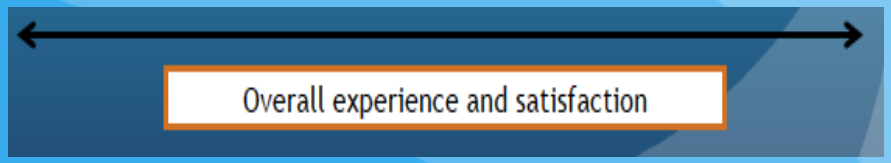
Overall experience



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Bad					**Neither good nor bad**					**Excellent**

Any further comments on your experience or suggestions for improvement?

National role out

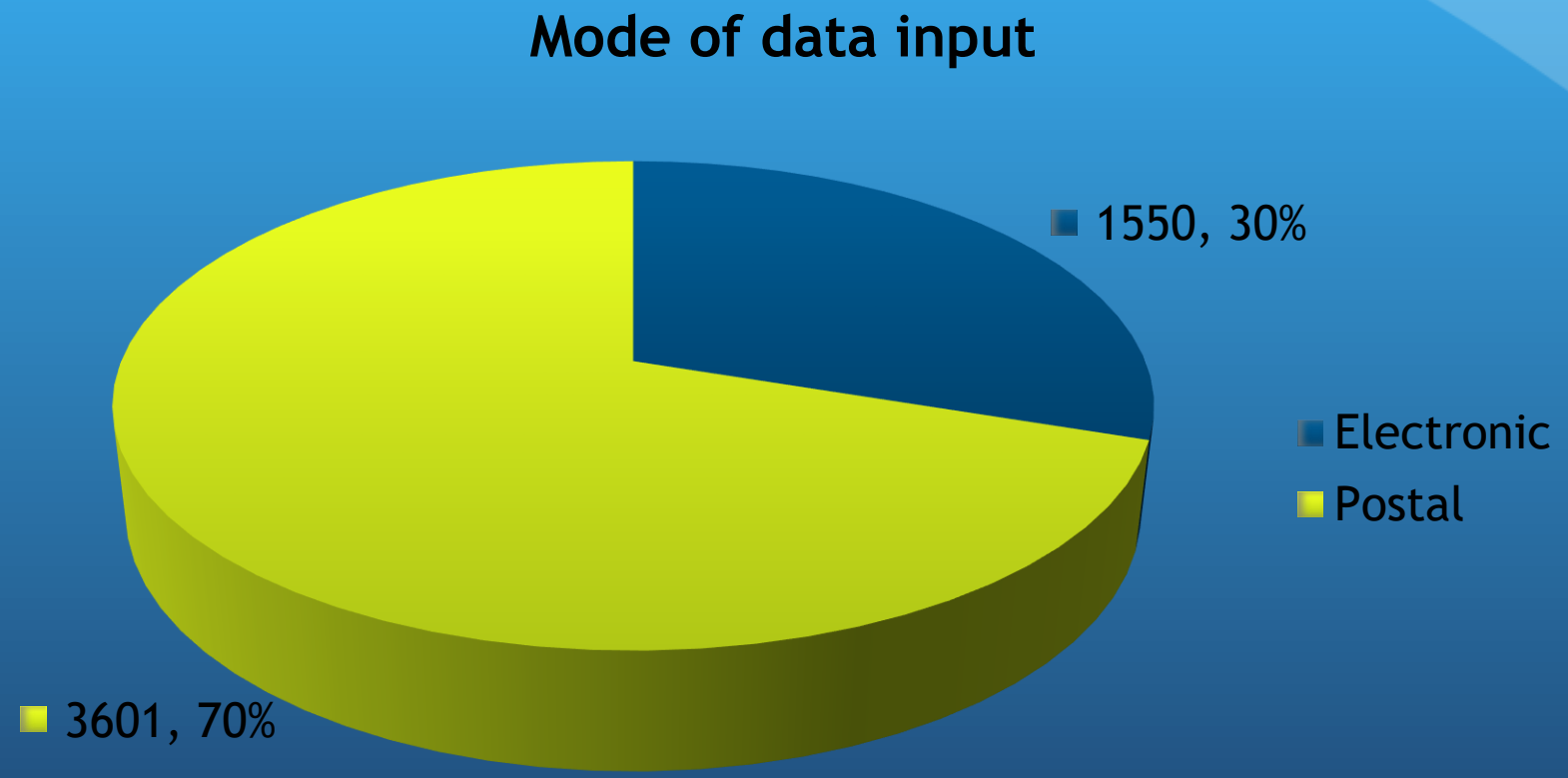
- OPH Questionnaire shared at last ACN meeting 2019
- BSGE Call for national data collection OCT-NOV 19
- Electronic (Googleforms) and paper data collection
- Target 2000 patient responses
- Data input and analysis Jan/Feb

Thank you

Creating the right setting

The BSGE OPH survey results

Responses (n=5151)

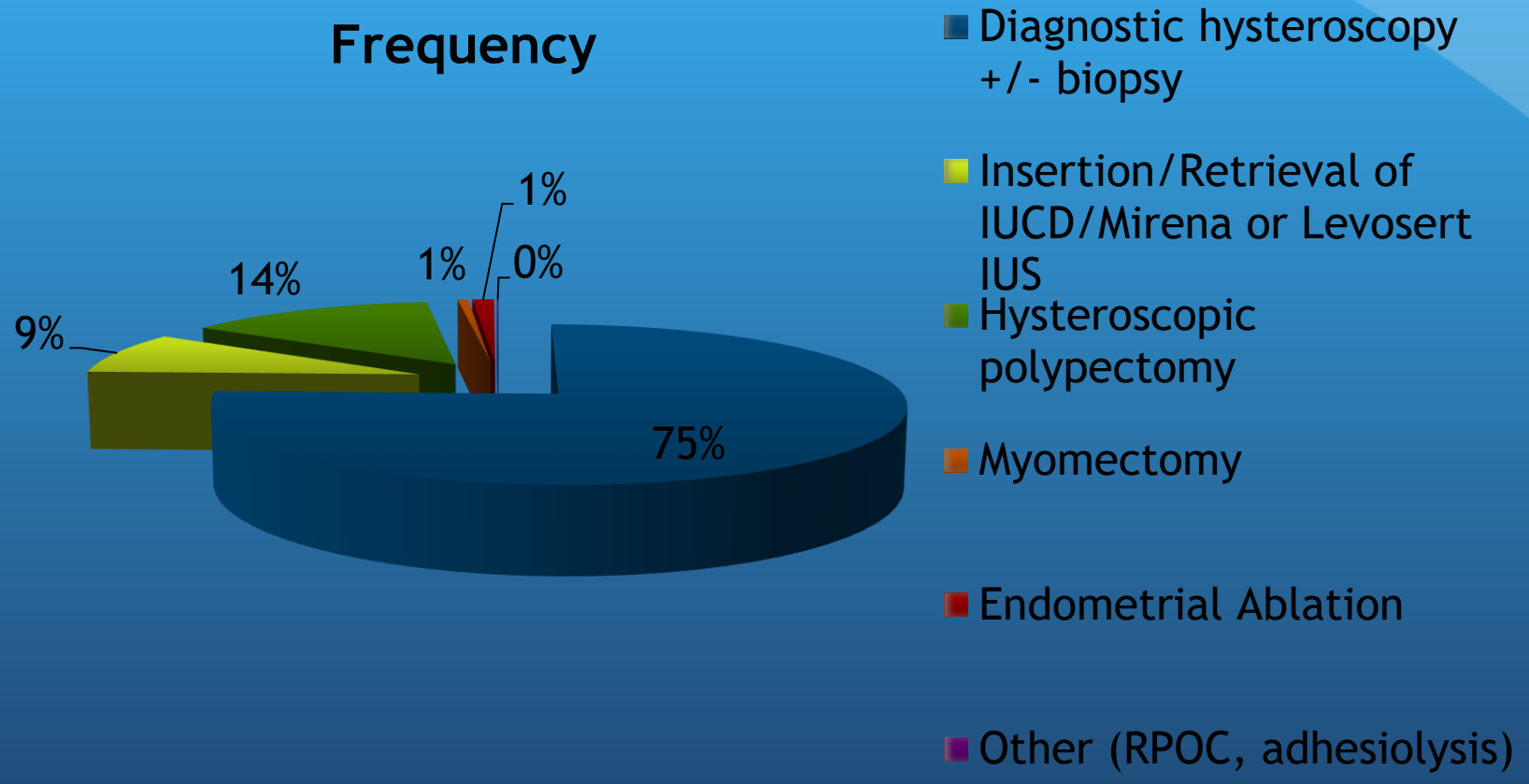


All data was predominantly collected on paper before electronic upload at participating units. Papers sent in by post for data upload are represented as Postal submissions.

Participating Units

- 81 hospitals across UK

Types of procedures (n=5151)



Type of procedure narrowed down to one with the following prioritisation when there were multiple procedures:
ablation>myomectomy>polypectomy>insertion/retrieval IUS> hysteroscopy +/- biopsy

Breakout session (Task 1)

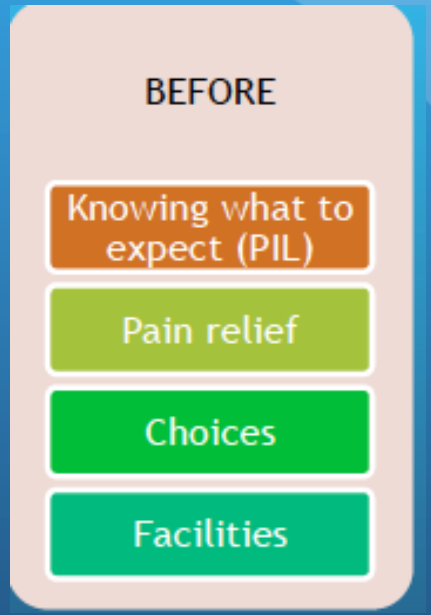
Group activity

Theme: Creating the right setting

Instructions: Interpret data and clinical implications

1. Differences in leaflet/information given
2. When you give it/how you give it
3. Consent (written/verbal/video)
4. WHO Checklists
5. Timing of discussion before proceeding
6. Staffing/Infrastructure/environment/recovery

SECTION 1 of handout



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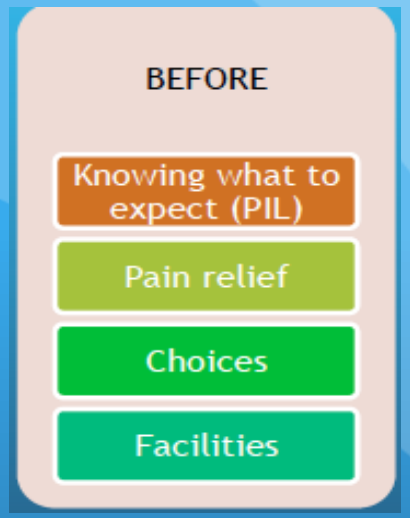

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Tea/Coffee Break

Pain and acceptability

Breakout session (Task 2)

Group activity

Theme: Pain and acceptability

Instructions: Interpret data and clinical implications

1. Interpret the good
2. Identify the not so good
3. Discuss clinical implications

SECTION 2 and 3 of handout

About your consultation today

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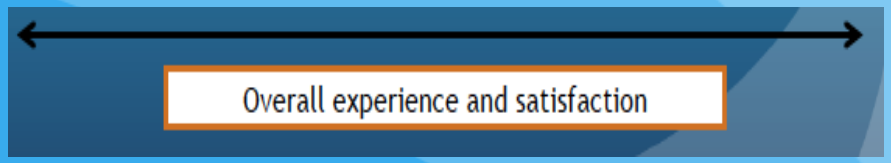

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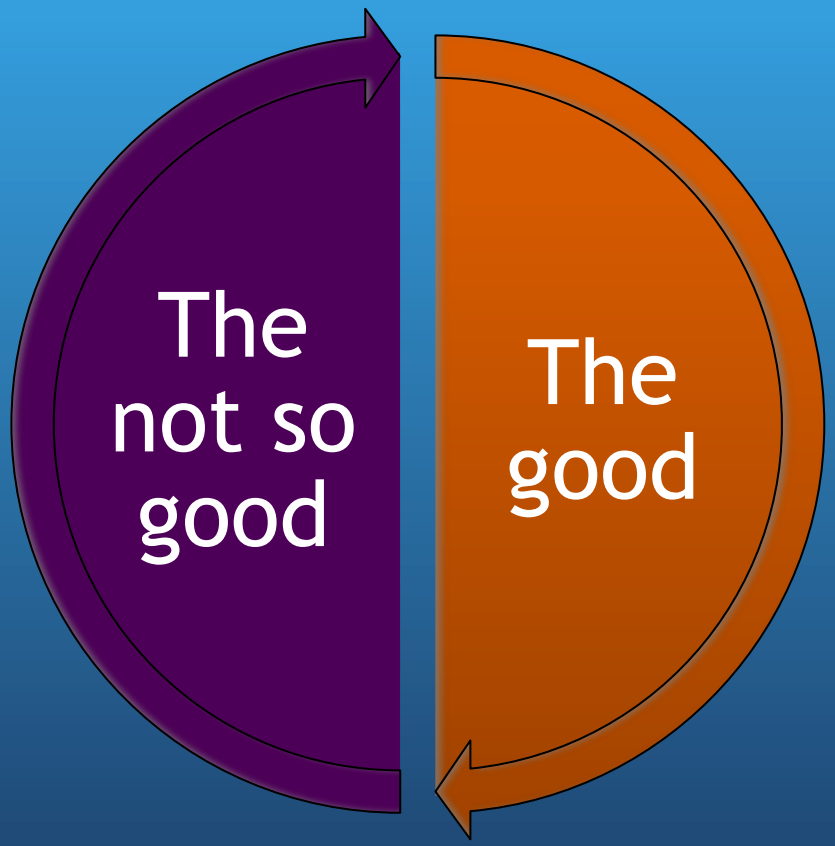
Bad					**Neither good nor bad**					**Excellent**

Any further comments on your experience or suggestions for improvement?

Statements of patients

Patient OPH feedback



Patient feedback

The good

“My advice to anyone having this procedure would be to not worry at all. Completely felt at ease, no pain and that all the staff were absolutely fantastic , professional and really made what could have been an embarrassing situation actually a good experience.”

“Procedure carried out quickly causing miminal pain/discomfort. Nurses kept me at ease, consultant explained procedure as he was doing it”

“The consultant and the staff involved in the procedure were extremely polite and helpful. I was given the choice at all levels to choose to opt out. However, it was meant to be done for my own good. Many thanks for taking the worry off my mind!”

“Friendly staff put me at ease, procedure clearly explained. No pain, quick and a cup of tea.”

The not so good

“Some sort of anaesthetic because even with normal painkillers it's still too painful. Staff had to terminate procedure for a biopsy as pain became unbearable.”

“It would be useful if its clear in the letter how the appointment might proceed.”

“I would have liked to receive information before today's appointment as I was unaware I would be having a procedure today.”

“Hospital phoned with a cancellation appointment. I would have liked an email of the information for today. It would have been easier to know what I needed to do eg. urine sample, pain killer, bring more effective pad.”

“i didn't know that i was going to have hysteroscopy today so i wasn't prepared. i didn't have a chance to take painkillers beforehand. it would have been good to mention it on the booking letter, when planned. aside from this, the care i received was amazing. thank you.”

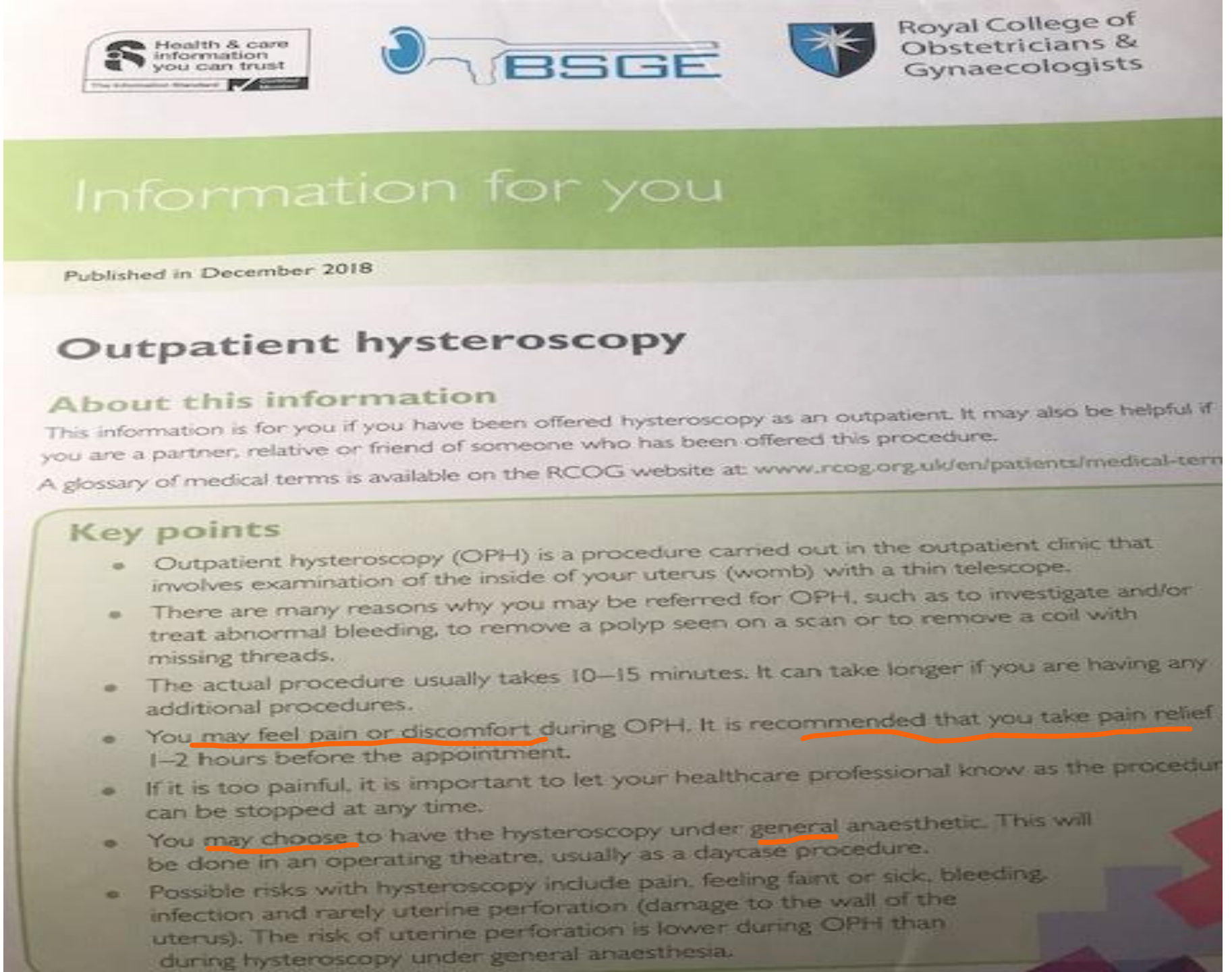
Thank you

BSGE ACN Meeting

Geeta Kumar
Consultant O&G & Deputy Medical Director (Q & S),
Wrexham Maelor Hospital, BCUHB
Visiting Professor, Glyndwr university, Wrexham

27.02.2020

OPH PIL



Health & care information you can trust

BSGE

Royal College of Obstetricians & Gynaecologists

Information for you

Published in December 2018

Outpatient hysteroscopy

About this information

This information is for you if you have been offered hysteroscopy as an outpatient. It may also be helpful if you are a partner, relative or friend of someone who has been offered this procedure.

A glossary of medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-term

Key points

- Outpatient hysteroscopy (OPH) is a procedure carried out in the outpatient clinic that involves examination of the inside of your uterus (womb) with a thin telescope.
- There are many reasons why you may be referred for OPH, such as to investigate and/or treat abnormal bleeding, to remove a polyp seen on a scan or to remove a coil with missing threads.
- The actual procedure usually takes 10–15 minutes. It can take longer if you are having any additional procedures.
- You may feel pain or discomfort during OPH. It is recommended that you take pain relief 1–2 hours before the appointment.
- If it is too painful, it is important to let your healthcare professional know as the procedur can be stopped at any time.
- You may choose to have the hysteroscopy under general anaesthetic. This will be done in an operating theatre, usually as a daycase procedure.
- Possible risks with hysteroscopy include pain, feeling faint or sick, bleeding, infection and rarely uterine perforation (damage to the wall of the uterus). The risk of uterine perforation is lower during OPH than during hysteroscopy under general anaesthesia.

Clinic appointment letter

Dyddiad	**Dydd Iau, 20 Chwefror 2020 / Thursday, 20 February 2020**	Date
Amser	**09:00**	Time
Lleoliad	**Shooting Star Unit - Department 15, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD**	Location

- Yn ystod yr apwyntiad hwn efallai bydd y meddyg yn gwneud **sgan uwchsain** a **hysterosgopi i gleifion allanol** (triniaeth syml sy'n cynnwys archwiliad telesgopig o du mewn i'ch croth). Weithiau byddwch angen mân driniaethau pellach fel biopsi a/neu dynnu polyp neu goil o'r groth yn ôl yr angen clinigol.
- Fe'ch cynghorir i gymryd **cyffuriau lleddfu poen** fel parasetamol (1gm) NEU ibuprofen (400mg) trwy'r geg (ar yr amod nad oes gennych alergedd atynt) o leiaf **1 awr** cyn yr amser a drefnwyd ar gyfer eich apwyntiad. Dylech fwyta, yfed a chymryd meddyginiaethau rheolaidd yn ôl yr arfer.
- Rydym yn cynghori eich bod chi'n dod â rhywun gyda chi i'r apwyntiad fel cefnogaeth. Dylent hefyd allu mynd â chi adref, gan efallai byddwch yn cael ychydig o boen yn dilyn y driniaeth. Dewch â chadach mislif gyda chi hefyd.
- Oherwydd natur rhai o'r triniaethau a gynhelir yn y clinig hwn, efallai bydd apwyntiadau yn rhedeg yn hwyr, felly

- During this appointment the doctor may undertake an **ultrasound scan** and **outpatient hysteroscopy** (simple procedure which involves telescopic examination of the inside of your womb). You may occasionally need further minor procedures like biopsy and/or removal of polyp or coil from the womb as clinically indicated.
- It is advisable to take **painkillers** in the form of paracetamol tablets (1 gm) OR ibuprofen tablets (400 mg) orally (provided you are not allergic to them) at least **1 hour** before your scheduled appointment time. You should eat, drink and take any regular medications as normal.
- We advise that you bring someone with you to your appointment for support. They should also be able to take you home, as you may experience some discomfort following the procedure. Please also bring a sanitary towel with you.
- Due to the nature of some of the treatments carried out in this clinic, appointments may run over the allocated

Consent form

NAME OF PROPOSED PROCEDURE OR COURSE OF TREATMENT
(include brief explanation if medical term is not clear)
Out Patient Hysteroscopy – Telescopic examination of the inside of the womb +/- obtain a sample of the lining of the womb +/- removal of polyp.

SPECIAL REQUIREMENTS (e.g. other language / other communication method)

.....

.....

ANAESTHETIC: This procedure will involve:

☐ Local Anaesthesia

ANY EXTRA PROCEDURES WHICH MAY BECOME NECESSARY DURING THE PROCEDURE:

☐ Blood transfusion: If bleeding excessive ☐ Other procedure: To deal with complications of they occur

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by a health professional with appropriate knowledge of proposed procedure, as specified in Consent Policy)

I have explained the procedure to the patient. In particular, I have explained: -

Benefits: the intended benefits of this procedure/ treatment are:

- Highlight any abnormality inside the womb
- If polyp is found, it may be removed
- Sample of lining of womb may be checked in the laboratory

Risks: these are the significant, unavoidable or frequently occurring risks:

During the operation:

- Vaginal bleeding /discharge (usually minimal)
- Pain /discomfort
- Uterine /cervical trauma (uncommon)
- Inability to do the procedure

Following the operation:

- Vaginal bleeding/discharge (usually minimal)
- Pain or discomfort in abdomen/ (usually helped by painkillers)
- Recurrence of polyps (occasionally)
- Infection (usually mild and easily treated by antibiotics)

Signature..... .....Name (PRINT).....Date_____/_____/_____

Job title.....Contact Details.....

GMC No. / NMC Pin No. / HPC No. / HPC Pre-Registered Group No.....

GIG NHS | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Outpatient Safer Procedure Checklist

Procedure planned:

Date: 18/2/20

SIGN IN (to be read out loud)

Before start of procedure

Do all members present know each other?
- ☑ Yes

Confirm patient identity (name and DOB), site (where applicable), procedure and consent?
- ☑ Yes

Are the emergency contact details recorded, if needed?
- ☑ Yes ☐ No

Does the patient have any allergies?
- ☑ Yes (verbally confirm & record in notes) ☐ No

Are there any identified medical problems?
- ☐ Yes (record in notes) ☑ No

Is the patient on any medications eg. anticoagulants?
- ☐ Yes (record in notes) ☑ No

Has the patient received pre-procedure information?
- ☑ Yes ☐ written ☐ verbal ☐ No

Is all required equipment and drugs checked and available?
- ☑ Yes

Pregnancy test done?
- ☑ Yes Result ☑ negative ~~☐ positive~~
- ☐ No: Reason:

Swab count done?
- ☐ Yes Number of swabs: 5

Does anyone (patient & staff) have any concerns ?
- ☐ Yes ☑ No

TIME OUT

Confirm everyone is ready – including the patient

SIGN OUT (to be read out loud)

On completion of procedure

Has the procedure been undertaken as planned?
- ☑ Yes
- ☐ No : Reason:

Is the patient comfortable?
- ☑ Yes ☐ No

Has the post-procedure information been given?
- ☑ Yes ☐ No ☐ N/A

Is a follow-up required?
- ☐ Yes ☑ No

All equipment disposed appropriately?
- ☑ Yes ☐ No

Swab count done?
- ☑ Yes Number of swabs: 5

Additional swabs if used : Number

Have specimens been labelled and checked?
- ☐ Yes ☐ No ☑ N/A

Form completed by:

Name: S/N C Jackson

Signature:

GMC/NMC No:

Date:

Countersignature by GMC/NMC No:

Cathenne Jackson
Staff Nurse
82A0152W

Mrs G Kumar
Consultant O&G
GMC No: 4577995

V 1.0 (10th) 03/04/2019

Survey of checklist usage in OPH

Compliance with Local Safety Standards for Invasive Procedures (LocSSIPs) in Gynaecology Outpatients: QI Project & Survey of service-user's experience

Dr Aishah Khanom, FY2; Dr Anu Ajakaiye, FY1; Mrs G Kumar, Cons
Wrexham Maelor Hospital

Quality Improvement & Audit Symposium
13th December 2019

GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.gov.wales

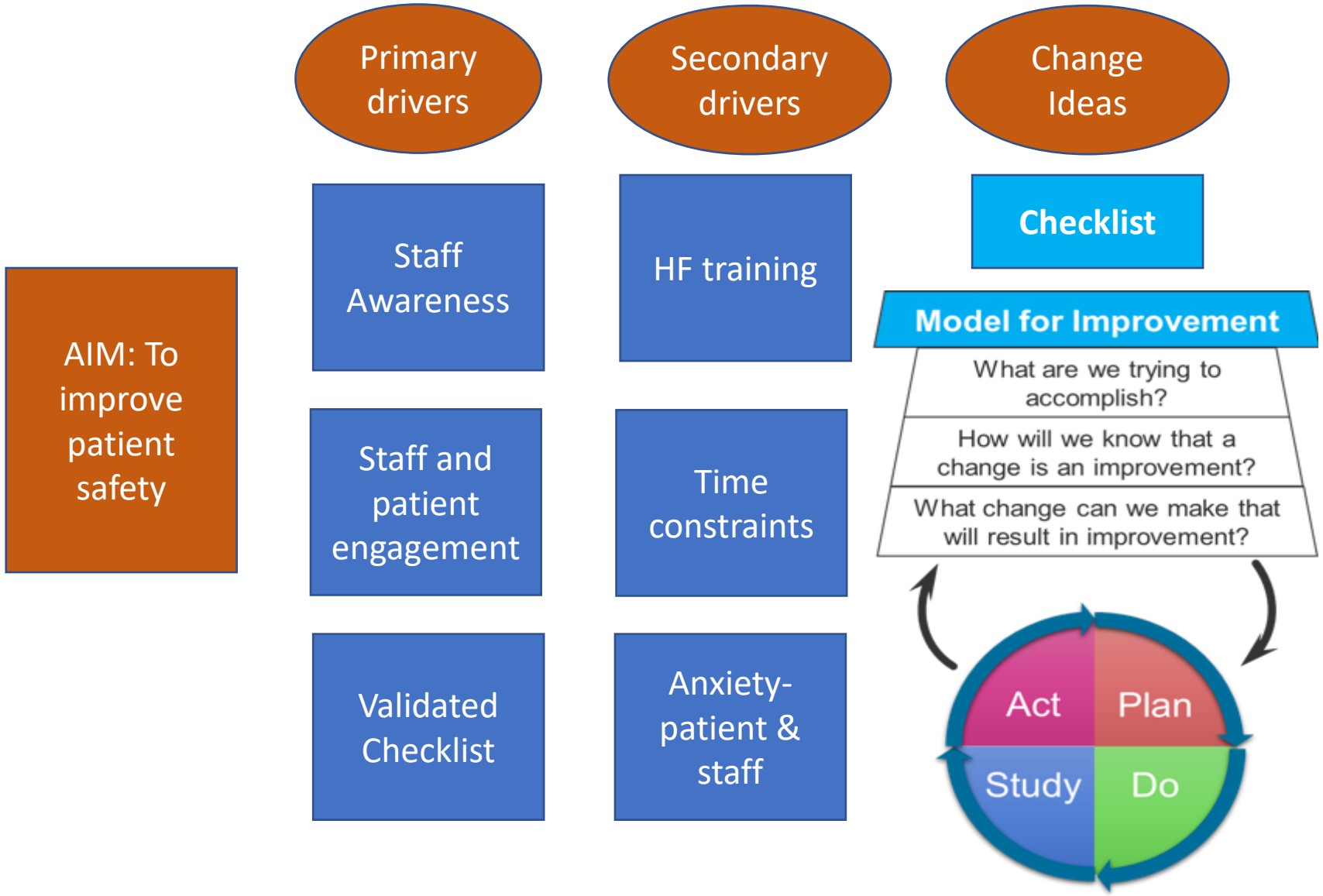
National Safety Standards for Invasive Procedures (NatSSIPs)

Amended for issue in Wales
September 2016

Objectives

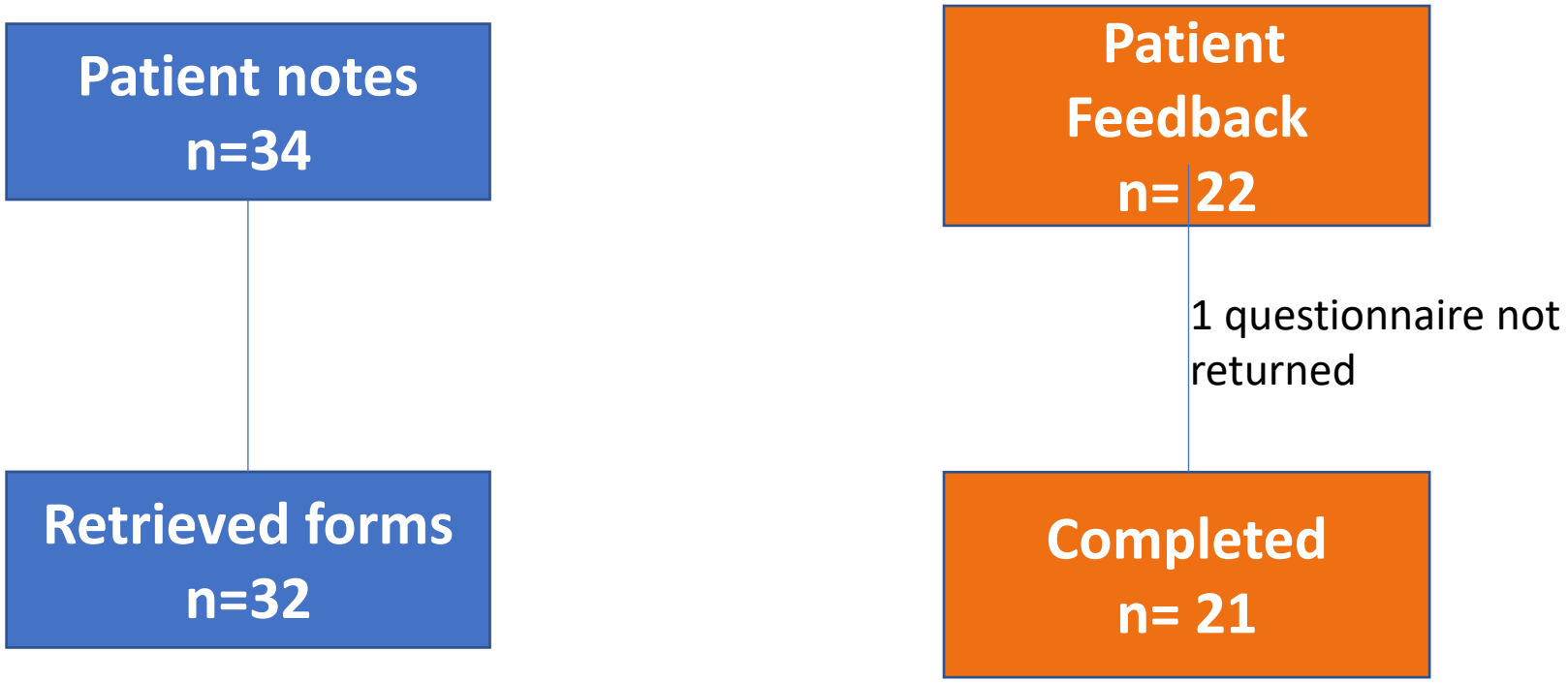
- Specific: To assess compliance with the newly introduced LocSSIP checklist in Gynae OPD & to assess patient's experience of the same
- Measurable: Validated checklist used across BCUHB filed in case-notes
- Achievable: Driven and motivated staff & small- scale project
- Relevant: Patient Safety & meeting National Standards
- Timely: Two-month period (February-March 2019)

Methodology: Driver Diagram

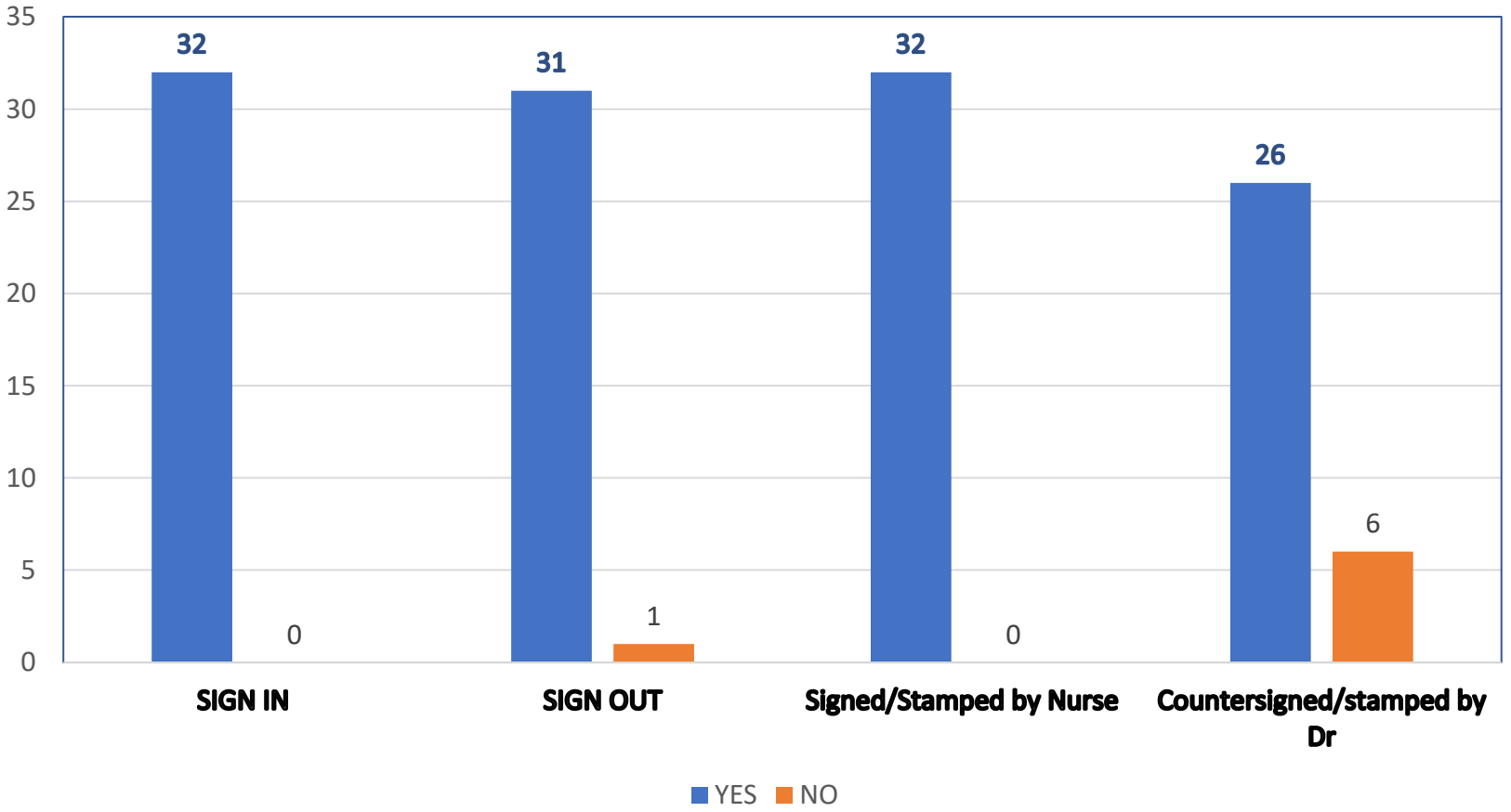


Methodology

- Contemporaneous review of case-notes from Gynaecology Out-Patient Hysteroscopy (OPH) clinic:



Results: Compliance with Checklist

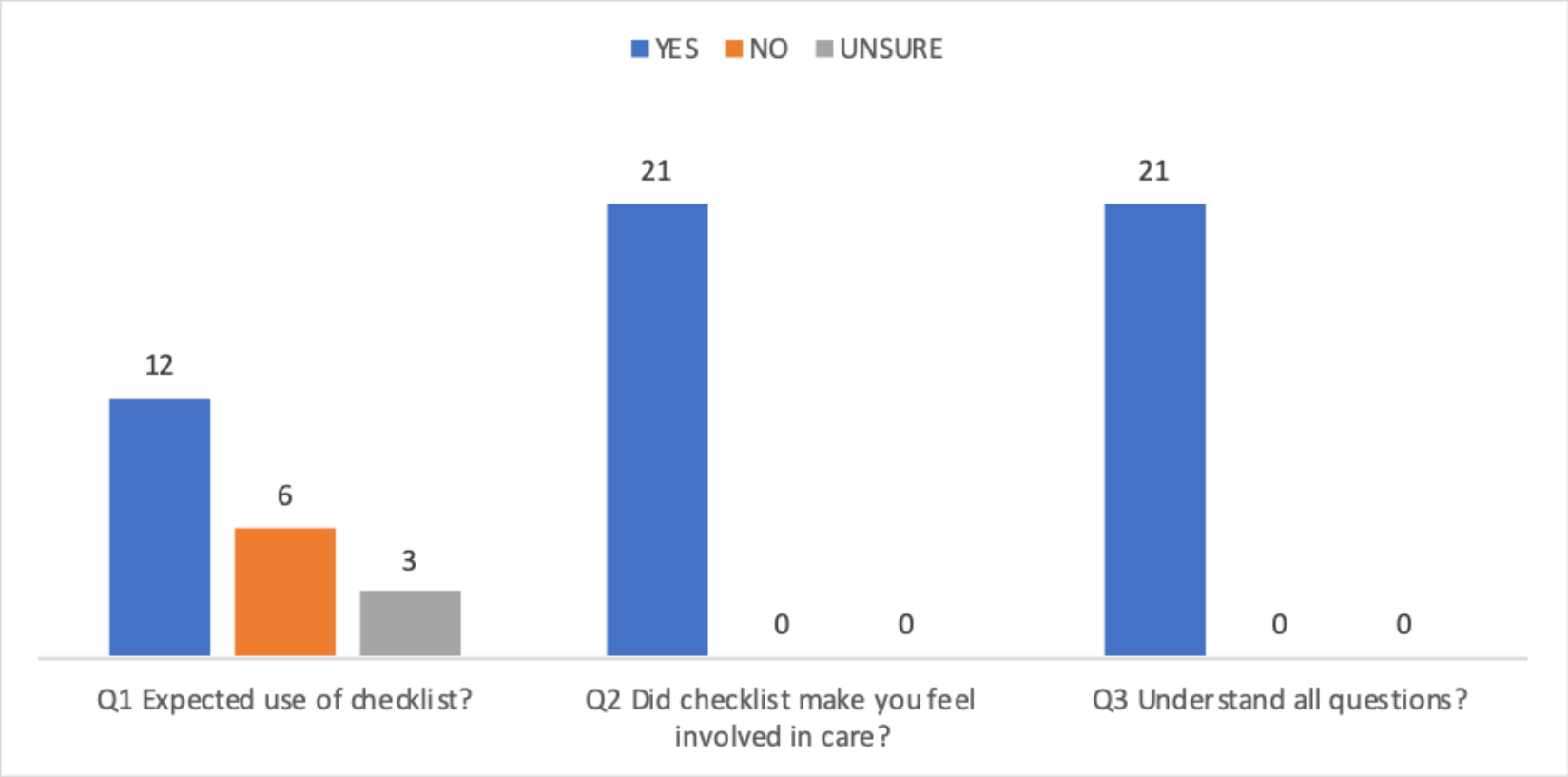


Results: Compliance with Checklist

- 100% compliance with the **Sign-in**
- 97% compliance with **Sign-out**
- 100% forms signed by nursing staff
- 81% compliance: Countersignature of doctor

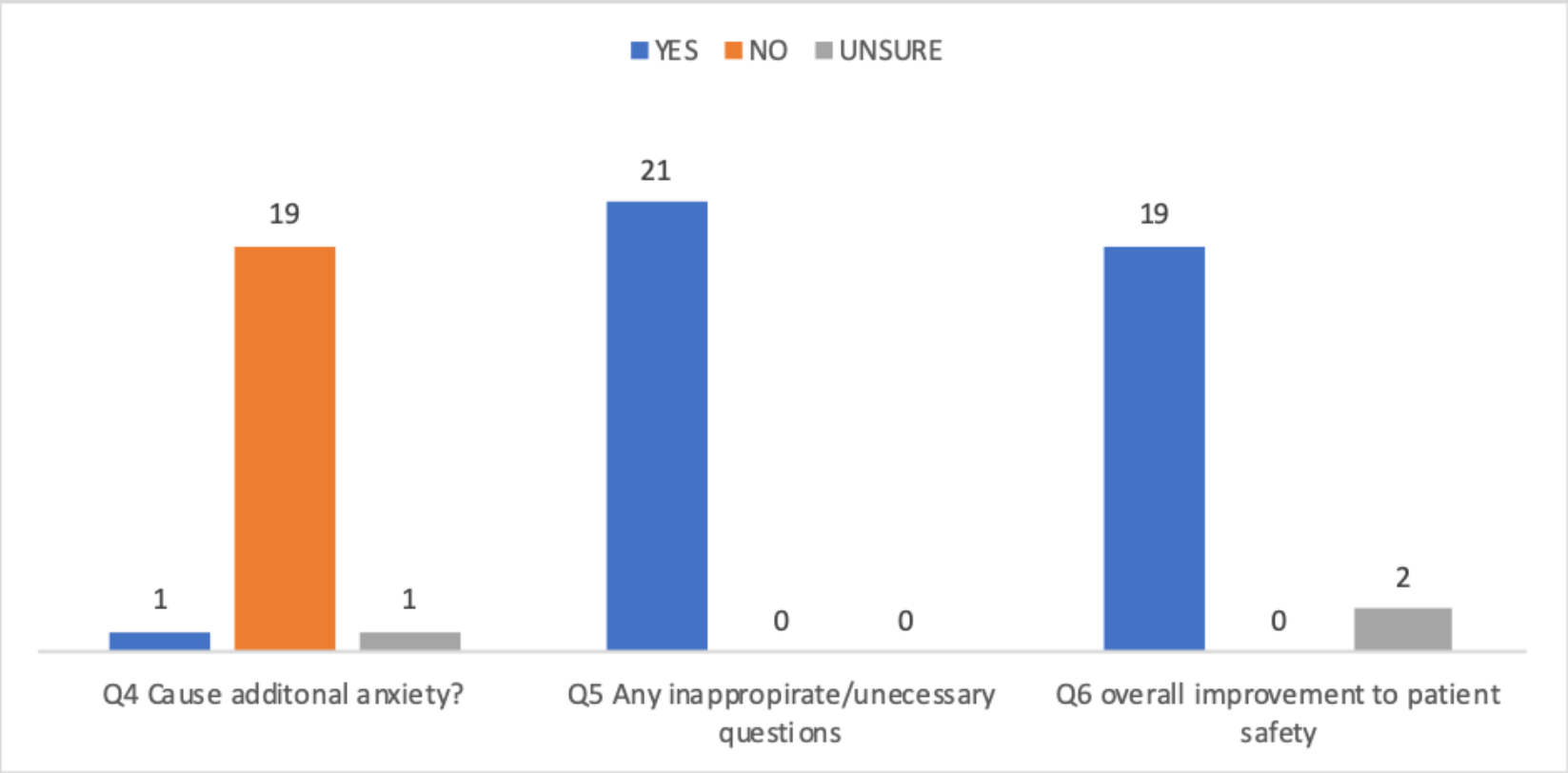
- **78%** : Full compliance with the checklist

Results: Patient Feedback



- All patients (100%) **felt** using the checklist involved them in their care-provision
- 56% expected use of such checklist prior to procedure

Results: Feedback



- 90% said the checklist did not cause additional anxiety
- 90% said it improved overall “Patient safety”

Conclusion

- 78% compliance with completion of a newly introduced checklist (LocSSIPs) in Gynae OP with positive service-user experience
- Small change impact: **Stamps** secured for all nursing staff in OPD: improved documentation & morale

Future

- Continuous measurement & improvement of practice: data from all Out-patient clinics
- Changes to be made as required & reviewed for improvement until we get it right &
- Sustain the improvement

Patient experience in outpatient hysteroscopy

Elizabeth Ball

MD, PhD, FRCOG
BartsHealth
Queen Mary University
City University, London, UK

Problems with consent

- Often done by junior doctors who may not have much experience
- Setting the indication –

  Benign conditions – patient must not be coerced

  Should the procedure be done at all?
- Permission to ‘opt out’ /abandon at any time is not mentioned

Problems with consent

- Women are unsure what to expect during an outpatient hysteroscopy
  - Scary consent conversation
  - ‘Playing down’ consent
  - Scary online content
  - Reading / language
  - Lacking details
  - Focus on medical issues / complications

Adding ‘Lived experience’ to consent

- Better preparation
- Complementing ‘medical’ consent information with women's’ voices
- Learning from MEMPHIS study
  - Co- development

Adding ‘Lived experience’ to consent

- Written testimony booklet
- BSGE/RCOG badges co developed film to aid consent for outpatient hysteroscopy

CITY
UNIVERSITY OF LONDON

Have you experienced hysteroscopy?

We would like to invite you to take part in our study

Who?
Women who have experienced outpatient hysteroscopy or have an interest in making patient information, we would like to hear from you.

What?
We are interested in your views about the best way of making an information video to show women before they give consent (or not) to having a hysteroscopy (telescopic examination of the inside of the womb) whilst awake. This will help make sure that women’s voices are heard and other women are given the best information to help them decide.

How?
If you would like to help us, we will ask you to come to a half-day workshop at City, University of London with an all-female team of researchers, gynaecologists, a film maker and a legal expert. We will also ask you to give feedback on the film via Skype.

Please get in touch with us if you are interested in taking part:-

Matthew Miles
Head of Patient & Public Involvement, Royal College of Obstetricians and Gynaecologists
Phone: 0207 772 6443, Email: mmiles@rcog.org.uk

- Barts charity funded
- Ethics application passed
- Collaboration with WAPH
- About to recruit from workshops

Music in the perioperative setting

- Barts team SR (Hole et al 2016)
- 6000 patients
- Pain VAS -2cm
- No side effects
- Own music and earphone(s) better

UNIVERSITY OF BIRMINGHAM

PRETH DE SILVA

UPDATING GTG 59: ANALGESIA, VAGINOSCOPY & LOCAL ANAESTHESIA

BSGE

ANALGESIA

- Systematic review and meta-analysi
- 22 studies for SR; 16 for MA
- All pre-procedural ana
  significantly reduced p
  after OPH:
  - NSAIDs
  - Opioids
  - Antispasmodics
  - Transcutaneous Electr
    Stimulation (TENS)
- HOWEVER, opioids and antispasmo
  were associated with a significant
  increase in side-effects

5. Analgesia

5.1 Do analgesics

Routine use of op
it may cause adv

Women without
doses of non-ster
scheduled outpat
immediate posto

ELSEVIER

JMIG The Journal of Minimally Invasive Gynecology

AAGL

Review Article

Analgesia for Office Hysteroscopy: A Systematic Review and Meta-analysis

Prathiba M. De Silva, BSc (Hons), MBBS, Ayesha Mahmud, PhD, MRCOG, Paul P. Smith, PhD, MRCOG, and T. Justin Clark, MD (Hons), FRCOG

From the College of Medical and Dental Sciences (Drs. De Silva and Smith), University of Birmingham, Birmingham, UK, Department of Obstetrics & Gynaecology (Dr. Mahmud), Walsall Manor Hospital, Walsall Healthcare NHS Trust, West Midlands, UK, and Department of Ambulatory Gynaecology (Professor Clark), Birmingham Women's Hospital, Birmingham Women's and Children's NHS Foundation Trust, Birmingham, UK

ABSTRACT **Objective:** To identify the most effective analgesia for women undergoing office hysteroscopy.

Data Sources: We searched Medline, Embase, the Cumulative Index to Nursing and Allied Health Literature, and the Cochrane Library from inception until August 2019 for studies that investigated the effect of different analgesics on pain control in office hysteroscopy.

Methods of Study Selection: We included randomized controlled trials that investigated the effect of analgesics on pain experienced by women undergoing diagnostic or operative hysteroscopy in an office setting compared with the control group.

Tabulation, Integration, and Results: The literature search returned 561 records. Twenty-two studies were selected for a systematic review, of which 16 were suitable for meta-analysis. There was a statistically significant reduction in pain during office hysteroscopy associated with preprocedural administration of nonsteroidal anti-inflammatory drugs (NSAIDs) (standardized mean difference [SMD] −0.72; 95% confidence interval [CI] −1.27 to −0.16), opioids (SMD −0.50; 95% CI −0.97 to −0.03), and antispasmodics (SMD −1.48; 95% CI −1.82 to −1.13), as well as with the use of transcutaneous electrical nerve stimulation (TENS) (SMD −0.99; 95% CI −1.67 to −0.31), compared with the control group. Moreover, similar reduction in pain was observed after office hysteroscopy: NSAIDs (SMD −0.55; 95% CI −0.97 to −0.13), opioids (SMD −0.73; 95% CI −1.07 to −0.39), antispasmodics (SMD −1.02; 95% CI −1.34 to −0.69), and TENS (SMD −0.54; 95% CI −0.95 to −0.12). Significantly reduced pain scores with oral NSAID administration during (SMD −0.87; 95% CI −1.59 to −0.15) and after (SMD −0.56; 95% CI −1.02 to −0.10) office hysteroscopy were seen in contrast to other routes. Significantly more adverse effects were reported with the use of opioids ($p < .001$) and antispasmodics ($p < .001$) when compared with the control group, in contrast to NSAIDs ($p = .97$) and TENS ($p = .63$).

Conclusion: Women without contraindications should be advised to take oral NSAIDs before undergoing office hysteroscopy to reduce pain during and after the procedure. TENS should be considered as an alternative analgesic in women with contraindications to NSAIDs. Journal of Minimally Invasive Gynecology (2020) 00, 1–14.

BSGE

VAGINOSCOPY

- Systematic review and meta-analysis
- 7 for SR; 6 for MA
- When compared with routine speculum use, vaginoscopy was significantly
  - Less painful
  - Associated with a lower incidence of vasovagal reactions
  - Quicker

11. Vaginoscopy

11.1 Does a vaginoscopic approach to outpatient hysteroscopy reduce pain and increase the feasibility of the procedure?

Vaginoscopy reduces pain during diagnostic rigid outpatient hysteroscopy.

Vaginoscopy should be the standard technique for outpatient hysteroscopy, especially where successful insertion of a vaginal speculum is anticipated to be difficult and where blind endometrial biopsy is not required.

LOCAL ANAESTHESIA

9.2 Should topical local anaesthetic be administered before outpatient hysteroscopy?

Instillation of local anaesthetic into the cervical canal does not reduce pain associated with diagnostic hysteroscopy.

Topical application of local anaesthetic to the ectocervix before application of a cervical tenaculum is necessary.

9.3 Should injectable local anaesthetic be administered to the cervix and/or paracervix before outpatient hysteroscopy?

Application of local anaesthetic into or around the cervix is associated with a reduction of the pain experienced during outpatient diagnostic hysteroscopy. However, it is unclear how clinically significant this reduction in pain is. Consideration should be given to the routine administration of intracervical or paracervical local anaesthetic, particularly in postmenopausal women.

Miniaturisation of hysteroscopes and increasing use of the vaginoscopic technique may diminish any advantage of intracervical or paracervical anaesthesia. Routine administration of intracervical or paracervical local anaesthetic should be used where larger diameter hysteroscopes are being employed (outer diameter greater than 5 mm) and where the need for cervical dilatation is anticipated (e.g. cervical stenosis).

Routine administration of intracervical or paracervical local anaesthetic is not indicated to reduce the incidence of vasovagal reactions.

BSGE

- Systematic review and meta-analysis
- 37 studies for SR; 20 for MA
- Local anaesthesia was associated with:
  - Significantly reduced pain **during** and **after** OPH
  - No sig. dif. in success or vasovagal rate
- Individual SGA showed that **all** types and routes of local anaesthesia significantly reduce pain **during** OPH
- Will our overall message change?
  - **Routine** local anaesthesia administration is not recommended in the context of smaller-diameter scopes allowing for vaginoscopy
  - Where cervical dilatation is anticipated, local anaesthesia should be considered

Current Training in Hysteroscopy IS FIT FOR PURPOSE

Biggest Proof

FOR this Notion is

ALL OF YOU IN ATTENDANCE TODAY!

Current Training in Hysteroscopy IS FIT FOR PURPOSE

1. An overview of the current curriculum of RCOG ATSM in Benign Gynaecological Surgery: Hysteroscopy (BGSH)

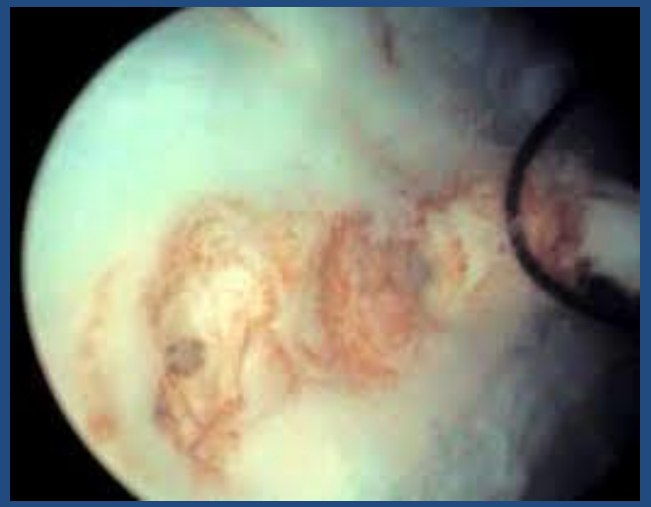
2. Better than the old hysteroscopy curriculum which was certainly NOT fit for purpose

3. Positives: Holistic approach to surgical skills
   - Encompassing the required competencies to run an ambulatory hysteroscopy service

Simulation Training models at various courses

Vegetable model ↙

Animal model
Pig heart or
Pig bladder ↗



Prodelphus Eve trainer ➔

BGSH CiP1

BGSH CiP 1: The doctor demonstrates skills and attitudes to manage the care of women requiring hysteroscopic surgery.	
Key Skills	**Descriptors**
Preoperative planning and case selection	• Counsels on the management options of benign gynaecological conditions. • Counsels women on the benefits, risks and alternatives in the surgical approach. • Conducts appropriate preoperative investigations. • Appropriately triages patients to inpatient or outpatient pathway.
Manages hysteroscopic surgery relying on a number of techniques and procedures	• Manages difficult cervical dilation. • Manages complications intra- and postoperatively. • Demonstrates safe use of mechanical instrumentation (conventional and tissue removal systems). • Demonstrates safe use of electro-surgery. • Demonstrates safe use of hysteroscopic fluid management.
Manages outpatient hysteroscopy	• Demonstrates awareness of outpatient methods of diagnosis and treatment. • Performs diagnostic and simple operative procedures where appropriate. • Applies principles of best practice in outpatient hysteroscopy.
Manages advanced outpatient procedures	• Counsels on and performs outpatient procedures where appropriate.

BGSH CiP 2

BGSH CiP 2: The doctor demonstrates the skills to develop and manage a hysteroscopy service.	
Key Skills	**Descriptors**
Demonstrates service development	• Liaises with management teams and Clinical Commissioning Groups. • Has an understanding of financial considerations. • Participates in clinical governance experience. • Demonstrates involvement in quality improvement. • Is able to undertake data analysis and collection related to outcomes.
Develops clinical guidelines and patient information	• Is aware of available sources of both written and web-based information. • Designs or adapts patient information for local use and understands local process. • Participates in writing protocols, clinical pathways, service development and evidence-based guidelines. • Establishes and/or enhances local clinical pathways.

Procedures	*Level by end of training*	*CIP 1*
Hysteroscopic biopsy / removal of foreign bodies	5	X
Hysteroscopic polypectomy	5	X
First generation ablations	5	X
Resect submucous fibroids (FIGO type 0-1)	5	
Resect submucous fibroids (FIGO type 2)	5	X
Resect filmy intrauterine adhesions without cavity distortion / incomplete septum	4	X
Resect fibrous intrauterine adhesions / complete septum	1	X
Second generation ablations	5	X

Table 3 – Levels of supervision

Level	**Descriptor**
Level 1	Entrusted to observe
Level 2	Entrusted to act under direct supervision: (within sight of the supervisor).
Level 3	Entrusted to act under indirect supervision: (supervisor immediately available on site if needed to provide direct supervision)
Level 4	Entrusted to act independently with support (supervisor not required to be immediately available on site, but there is provision for advice or to attend if required)
Level 5	Entrusted to act independently

NOTSS

Non-Technical Skills for Surgeons (NOTSS) - new

The NOTSS system provides a framework and common terminology for rating and giving feedback on non-technical skills. Used in conjunction with medical knowledge and clinical skills, NOTSS is a tool to observe and rate behaviour in theatre in a structured manner. This enables clear and transparent assessment of training needs. NOTSS describes the main observable non-technical skills associated with good surgical practice, under the following headings:

- Situation awareness
- Decision making
- Communication and teamwork
- Leadership.

Extremely Useful for trainees to achieve consultant level ability to manage own clinic/ work-load/ prioritise

Conclusion

1. Hysteroscopy Training for O&G trainees as well as Nurses/ GPs is the way forward to meet the increasing demand
2. Improved format of curriculum now in BGSH integrates ambulatory hysteroscopy
3. Current Hysteroscopy Training IS FIT FOR PURPOSE and I support this notion!

Thank you

shilpakolhe@nhs.net

Statement

Current nurse hysteroscopy training fully meets the needs of today's modern ambulatory services

Gillian Smith, Nurse Consultant & Clinical Lead for Ambulatory Gynaecology Services
Northampton General Hospital NHS Trust

Reason

Longevity, first NH qualified in 2002
Academic & Professional recognition
Evidence based training
Robust training & assessment method
Experienced in-house training & mentoring
Supported service development
Critical thinking skills supports one-stop services

Evidence

Ludkin H, Quinn P (2002) Extended training equips nurses to undertake diagnostic hysteroscopy, Nursing Times, 20;98(34):38-9

Ludkin H, Quinn P *et al* (2003) The benefits of setting up a nurse hysteroscopy service, Professional Nurse, 19(4):220-2.

Jones S (2005) The role of the nurse hysteroscopist , Elsevier, 5(3): 196-199

Pansini-Murrell J (2010) Scoping the reality of nurse hysteroscopists: A case study, https://www.semanticscholar.org

Evidence

Debate Birmingham February 2020

Against Nurse hysteroscopy Training

Bradford Training

- Current nurse Training:-
- Competency Log book to be signed by trainer/trainers (minimum 50 direct, 100 indirect)
- Audit of practice against a national or local standard (2500 words)
- Portfolio including 6 case studies of different pathologies (2 IUS inserted)(6000words)
- OSCE including MCQ (2.5 hours) (6 stations)

Against

1) No one from university goes out to jointly assess the students, mentors can teach such different things eg: some make students use speculum and volsellum for a diagnostic scope.

2) No set instruction in log book GA/office hysteroscopy, would be good for student to get experience in both.

3) Nationally we don’t know how many nurse hysteroscopists there are, no register, no governance,

- 4) clinics can be nurse led but the training programme doesn't include prescribing or management of ovarian cysts.

Ablation and Mirena

Which?

Why? Who?

Both?

Mirena

Explain what it is, how it works, and why it shouldn't be confused with copper coils

- **Good news**
- 85% less blood loss
- Excellent Rx for dysmenorrhoea
- 5 year lifespan
- Safety, cancer, infection
- Popular with professionals
- Contraception / HRT
- Reversible
- Not an operation
- Challenge the myths…my friend had one and……
- Good if endometriosis
- Good if adenomyosis
- NICE
- Avoids hysterectomy

- **Bad news**
- Concept of 'thing inside'
- It's a hormone Rx
- Initial bleeding pattern
- 5% removed for problems
- Procedure to fit
- Expulsion/misplaced
- Perforation
- Very common misconceptions

Ablation (Novasure)

- Good news
- Decent success rates if amenorrhoea not required
- Avoids hysterectomy
- Safe, rapid recovery
- LA option
- Non hormonal
- One off Rx
- Mirena also?

- Bad news
- Individualised outcome quote 30/40/30%
- Thermal injury
- Perforation
- Difficulty with PMB/Mirena
- Adenomyosis and endometriosis failures (pain)
- Late failures
- Can’t be redone
- Cost vs mirena
- Poor results in younger women

Careful patient counselling

Careful patient selection

Individualised approach

NICE supports both

Poorer success rates as anatomy deviates from normal

Mirena first generally

Can insert Mirena at time of Novasure but not later

Mirena suits the ‘one-stop’ clinic approach

Influenced by local results in that when Novasure adopted liberally, long term results poorer than published outcomes

The advent of safe laparoscopic hysterectomy can influence the counselling

PMB pathway

Wessex Cancer Network
Urgent Gynaecology Cancer Suspected Cancer Referral

Endometrial cancer
☐ Aged ≥55 with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause).
☐ Consider if aged <55 with post-menopausal bleeding

Triage letter 2WW team
TVS
Biopsy > 4 mm
Then decide re hysteroscopy
Scope all women on Tamoxifen
MDC for polyps

Management of endometrial cancer:
https://.bgcs.org.uk/wp-content/uploads/2019/05/BGCS-Endometrial-Guidelines-2017.pdf

What do you do?
What works well for you?

- Do you have a clear separation between the 2WW and ‘benign’ pathways?
- How do you organize the scan/pipelle/oph?
- See and treat polyps?
- Who is the practitioner?

Ambulatory Hysteroscopy Meeting 2020

(Birmingham, February 2020)

Unusual cases or complications

Paul Smith BSci (Hons), MBChB (Hons), PhD, MRCOG

Advanced laparoscopic and NIHR post-doctoral research fellow

Birmingham Women's Hospital & University of Birmingham
United Kingdom

BSGE

Background

- 77yr old Caucasian female presented with 2 month Hx of brown vaginal discharge
- Medical co-morbidities including heart failure, hypertension and dementia
- Both TVS and and vaginal examination were abandoned due to patient distress
- TAS indicated an ET of 4mm which was regular in outline
- She had presented 20 mth earlier with light vaginal bleeding where clinical examination and TAS were considered normal

Procedure

- In view of re-presentation and suboptimal work-up OPH was arranged
- Vaginoscopy was used to show a normal cervix that led unto a uterine cavity filled with turbid material consistent with chronic pyometria
- Patient discomfort curtailed the procedure such that a clear view of the cavity following irrigation could not be obtained.
- An aspiration biopsy was performed for histological and microbiological analysis.

Post-procedure

- Patient clinically stable and comfortable and discharged with oral Abx and follow-up in 6 weeks.
- Within 3 hrs admitted with septic shock.
- Treated on ITU with care including: central lines, high dose intravenous antibiotics, respiratory and cardiac support with inotropes.
- Failed to respond and died 4 days later

Results of investigations/post mortem

- Microbiology:
  - Intrauterine pus sample reported heavy growth of anaerobes and *Gardnerella*
  - Blood cultures showed *E. coli*
- Endometrial histology - “the presence of pyometra with ulceration of the endometrial surface”.
- No uterine or visceral injury was found at post-mortem
- The coroner recorded the verdict of death as “anaerobic bacterial sepsis following instrumentation of the endometrial cavity and endometrial sampling for pyometra”.

If you diagnose a chronic pyometra during an outpatient hysteroscopy when investigating a woman for post-menopausal bleeding, do you:

- Irrigate the uterine cavity to remove purulent material?
- Yes 52% (BSGE survey of people routinely performing hysteroscopy n=140)

- Take an endometrial sample for histology?
- Yes 100%

- Take an endometrial sample for microbiology?
- Yes 83%

The patient is well immediately following the hysteroscopy. Regarding the post procedural care would you:

- 1) Allow the patient to go home in accordance with your standard outpatient hysteroscopy practice
- 2) Observe the patient for an additional period of time on a hospital ward or recovery area
- 3) Admit the patient to hospital

- 1=77%; 2=16%; 3=6%

The patient is apyrexial. Would you:

- 1) Prescribe a course of oral antibiotics
- 2) Prescribe an intravenous antibiotic

- 1) 61%; 2) 7% ; ?no antibiotics 32%

Does anyone else have any interesting cases or complications they would like to share?

“MY EXPERIENCE, PRACTICE DEVELOPMENT AND PRACTICAL REFLECTIONS IN OUTPATIENT HYSTEROSCOPY”

BSGE Ambulatory Care Network Annual Meeting

Birmingham February 2020

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

No disclosures in the UK or elsewhere

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

Hysteroscopic surgery –

My transition from hospital to office

With focus on challenges, stumbling blocks and learning points of interest to a broader audience

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

My approach

Treatments had to

- **Be safe and effective –** *patient perspective*
- **Be performable by the general hysteroscopist –** *clinicians perspective*
- **Cause a reasonable level of expenses –** *financial perspective*

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

The setting

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

BSGE AMBULATORY CARE NETWORK ANNUAL MEETING
BIRMINGHAM FEBRUARY 2020

No access to

- Theatre
- Anaesthesiologist
- General anaesthesia
- Emergency care
- Gynaecologist on call 24/7

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Started in January 2002

- **Resections of polyps and fibromas using the twizzle electrode**

- **Endometrial ablations using the Novasure device**

Under either intracervical or paracervical block

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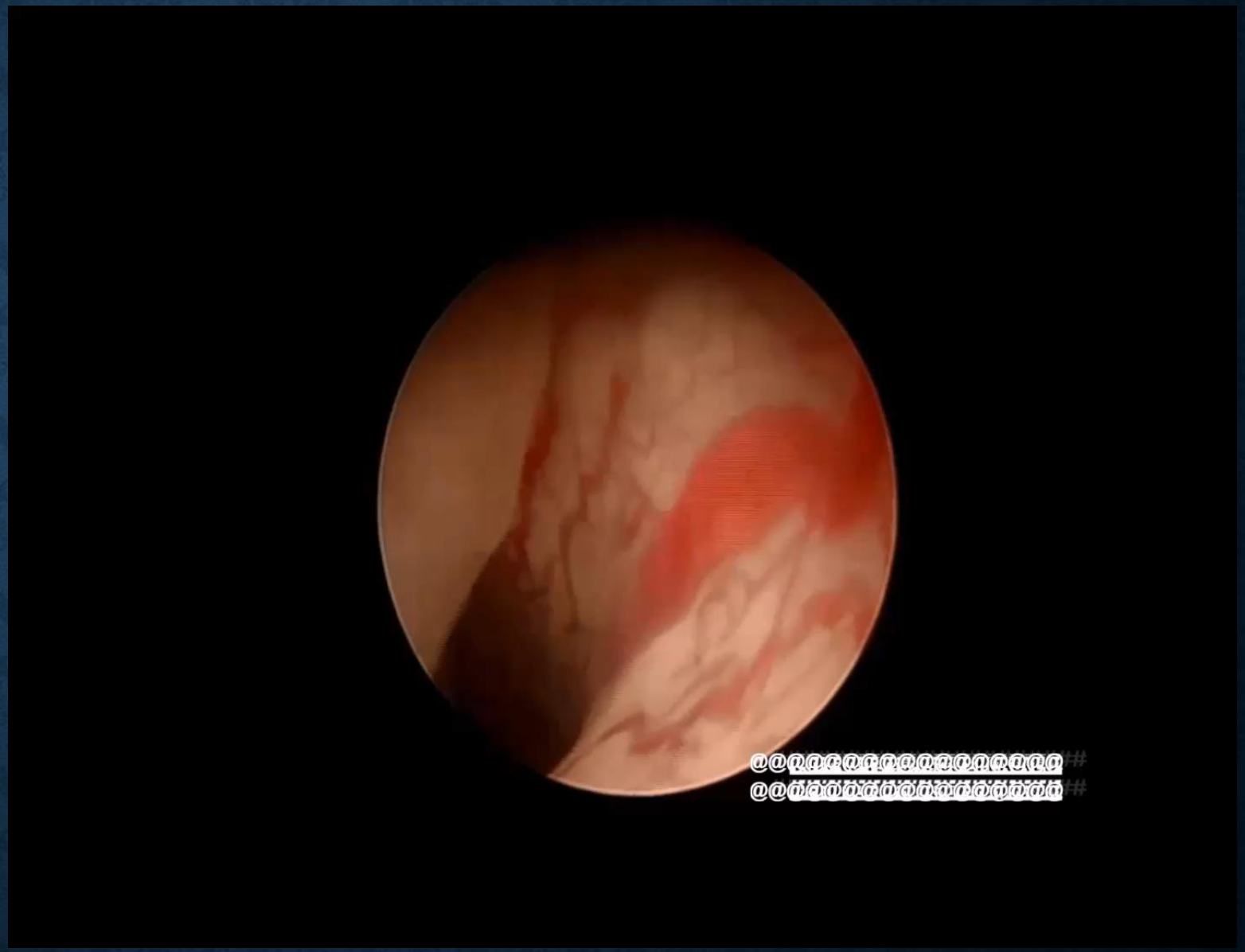
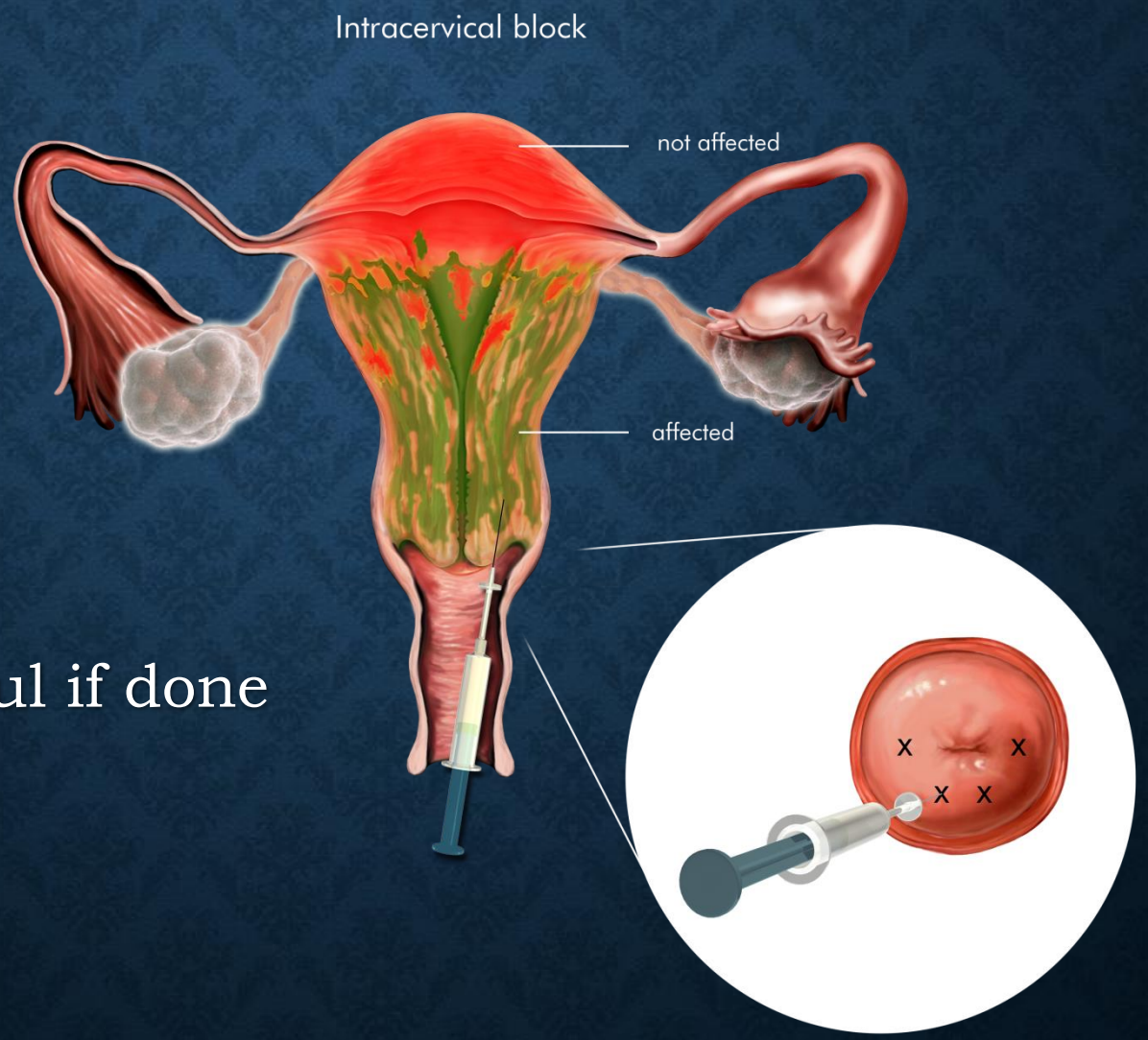
- Removal of polyp with twizzle electrode under intracervical block



Intracervical Block



Effect often patchy

Effect unpredictable

Injection can be painful if done too quickly

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If you have lost her, you have lost it

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Surgeon's stress

derived from the unpredictability of the course of events

Will the next sweep of the electrode make her scream and jump out of the chair ?

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First obstacle

Effective Pain Management

The lack hereof limited the group of patients I could treat

- The older woman
- The nervous woman
- The women with large uteruses

And the procedures were stressful

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Skensved's 1st law on hysteroscopic surgery

When using gravity or a cuff for fluid mangement:

The pressure always drops just when you need it the most

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An irrigation pump

- Frees staff to concentrate on the patient and the procedure
- Enables the hysteroscopist to have her sole focus on the procedure and the patient

Novasure endometrial ablation

- All treatments were timed according to cycle
- Woman accompanied by spouse, relative or acquaintance

Pain management

Paracervical block: 4 x 10 ml of 2% Ropivacaine

Rescue analgesia: ½ - 1 ml Alfentanil intravenously

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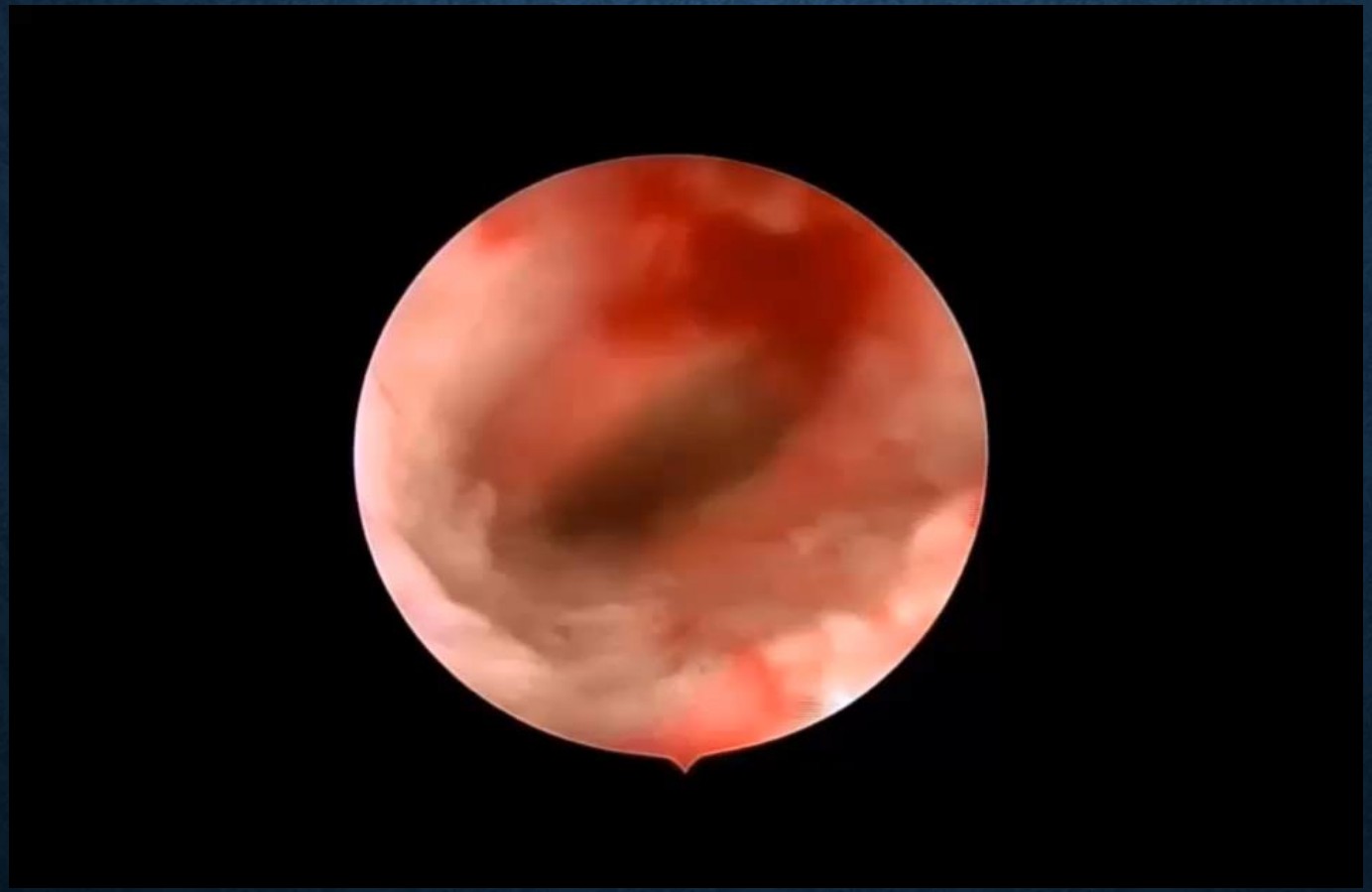

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Cyclical timing of endometrial ablations leads to

- Shorter treatments (up to twice the ablation time on thicker endometrium)
- Shorter periods of pain stimulus
- Shortened time to cessation of discharge

Second challenge

73% of the women treated asked for Alfentanil

The logistics were not on my side:

- Treatments to be booked according to cycle, her work schedule – and that of her escort
- Need of a recovery room
- Need of assistant to tend to the woman
- Risk of calls to the surgeon on the night following the procedure

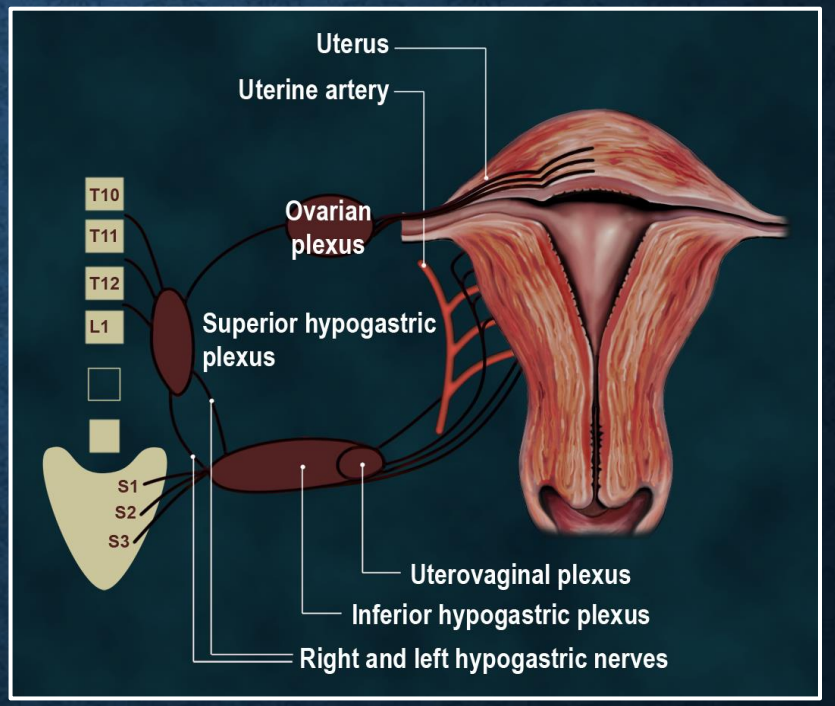
French study on surgical abortions

Mean pain scores (VAS)	PC group	IC group	p
	(n = 124)	(n = 125)	
Dysmenorrhoea	3.9 ± 2.8	3.5 ± 2.5	0.1877
Insertion of an intravenous catheter	2.4 ± 2.4	2.0 ± 1.9	0.2886
Arrival in the operative room	0.8 ± 1.6	0.8 ± 1.7	0.9960
Insertion of speculum pain	2.4 ± 2.4	2.8 ± 2.3	0.1763
Local anaesthetic injection pain	2.5 ± 2.1	3.9 ± 2.4	<0.0001
Cervical dilatation pain	4.1 ± 2.8	4.8 ± 2.8	0.0608
Aspiration pain	6.2 ± 2.8	6.6 ± 2.6	0.3259
Pain scores seen by the physician	3.8 ± 2.4	3.7 ± 2.2	0.6696
Pain scores seen by the nurse	4.4 ± 2.2	4.7 ± 2.0	0.3219
Pain 1 h after the procedure	2.1 ± 2.6	1.8 ± 2.2	0.3683
Pain 4 h after the procedure	0.2 ± 0.7	0.3 ± 1.0	0.3530

The innervation of the uterus

- The upper third by nerves from T10 – L1 through the superior hypogastric plexus - which is not reachable through para- or intracervical injection

- The lower two thirds by nerves from S1 – S3 through the inferior hypogastric plexus - which can be reached by the paracervical route



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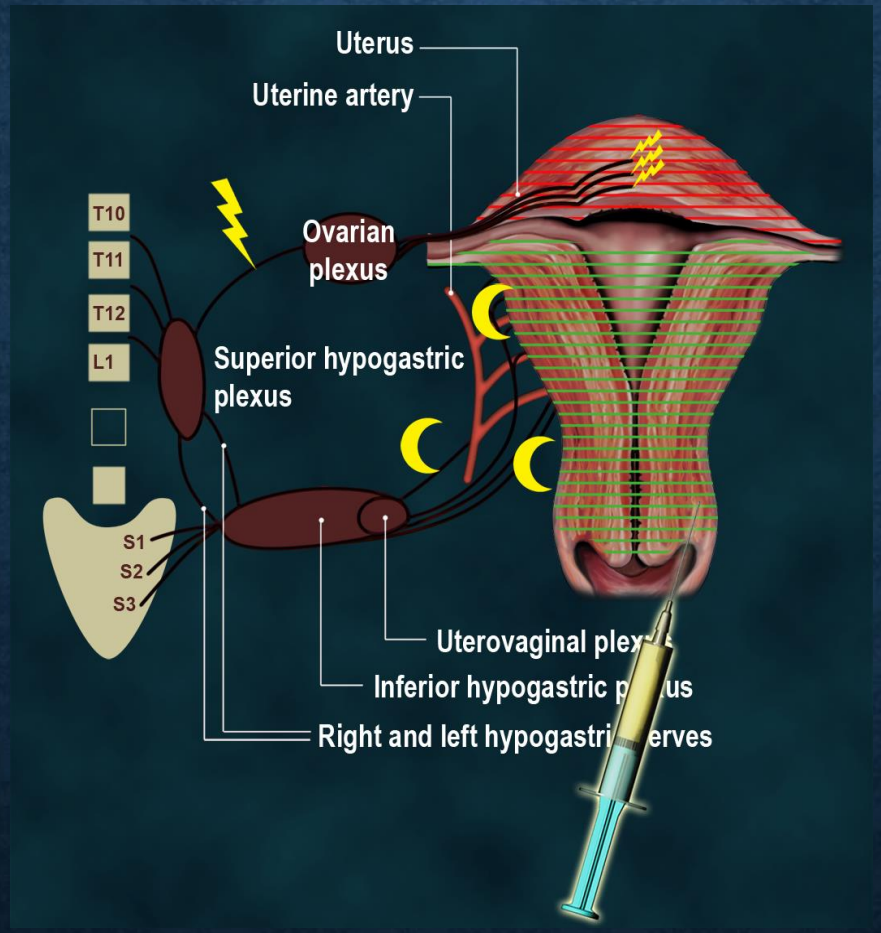
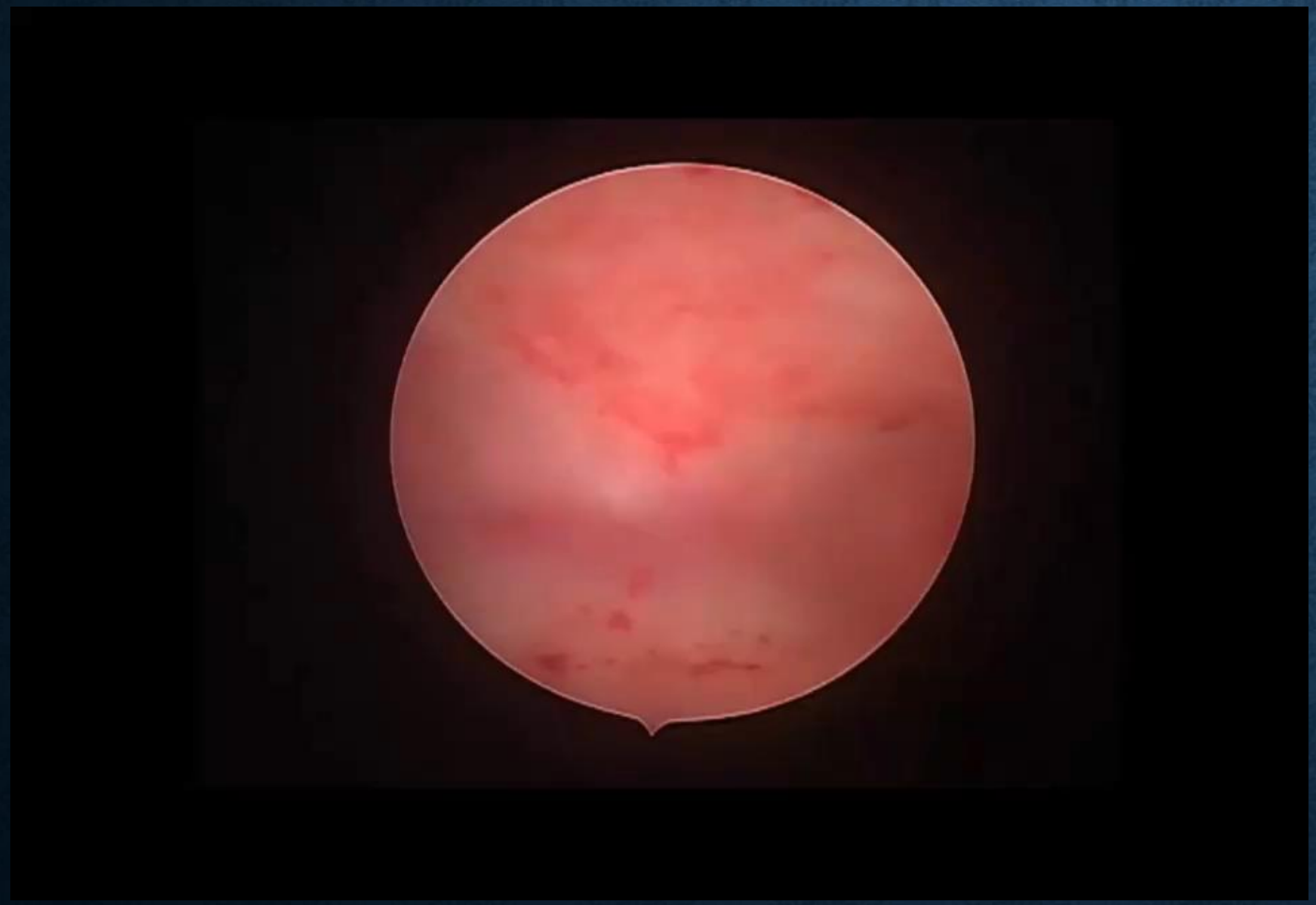


The *focal local* for resection of polyp at base (Postmenopausal bleeding)



The fundal block

Fundal injection of local anaesthesia supplementing the paracervical block before endometrial ablation

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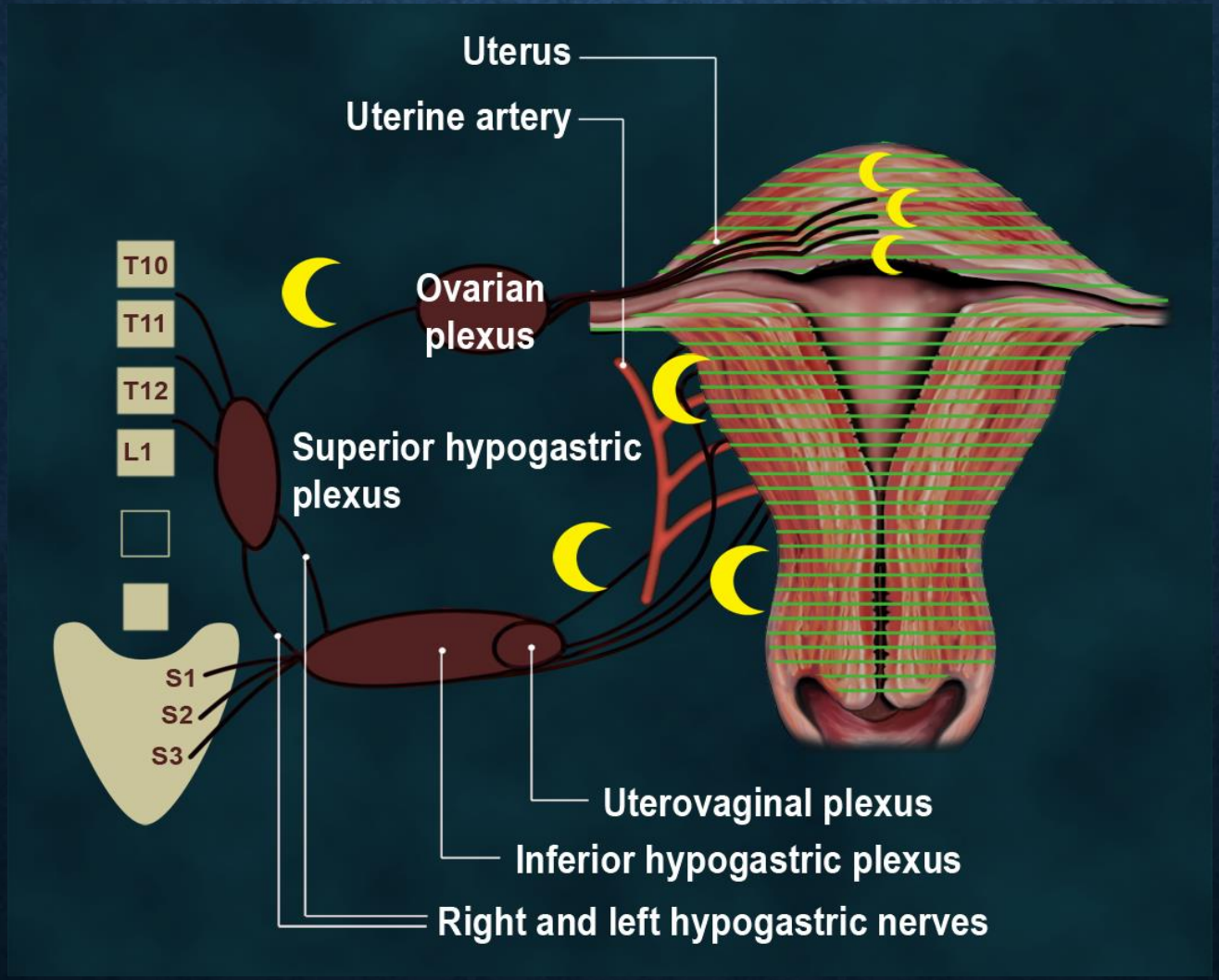

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The fundal block enables me to

- Perform ablations without conscious sedation at a VAS score of 0-2
- Allow the women to drive to the clinic and home
- Make bookings less complicated
- Remove polyps and fibroids on a wider range of women (23 – 90 y)
- Be more relaxed during procedures
- Skip the recovery room
- Sleep at night

Logistics solved

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Challenge number 3

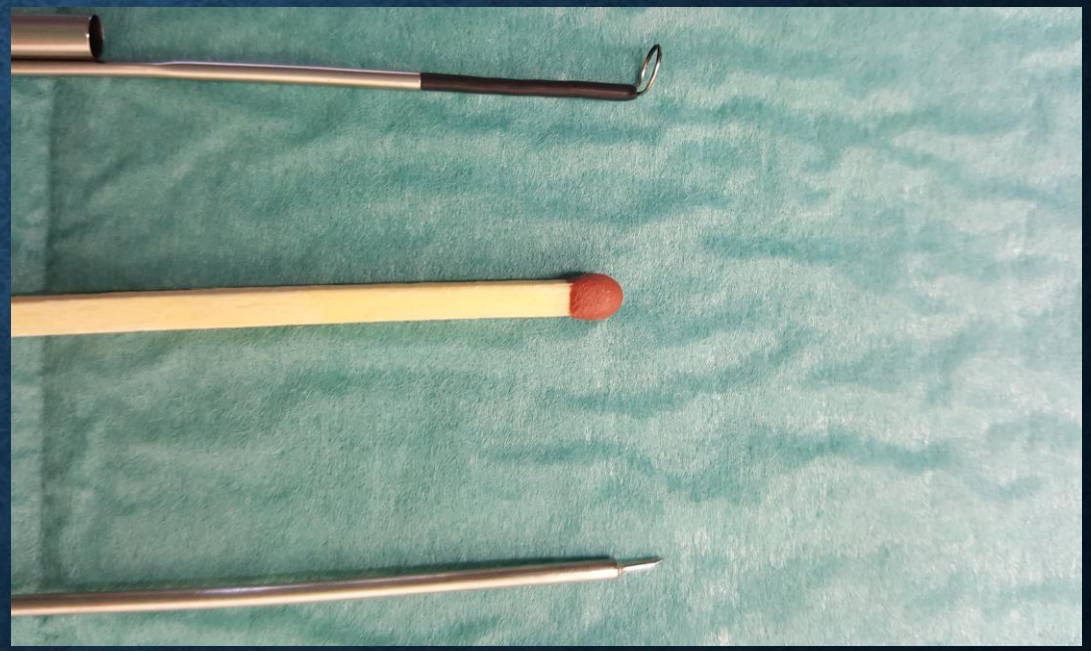
- Poor results from blind endometrial biopsies (BEB) in women with postmenopausal bleeding (30-40% without tissue)

- BEB very painful (Pipelle, 6.21 ± 2.41 cm; Explora, 6.91 ± 2.88 cm)

- Missed hyperplasia and cancer even in cases with normal histology on BEB (van Hanegem)

The 15 Fr micro-resectoscope

- Hysteroscopically guided endometrial biopsies – also from the cervical canal
- Removal of polyps and smaller fibroids
- Seldom need for dilatation of the cervical canal – also in postmenopausal women



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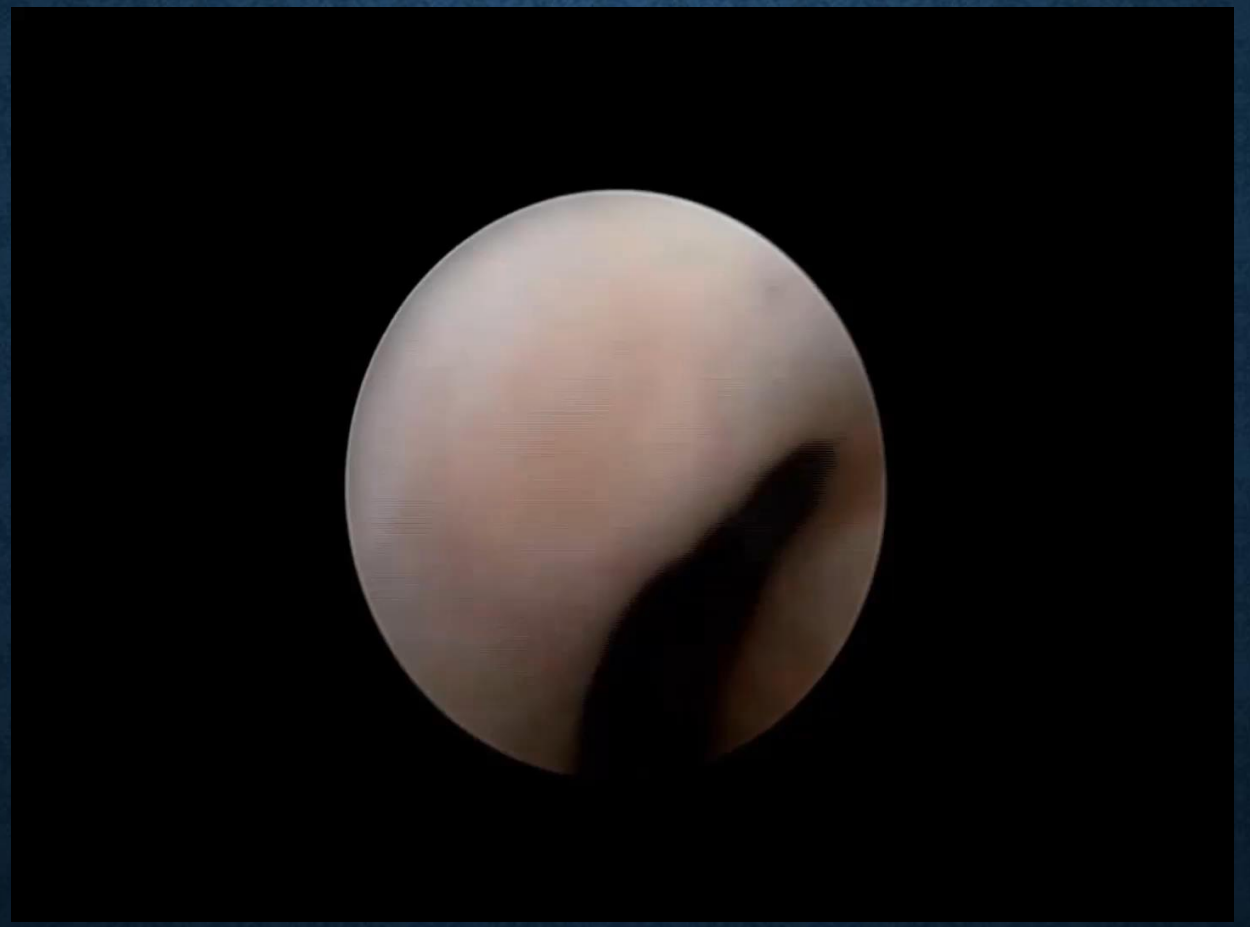

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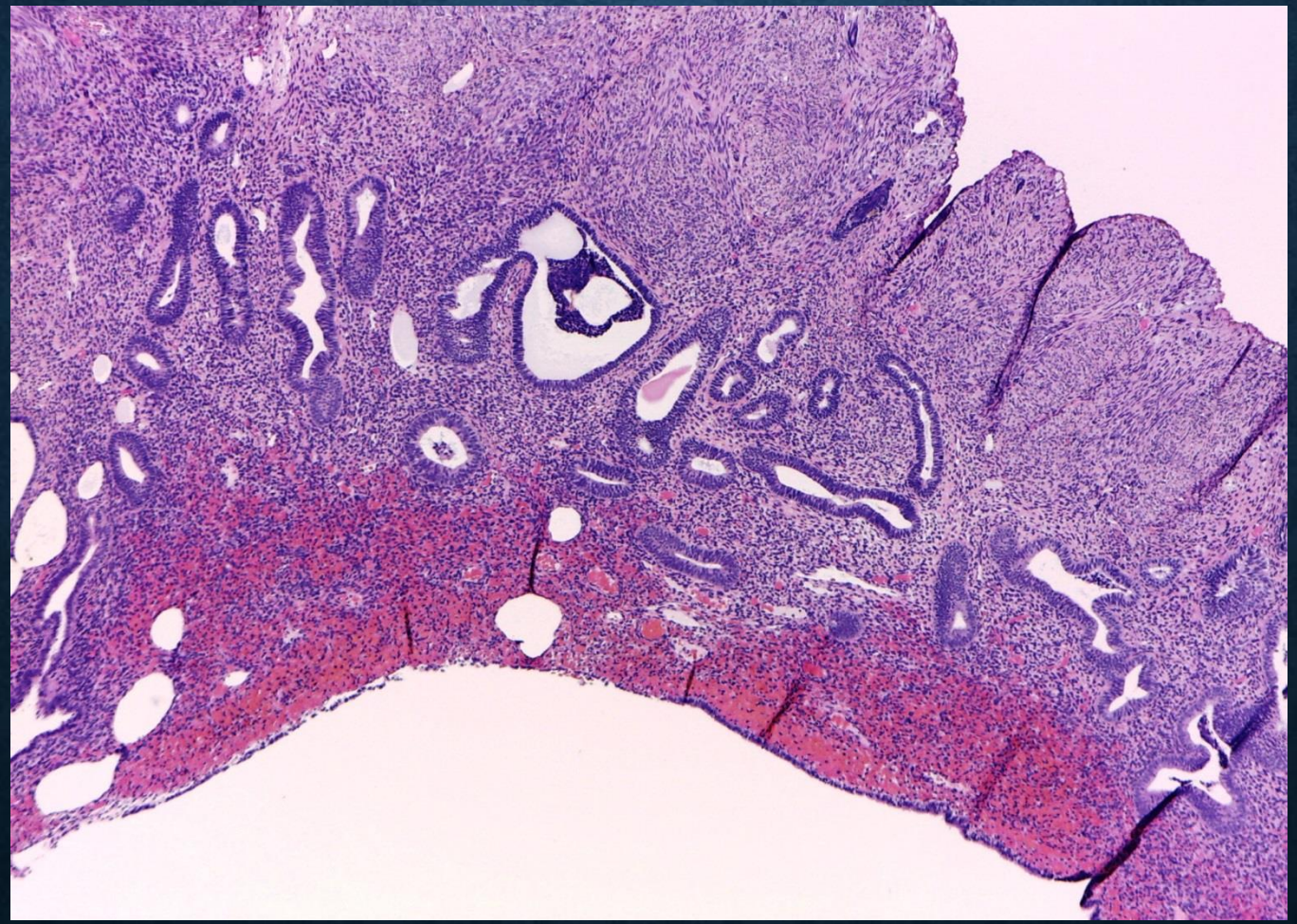

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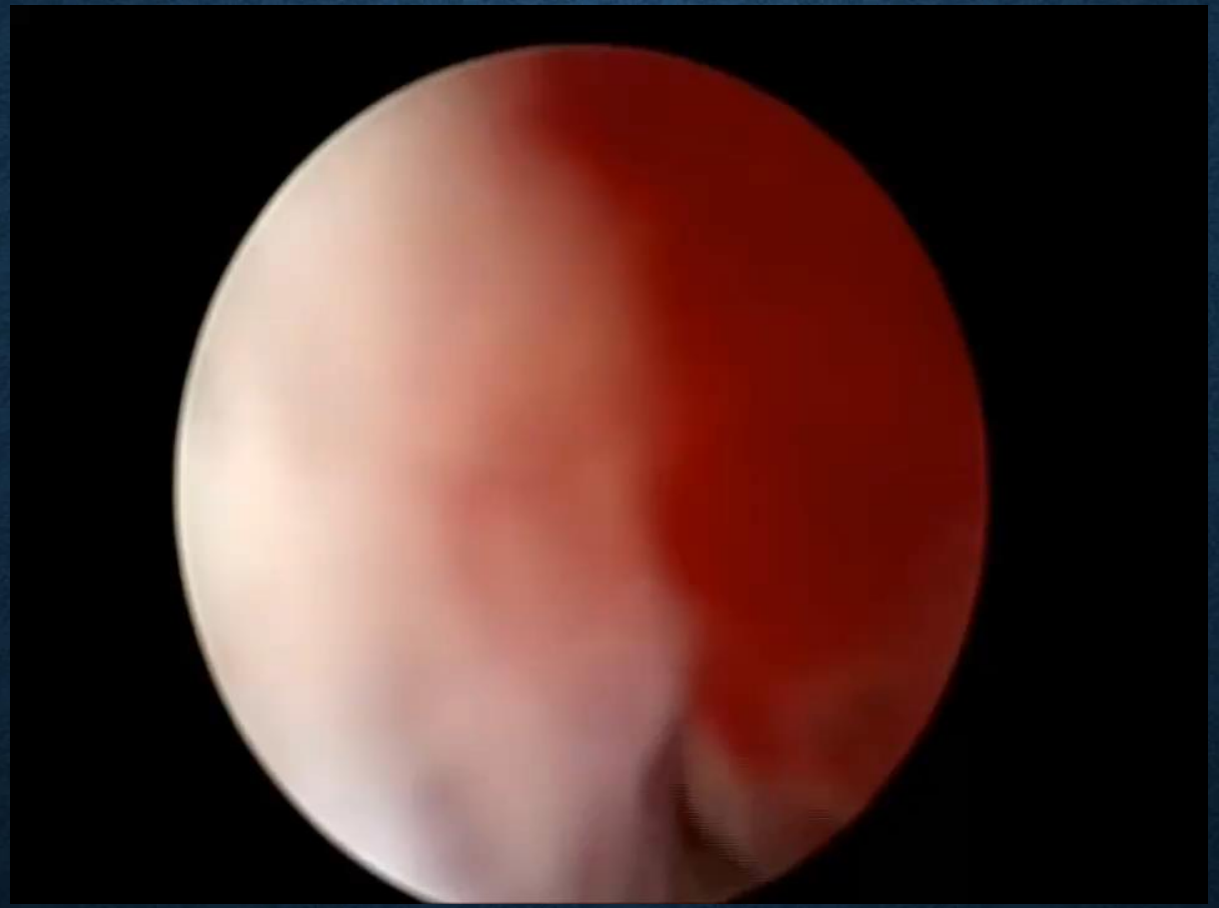

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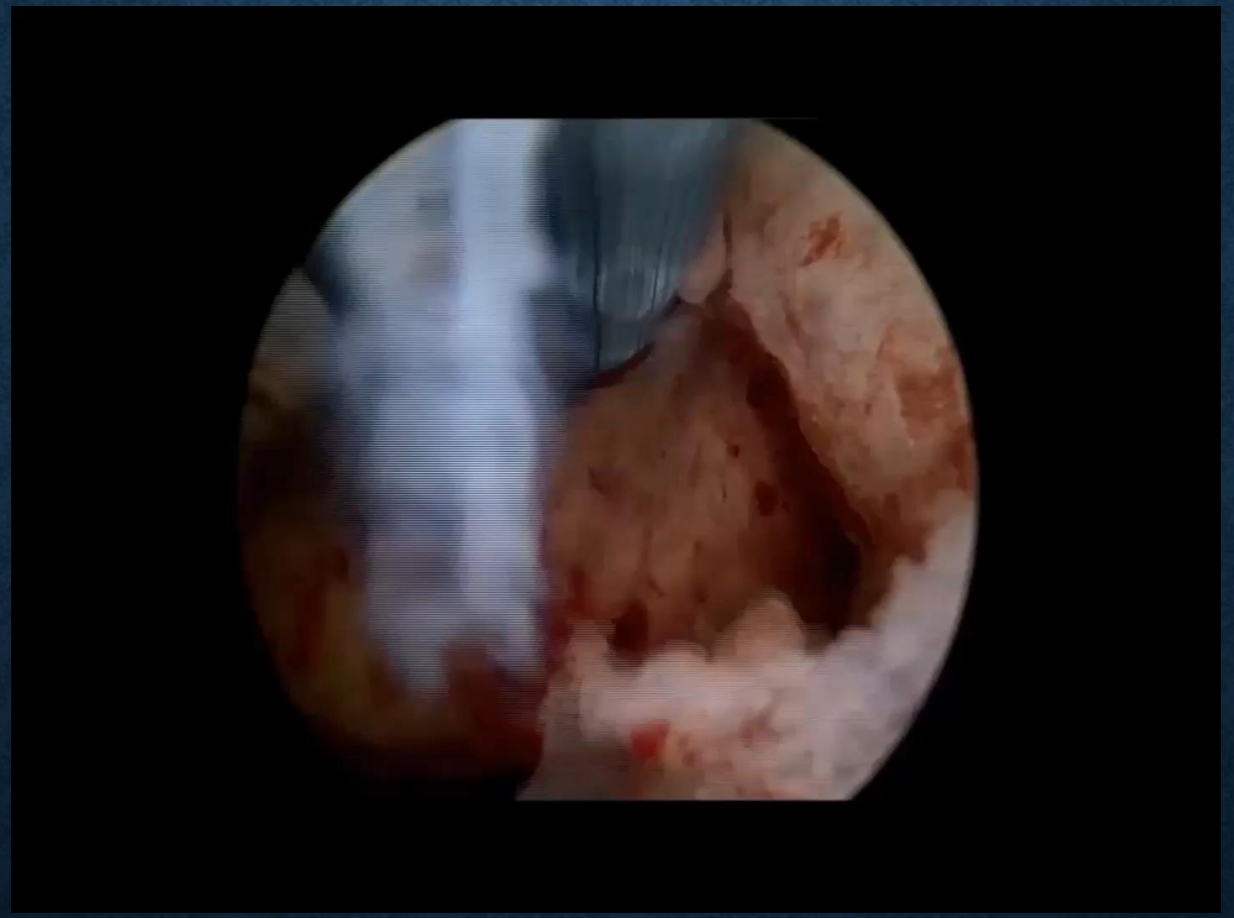

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Felypressin (Phenylalanine Lysine Vasopressin) is a weak(er) vasopressin agonist added to local anaesthetics in order to increase the duration of anaesthetisation and reduce the risk of toxicity during dental procedures.

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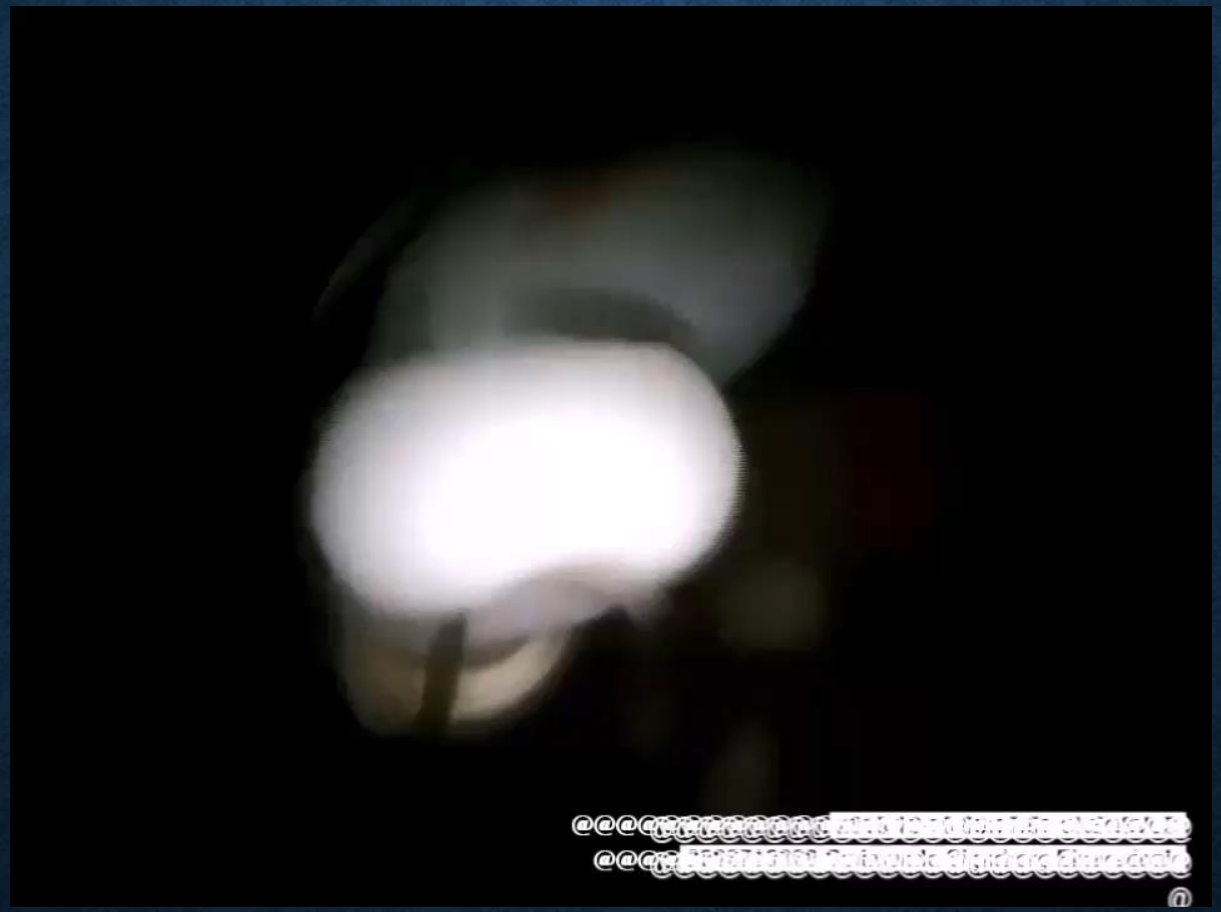

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Pain and risk of fluid absorption have been eliminated

I safely perform the following with pain scores of 0 -3:

- Endometrial ablation
- Endometrial resection
- Polyp and fibroid resections (depending on size)
- Septae resection
- Ashermann's syndrome (iatrogenic and lighter cases)
- Investigating postmenopausal bleeding

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My entire nursing staff

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What have I learned from these 20 years?

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It is all about confidence building – from start to finish

Establishing a contact – and a tacid contract

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Same doctor (and same nurse) for first visit and treatment

Patient selection

- Gynaecological (stay within reasonable boundaries)
- Physical (ASA group 1-2)
- Psychological (fear vs loss of control)

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Written information plus E-mail access

No queries left unanswered when she returns for treatment

A “leisurely” atmosphere – sending a signal of “this is no big thing”)

- Woman wearing her own clothes
- No green tiles on the walls
- No anaesthesia cart

Doctor's patience

- Place the local slowly
- Wait until it is effective ('I'll give an extra two minutes to be sure')
- We cover her while waiting – signals concern of her integrity

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Woman has her own monitor

The majority wants to look at what you are doing

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The hysteroscopist in contact with the woman

- It is about contact not distraction
- Show a keen interest in more than her uterus

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- Telephone number to call at night

  Conveys a sense of security – which is why they never call

- Call by nurse next morning to learn about the night

  We learn what works and what doesn't e.g. pain relief after Novasure

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Not all doctors and not all nurses are comfortable with or suited for handling treatments under local

– which should be acknowledged and appreciated

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Limitations, not abundance lead to innovation and progress

Thank you
for your patience

Research, innovations, hot topics and future ACN collaborative projects

Must read papers

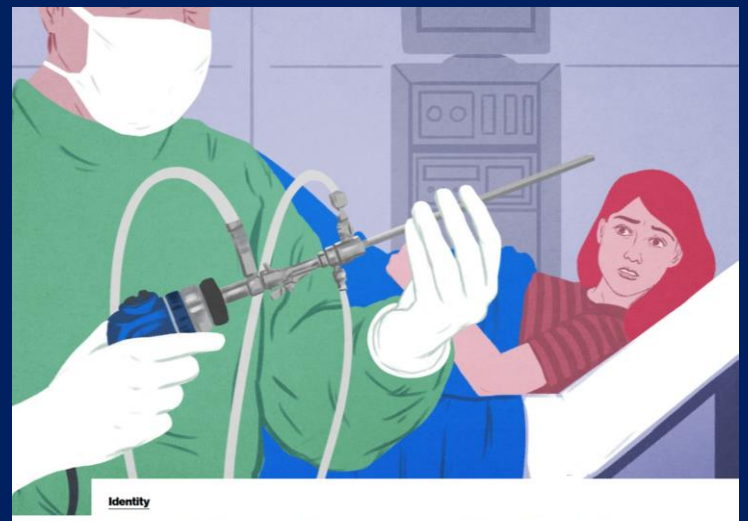
Must know technologies

Horizon scanning – what will ambulatory care look like in 20 years

BSGESICS

Guideline development e.g. PMB, outpatient endometrial ablation protocols, bleeding disorders etc.

Hot Topics



Identity

When Women Are Denied Pain Relief During Invasive Procedures

In the UK, hysteroscopies – a procedure by which doctors examine the inside of the uterus – are routinely performed without any form of pain relief. For some women, the experience can be unbearably painful, and traumatizing.

By Jessica Furseth

Jan 16 2019, 5:52pm Share Tweet Snap

www.vice.com/en_us/article/zmdday/is-hysteroscopy-painful-womens-health

change.org

End barbaric NHS ... **relief**

Campaign Against Painful Hysteroscopy started this petition to The Right Hon Matt Hancock, MP (Secretary of State for Health)

The Campaign Against Painful Hysteroscopy www.hysteroscopyaction.org.uk has amassed hundreds of stories of severely painful NHS outpatient hysteroscopies performed with no or inadequate pain-relief on women of all ages, shapes and sizes. Many patients have gone on to suffer PTSD. None have been warned of the <25% risk of severe pain reported in recent NHS audits.

The words our campaign hears over and over are **'barbaric'**, **'medieval'**, **'torture'** and **'violated'**. Many women weep, faint or vomit.

UK Parliament

Parliamentary Business MPs, Lords and Offices About Parliament

Hansard Commons Lords About

House of Commons **Hansard**

Contents / Westminster Hall

House of Commons data for 29 January 2020 is currently being processed. Data for this date may tem

NHS: Hysteroscopies

Share

11 December 2018

Volume 651

Many women experience severe pain during hysteroscopy. It is usually done with little or no anaesthetic, and many women are told nothing to prepare them for the agony that awaits.

Must Read Papers

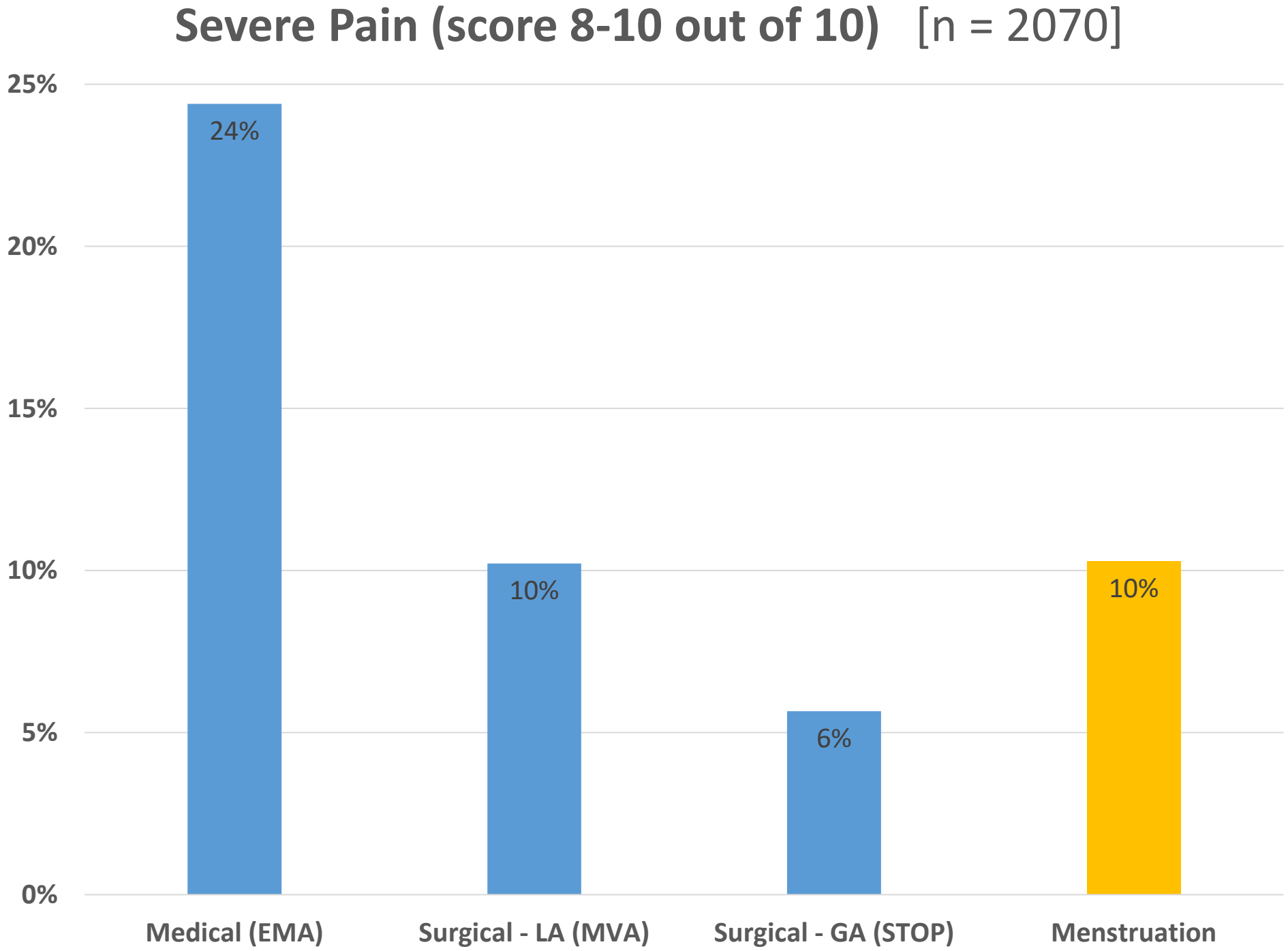
Published Guidelines / Review –
Society of Family Planning

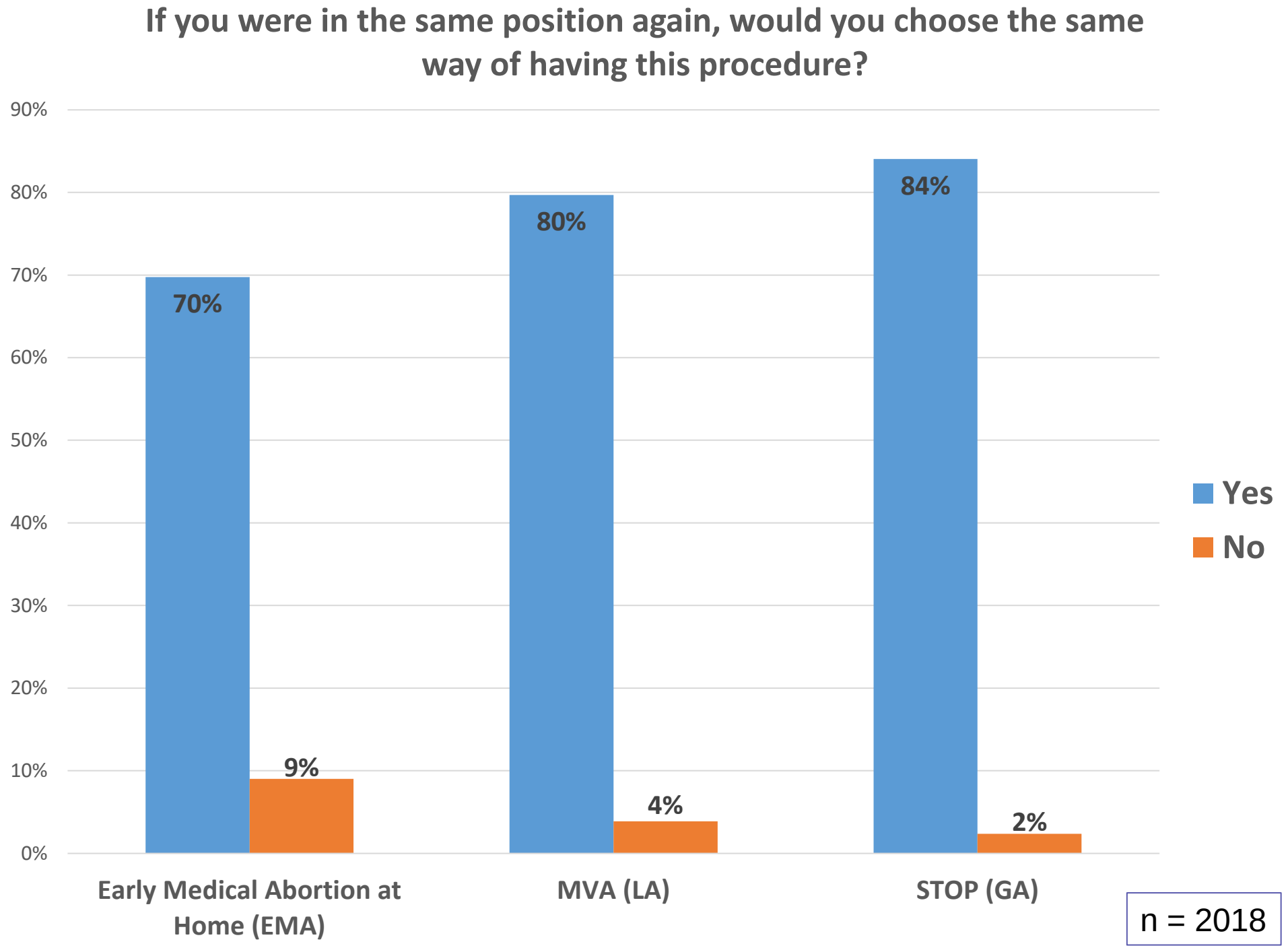
Some evidence for:

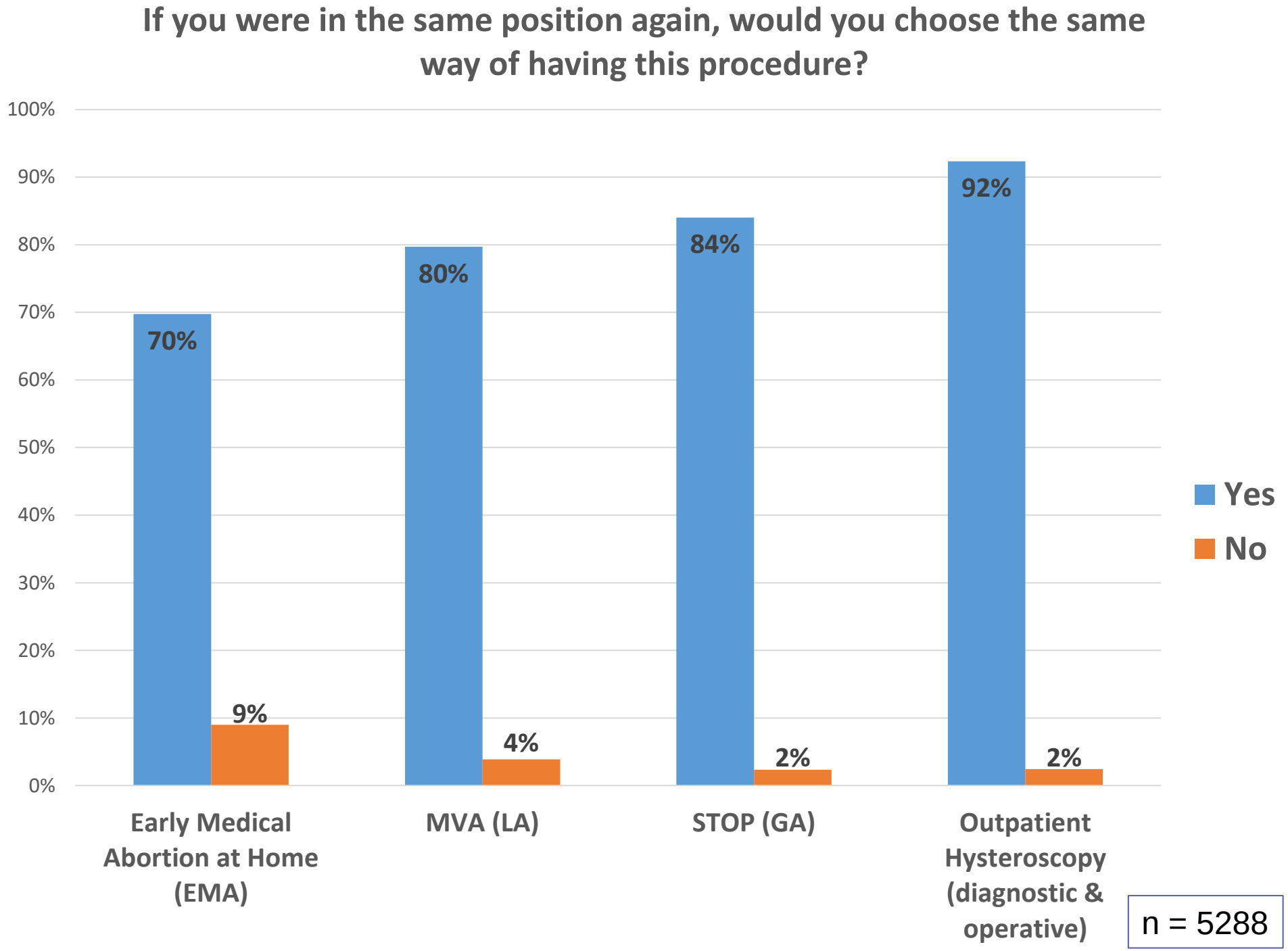
- Preoperative NSAIDs
- High vs low volumes (20mls vs 10mls)
- Buffered vs acidic lignocaine
  (1 mL of 8.4% sodium bicarbonate for every 10 mL of anaesthetic solution)
- Slow vs fast injection
- Deep para-cervical vs shallow (1.5cm)
- Addition of 4% intrauterine lignocaine vs 1% or placebo
- No pain reduction from: lorazepam, oral opioids, Entonox, cervical preparation, wait up to 3 mins

20mls buffered para-cervical block

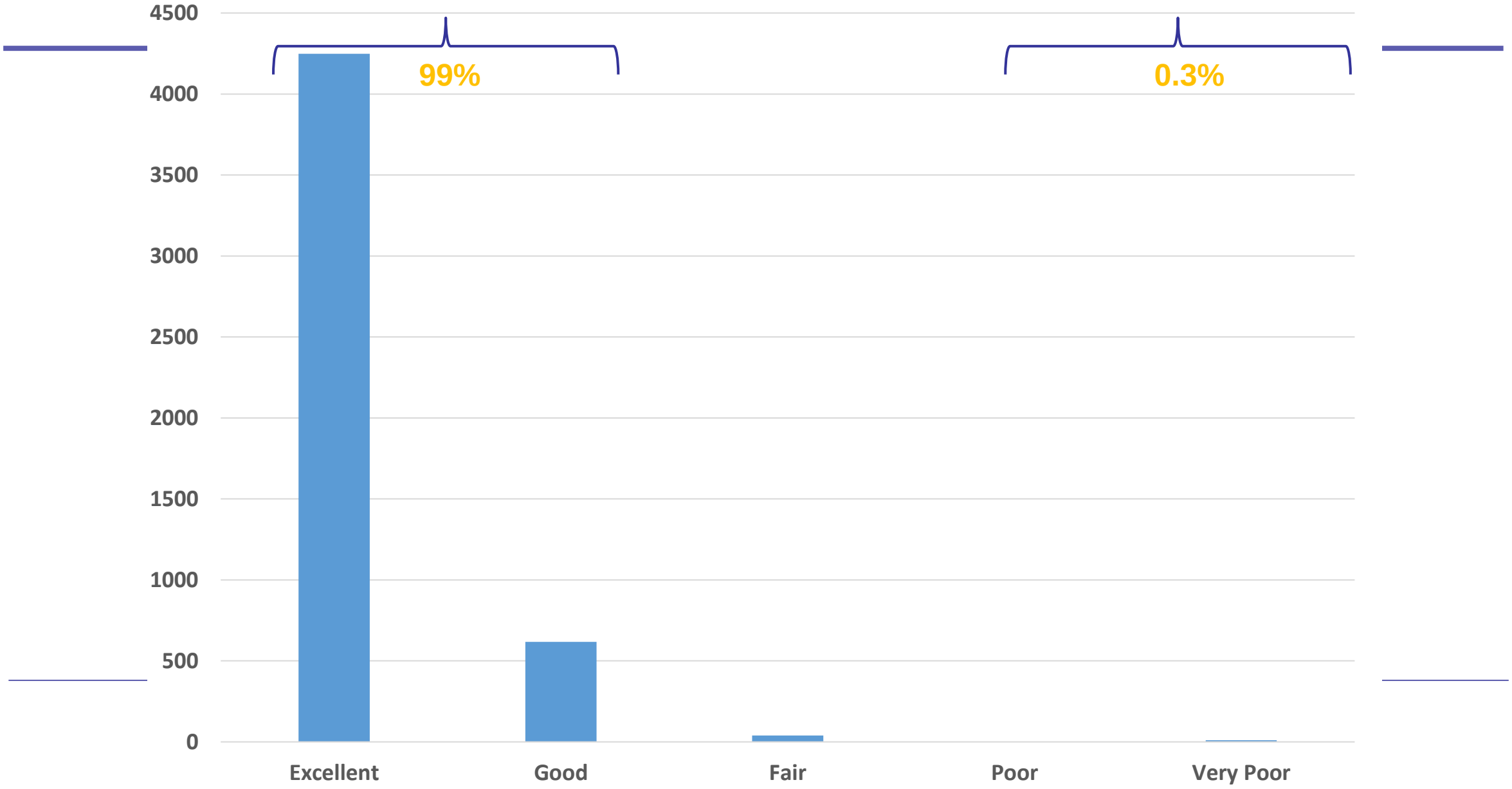
Allen & Singh 2018, Contraception 97, p471-477


Severe Pain (score 8-10 out of 10) [n = 2070]
25%
20%
15%
10%
5%
0%
24%
10%
6%
10%
Medical (EMA)
Surgical - LA (MVA)
Surgical - GA (STOP)
Menstruation

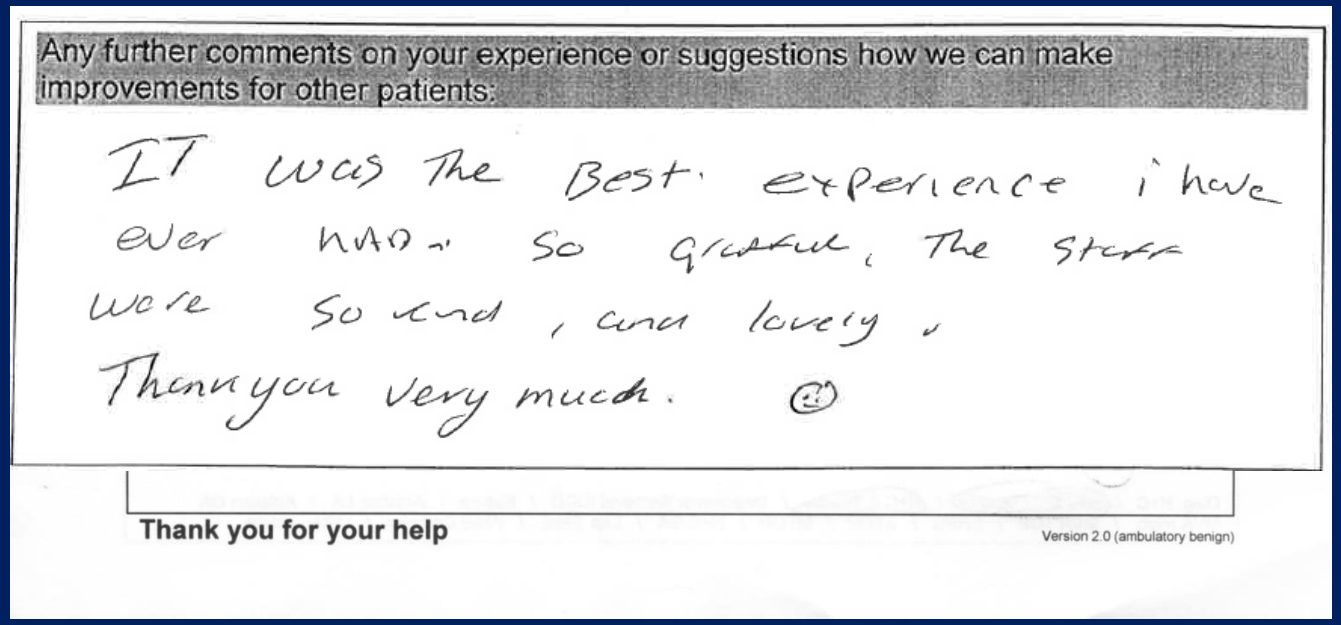

If you were in the same position again, would you choose the same way of having this procedure?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
9%
80%
4%
84%
2%
Yes
No
Early Medical Abortion at Home (EMA)
MVA (LA)
STOP (GA)
n = 2018


If you were in the same position again, would you choose the same way of having this procedure?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
9%
80%
4%
84%
2%
92%
2%
Yes
No
Early Medical Abortion at Home (EMA)
MVA (LA)
STOP (GA)
Outpatient Hysteroscopy (diagnostic & operative)
n = 5288

Overall, how would you rate your experience (BSGE, 2020. n = 4920)



“The customer is always right…”



Any further comments on your experience or suggestions how we can make improvements for other patients:

IT was the Best experience i have ever had - so grateful, The staff were so kind, and lovely.

Thank you very much.

Thank you for your help

Version 2.0 (ambulatory benign)

Patient feedback (hysteroscopy & biopsy)

ACN Collaboration

Benchmarks
Pain Scores (10 point scale)

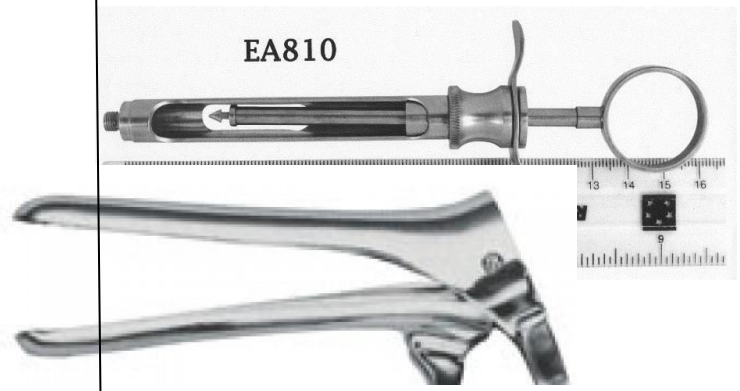
	n =	Mean Pain Score
VAST RCT (UK), 2019 (Diagnostic only)	1597	4.3
Our Unit (All procedures)	3462	4.2
BSGE Survey 2020	5151	5.2
Menstruation	2011 (Cornwall) 5151 (BSGE)	5.3 5.5

Goal –
- Less than menstrual pain
- <4.5
- All procedures

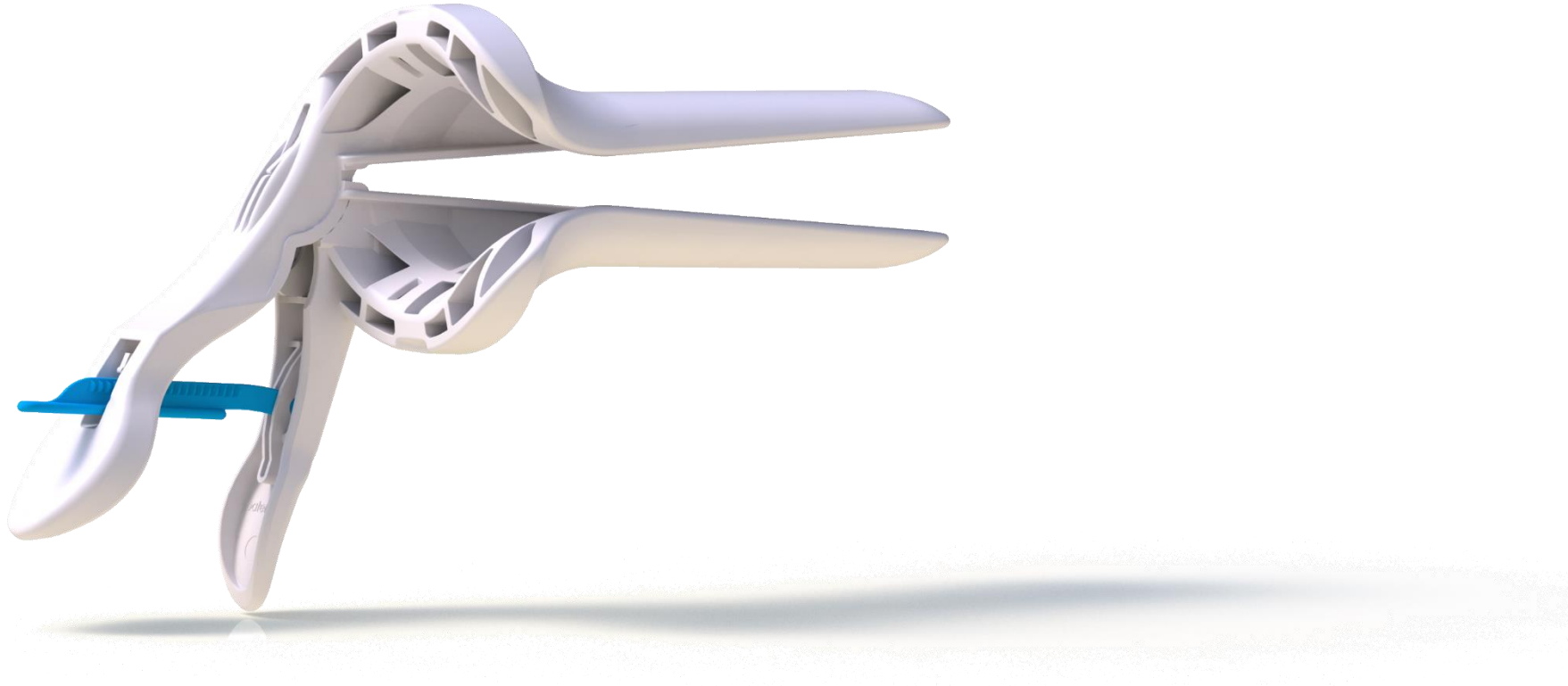
Must Read Papers & ACN Collaboration

Must Know Technologies

Dental Syringes



Innovations & Horizon Scanning



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www.brideamedical.com


Aquilex
Fluid Control System
Press Prime Button
Pressure
Intrauterine
0
Setting
80
Prime
Pause Resume
Fluid
Deficit
0
Deficit Limit
1000
Zero
HOLOGIC


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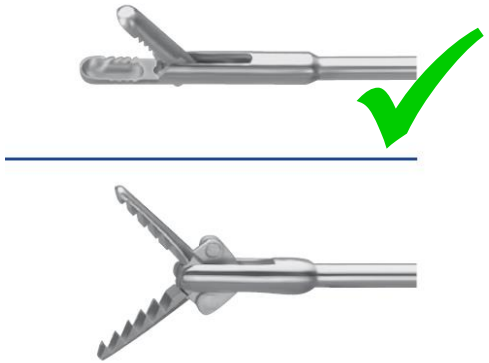
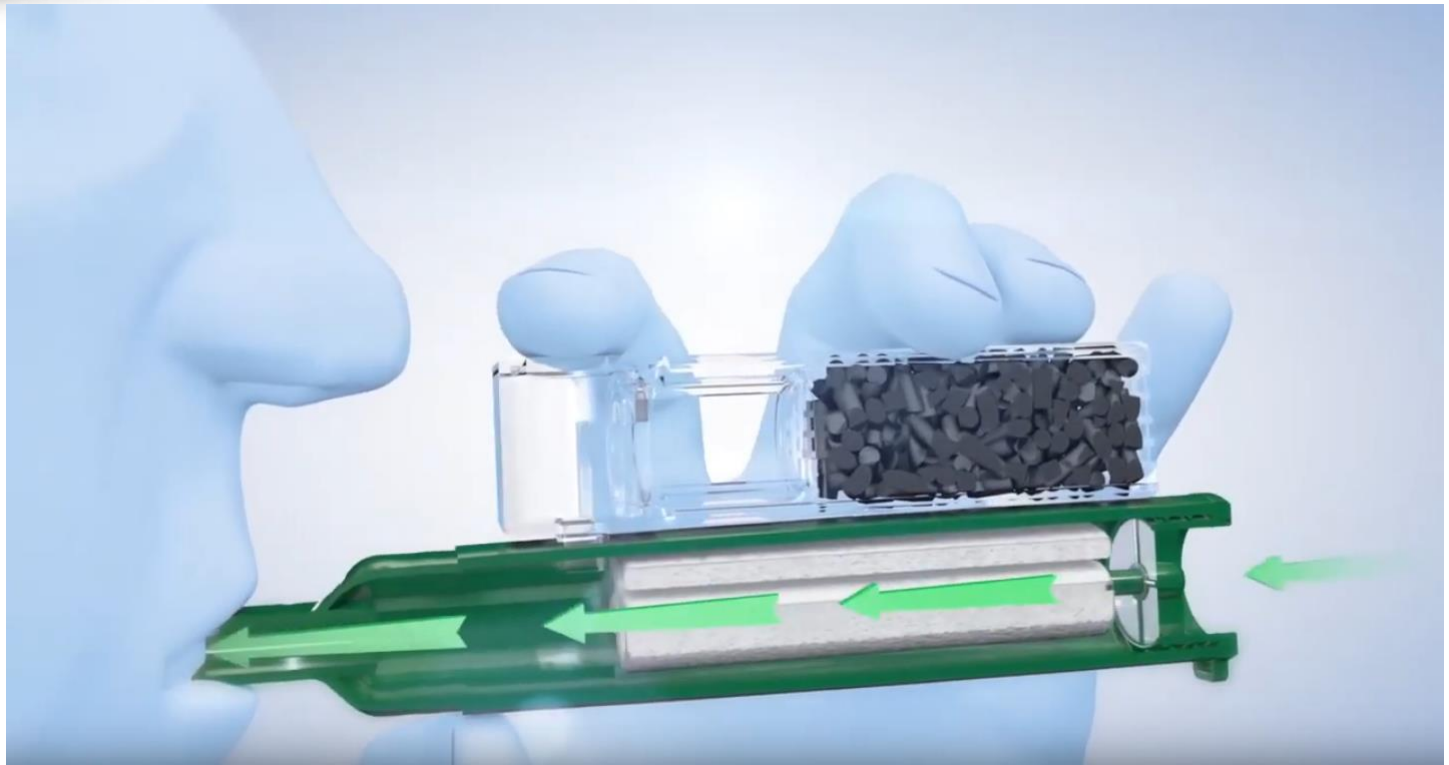
hysteromat E.A.S.I. 263400 20
STORZ
KARL STORZ - ENDOSKOPE
hysteromat® E.A.S.I.
Endoscopic Automatic System for Irrigation


SOCOMED
SOCOMED




3 mL
Pt Penthrox
methoxyflurane/méthoxyflurane



New Technologies, Innovations & Horizon Scanning

Guideline Development

NICE National Institute for Health and Care Excellence

Quality standards

Set out priority areas for quality improvement in health and social care.

Due 23.6.20

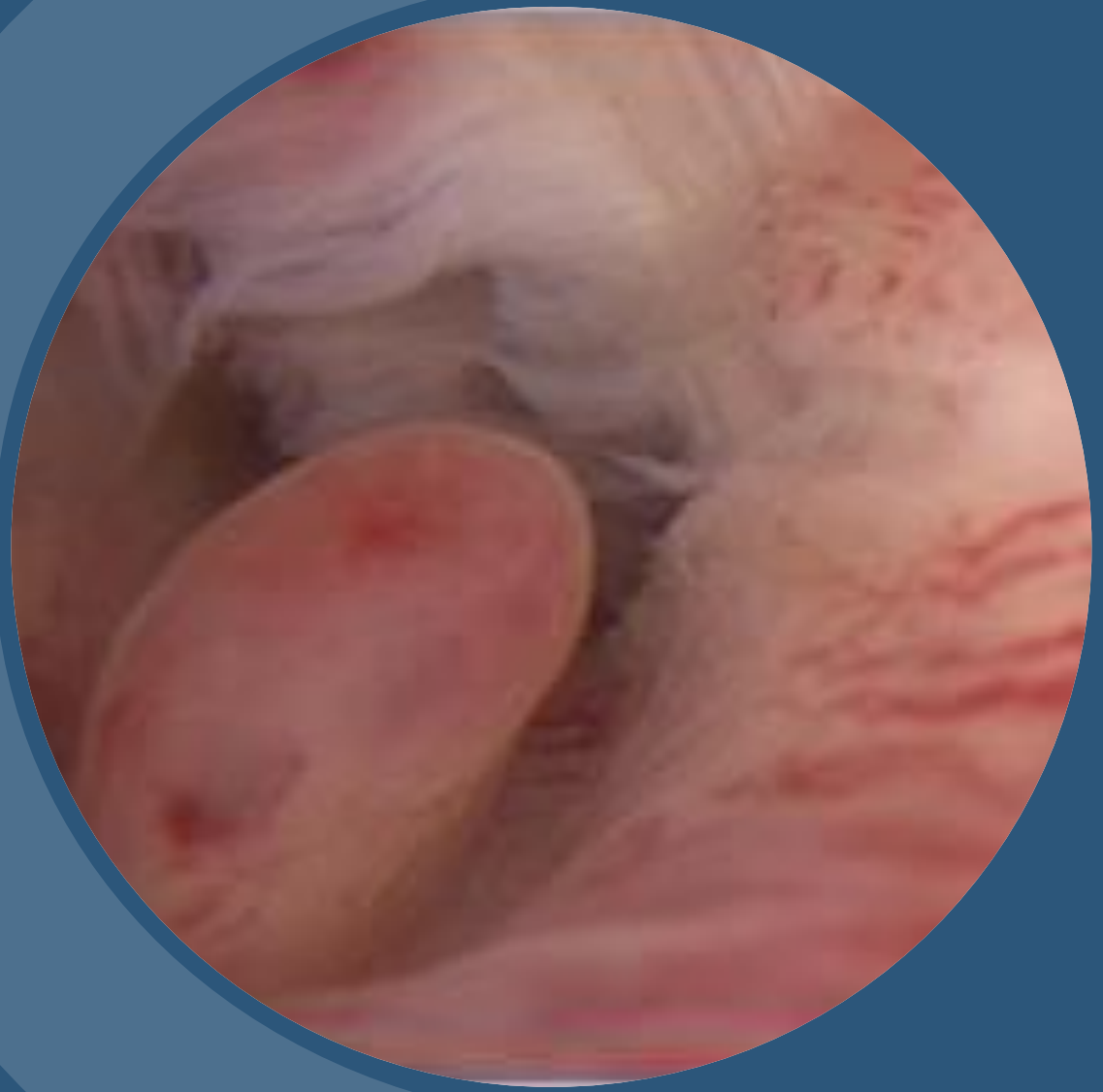
People presenting with symptoms of heavy menstrual bleeding have a detailed history taken that includes the impact on their quality of life

People with heavy menstrual bleeding and suspected submucosal fibroids, polyps or endometrial pathology have outpatient hysteroscopy

People with heavy menstrual bleeding have a discussion with their healthcare professional about all their treatment options

PRETH DE SILVA

ENDOMETRIAL POLYP CLASSIFICATION STUDY



AIM

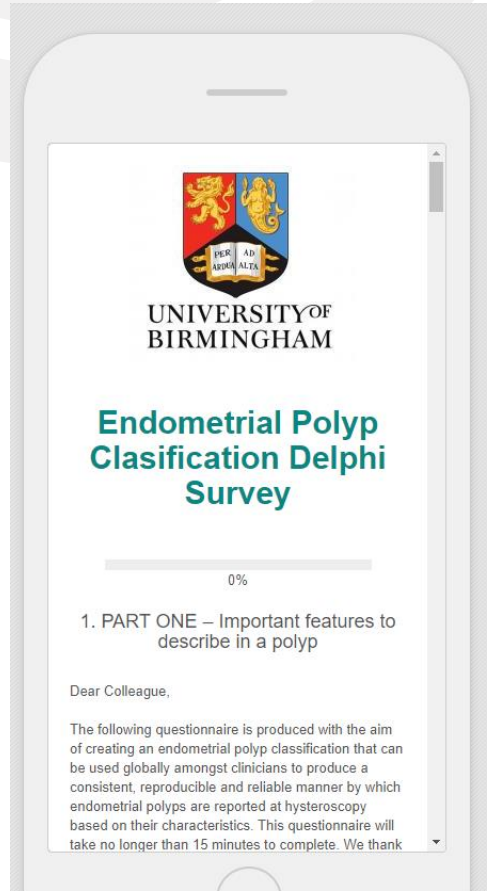
TO PRODUCE AN AGREED SET OF CRITERIA TO DEFINE POLYPS THAT ARE EASILY **REPRODUCIBLE**, **RELIABLE** AND **CONSISTENT** AND CAN BE USED AMONGST **NURSES AND DOCTORS OF VARYING EXPERIENCE**.

ACCESSING THE SURVEY

QR Code

https://www.smartsurvey.co.uk/s/polypsurvey/

DON’T START JUST YET!



BSGE

PART 1 – IMPORTANT FEATURES TO DESCRIBE IN A POLYP

Please DO NOT PRESS NEXT PAGE until we move onto the next slide

PART 2 – DISTINGUISHING BETWEEN BENIGN AND (PRE-)MALIGNANT POLYPS

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PART 3 – DEFINING FEATURES TO OPTIMISE REPRODUCIBILITY

- Remember that the aim is to produce an agreed set of criteria to define polyps that are easily **reproducible**, **reliable** and **consistent** and can be used amongst **nurses and doctors of varying experience**.

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PART 4 – IMPORTANT CLINICAL AND DEMOGRAPHIC DATA

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PART 5 – CONTINUING INVOLVEMENT IN DEVELOPING THE BSGE POLYP CLASSIFICATION

QUESTIONS OR COMMENTS?