

Outpatient Hysteroscopy Pain Management Audit

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Background

NICE recommends outpatient hysteroscopy (OPH) or ultrasound as a first-line investigation for dysfunctional uterine bleeding. Best practice includes advising patients to take analgesia pre-procedure and using vaginoscopic techniques with miniature hysteroscopes. Pain is one reason why OPH can fail and a repeat procedure under GA necessary. We audited our adherence to NICE's pain management recommendations and our patients' perception of their pain and pain management.

Standards

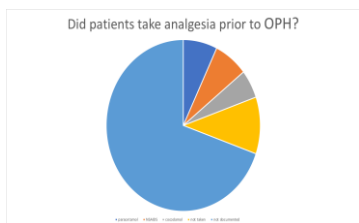
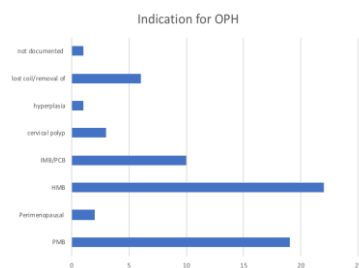
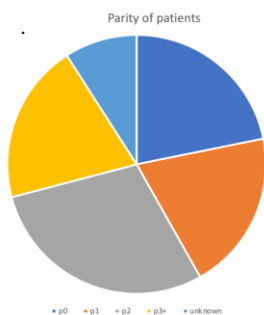
100% of patients should:

- take analgesia prior to procedure
- have a vaginoscopic approach to OPH
- have a miniature hysteroscopy (a scope with 2.7mm diameter with a 3-3.5mm sheath)

Methods

55 consecutive OPH cases over 4week period, Nov-Dec '19 were reviewed. Data was collected from the OPH proforma and where necessary, electronic notes were cross-checked. Patients completed a self-assessment questionnaire at the end of their appointment, anonymously. Data was analysed on Excel.

Results



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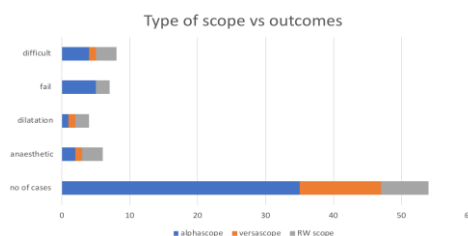
Pre-procedure: 72% patients felt **well-informed** and 61% reported they took analgesia. 45% reported adequate time to discuss analgesia during their appointment.

19% of patients had documentation of having taken analgesia pre-procedure.

Procedure: 53% deemed OPH '**slightly**' painful, with 4% feeling pain 'constantly'. 85% deemed the overall experience as '**excellent**', the remaining 15% considering it '**good**'.

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Miniature hysteroscopes were used in 85% of cases and 5mm scopes were used in 13%.

Conversion to GA – 5/55 patients (9%)

1/5 – too painful

4/5 – failed

An additional 5 patients went on to have a GA for a further operative procedure.

Post-procedure: 89% post-procedure analgesia not documented, 11% 'not needed'

Conclusions & Recommendations

Failure rates, use of anaesthetic and dilatation of cervix rates were higher for cases with the RW 5mm hysteroscope. This audit confirms miniature hysteroscopes are vital to reduce OPH failure rates and the need for the procedures to be converted to GA, which furthers the proposal for purchasing more miniature scopes in our unit.

Significant discrepancy was noted between patient self-reporting of pre-procedure analgesia compared to clinicians documentation. Improved documentation going forward will enable accurate analysis of interventions.

We have instigated a new practice of calling patients pre-appointment to remind them of analgesia use before OPH. Hopefully this will reduce reported pain and improve the patient experience further. This will be re-audited in due course.

A new information leaflet will be available for patients to help them decide about proceeding with either an outpatient or GA hysteroscopy. Better information and counselling at this stage would hopefully select a pool of appropriate and more prepared patients, reduce failure rates and the associated costs of conversion to GA procedure when OPH is not tolerated.