

Minimally Invasive Surgery Week

MINIMALLY INVASIVE SURGERY WEEK 2013
ANNUAL MEETING & ENDO EXPO
HYATT REGENCY RESTON
RESTON, VA (WASHINGTON DC)

ISGE BREAKOUT SESSION:

OFFICE HYSTEROSCOPY: INNOVATIONS IN WHAT CAN BE ACCOMPLISHED OUTSIDE THE OR

In order of presentation

Thursday 8:30am-12:30pm

Indications for “Office Hysteroscopy”

Bruno J van Herendael, Prof Dr Med

Indications for office hysteroscopy **without anaesthesia** or **under local anaesthesia** are divided in **Diagnostic Indications** and **Operative Indications**. The diagnostic indications are confined to the detection of anatomical abnormalities (18-20%) and abnormalities in the development of the endometrium and infections of the same (75%). Together these account for most of the Abnormal Uterine Bleeding episodes. As hysteroscopy provides the gynaecologist with the visual impression of colour, contour, compliance of the uterus to distension and a visual impression of the tubal ostia diagnosis of physiology and pathophysiology of the endometrium can be made at the level of the uterine cavity. More important the same can be done at the level of the cervical canal an entity very difficult to explore with other indirect techniques. In office operative gestures include polypectomy of all sizes provided the adequate technique of slicing is used. Adhesions of the cervical canal and of the uterine cavity can be lysed provided the gynaecologist does not enter the myometrium where the nerve fibres are located. Touching the nerve fibres in the myometrium causes discomfort to the patient. Fibroids grade I up to 3 cm can be managed as well as uterine septa. Tubal ostium cannulation and sterilization are frequent indications. When **general anaesthesia** is provided for office hysteroscopy is able to cover a larger variety of major operative indications as there are Endometrial Resection and Resection of larger type I Fibroids and type II fibroids.

Office Diagnostic and Therapeutic Hysteroscopy Equipment

Mark Hans Emanuel MD PhD Gynaecologist Dept. Ob/Gyn

Spaarne Ziekenhuis Hoofddorp/Amsterdam (University of Amsterdam) The Netherlands

In this lecture an overview will be given of alternative imaging (fluid enhanced ultrasound), different types of hysteroscopes (single flow, continuous flow and flexible) and different types of therapeutic equipment.

Furthermore all types of intracavitary abnormalities that can be diagnosed and treated in the office will be presented and discussed.

Office Diagnostic and Therapeutic Hysteroscopy Techniques

Mark Hans Emanuel MD PhD Gynaecologist Dept. Ob/Gyn**Spaarne Ziekenhuis Hoofddorp/Amsterdam (University of Amsterdam) The Netherlands**

In this lecture we will discuss: basic techniques for vaginoscopic introduction of hysteroscopes, basic hysteroscopic techniques and different therapeutic techniques that can be used in the office (conventional, high frequency electrical and mechanical morcellation).

Office Hysteroscopic Sterilization**Aarathi Cholkeri-Singh, MD**

This presentation will review the current FDA approved hysteroscopic sterilization device and procedure. At the conclusion of this presentation the participants will understand the mechanics and the mechanism of action of the *Essure*® Permanent Birth Control System. The technique of placement of the hysteroscopic tubal occlusion device will be reviewed along with postoperative care and follow-up. Risks and benefits to office hysteroscopic sterilization will be discussed.

Endometrial Ablation Overview**Aarathi Cholkeri-Singh, MD**

This presentation will demonstrate familiarity with all approved endometrial ablation devices and techniques. The indications and contraindications of each technique will be reviewed along with data comparing postoperative outcomes. Complications and management will be discussed.

Anaesthesia for “Office Hysteroscopy”**Bruno J van Herendael, Prof Dr Med**

Anaesthesia can be divided in **Local** and **General**. In Europe Office Hysteroscopy is performed without or with local anaesthesia. The conditions where Local Anaesthesia is considered are: known stenosis of the cervical canal, manipulation of the tubal ostium and intramural region is required, need to over dilate the uterine cavity – to counter act the induced muscle contractions - and the need to manipulate or extract volumes of over 2 mm³. Experience can overcome these indications so that these hysteroscopies can be done without anaesthesia. Preparation of the cervix can overcome functional stenosis. Misoprostone or Sulprostone intravaginal tablets can be used according to local law restrictions. **Local Anaesthesia** has the disadvantage that the patient will become tense at the sight of the syringe and that she will feel a numbness for several hours after the hysteroscopy. Systemic effects are rare and occur in situations where the drug is injected in a vessel. Local Anaesthesia is given in a para cervical block 3 ml of a 1 % solution at 10 and 14 hours. A further 5 ml of the 1% solution is injected at the insertion of the sacrouterine ligaments. It is crucial to inject only a few mm under the mucosa, a dentists syringe is ideal. The gynaecologist should stick to one product best known to him. Anaesthetic affect starts within 2-3 min. Good anaesthesia and hence procedure time is 15-20 min. Further **moderate and deep Sedo-Analgesia and General Anaesthesia** are used.

Integrating Office Hysteroscopy (Coding and Reimbursement)**Aarathi Cholkeri-Singh, MD**

This presentation will review integration of hysteroscopy into the office setting. CPT codes currently used for hysteroscopic procedures will be reviewed. Tips on optimizing reimbursement and practice revenue will be discussed.

Complications in “Office Hysteroscopy”

Bruno J van Herendael, Prof Dr Med

Complications are less frequent in Office Hysteroscopy because the patient is awake and can guide the gynaecologist. Perforations both of the cervix and the uterine walls are less likely to happen. The distension medium used is Normal Saline or Ringers lactate seldom Dextrose 5%. In all circumstances it is important to maintain the osmolality of the plasma to 280-300 mOsmol/l. Low viscosity fluids without electrolytes should therefore be avoided. As uni-polar electro surgery is not used there is no need for these media. To avoid fluid overload appropriate monitoring of both inflow and outflow is most important and if intravasation of > 1,5-2 l. of fluid occurs the hysteroscopy has to be stopped and immediate diuresis should be established to prevent pulmonary edema. Three factors should be taken into consideration: intra uterine pressure to no more than 100 mmHg not to over-ride the main arterial pressure, expedite the procedure – never more than one hour – and avoid extensive intra-myometrial dissections. In case of doubt it is important to monitor the electrolytes, especially sodium. The TURE syndrome is a constellation of symptoms and signs associated with the absorption of large volumes of distension medium. Dilutional hyponatremia and decreased osmolality are the most important. In office hysteroscopy the patient will let the gynaecologist know to have peculiar feelings and shortness of breath. Menstruating women are more prone to TURE. Active management of TURE is mandatory. Restoration of normal sodium levels should be slow and cautious.