Plenary 3 - Hysteroscopy

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Professional Education Information

Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

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AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Plenary 3 - Hysteroscopy

Moderators: Philip G. Brooks, Angelos G. Vilos

Faculty: Attilio Di Spiezio Sardo, Simone Ferrero, Karina M. Haber, Tadeusz Issat, Nicholas A. Ryan, Lennie van Hanegem

This session is comprised of presentations by experienced hysteroscopists who will describe how hysteroscopy can be used safely and more effectively to improve reproductive function and/or reduce symptoms of bleeding from retained products of conception, intracavitary myomata and/or congenitally deformed uteri. Studies of medications to reduce myoma size or decrease operative pain from hysteroscopies will be reported.

**Learning Objectives:** *At the conclusion of this course, the participant will be able to:* 1) Describe the use of operative hysteroscopy in patients with various congenital uterine deformities, emphasizing the safety and efficacy of hysteroscopy in the management of abnormal uterine bleeding.

**Course Outline**

2:15  Safety, Efficacy and Reproductive Outcomes of Hysteroscopic Outpatient Metroplasty to Expand Dysmorphic Uteri (HOME-DU) Technique  A. Di Spiezio Sardo

2:25  Office Essure in Septate Uterus and Double Cervix  K.M. Haber

2:31  Triptorelin, Letrozole and Ulipristal Acetate Treatment before Hysteroscopic Resection of Large Myomas: Prospective Comparative Study  S. Ferrero

2:41  Resection of Retained Products of Conception with the Myosure XL  N.A. Ryan

2:48  Diagnostic Work-Up for Postmenopausal Bleeding – A Randomized Controlled Trial  L. van Hanegem

2:58  A Randomized, Single Blind, Placebo-Controlled Trial for the Pain Reduction during the Outpatient Hysteroscopy after Ketoprofen or Intravaginal Misoprostol  T. Issat

3:15  Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
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Kimberly A. Kho*
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M. Jonathon Solnik*
Johnny Yi*

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FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Philip G. Brooks*
Attilio Di Spiezio Sardo*
Simone Ferrero*
Karina M. Haber*
Tadeusz Issat*
Nicholas A. Ryan*
Nehalennia (Lennie) van Hanegem*
Angelos Vilos*

Asterisk (*) denotes no financial relationships to disclose.
“HOME-DU TECHNIQUE”

- Ambulatory setting
- Conscious sedation
- 5-mm hysteroscope
- Vaginoscopic approach
- 5 Fr bipolar electrode
- Polyethylene oxide-sodium carboxymethylcellulose gel

The ESHRE-ESGE Classification

Diagnosing class U1 uteri...

Population

<table>
<thead>
<tr>
<th>T-shaped</th>
<th>Tubular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (year)</td>
<td>Median (IQR)</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>34.6 (28)</td>
</tr>
<tr>
<td>History of reproductive surgery</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Indications for surgery</td>
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<tr>
<td>Primary infertility</td>
<td>32 (19.3%)</td>
</tr>
<tr>
<td>Secondary infertility</td>
<td>7 (46.7%)</td>
</tr>
<tr>
<td>Pelvic adhesions</td>
<td>1 (6.4%)</td>
</tr>
<tr>
<td>Sclerosed Fallopian tubes</td>
<td>13 (82.8%)</td>
</tr>
<tr>
<td>Sclerosed uterine horns</td>
<td>6 (38.4%)</td>
</tr>
<tr>
<td>Uterine volume at menopause [cm³]</td>
<td>64.5 (35.4)</td>
</tr>
<tr>
<td>L/D ratio at menopause</td>
<td>0.39 (0.07)</td>
</tr>
<tr>
<td>Tubular uterine horns</td>
<td>2 (10.5%)</td>
</tr>
</tbody>
</table>
Anatomical results (1)

Inclusion criteria

- Pregnancy Abortion rate
- Term delivery rate
- Live birth rate

Primary infertility (n=22)

- 12/22 (54%) 3/12 (25%) 9/12 (75%) 9/12 (75%)

Repeated early abortions (≥2) (n=7)

- 5/7 (71%) 2/5 (40%) 2/5 (40%) 3/5 (60%)

Preterm delivery (n=1)

- 0/1 (0,0%) - - -

Total (n=30)

- 17/30 (56%) 5/17 (29,4%) 11/17* (64,7%) 12/17 (70,6%)

*only 1 case of preterm delivery (5,9%)

Functional results

Inclusion criteria

- Perspectives

- Further studies with a control group managed expectantly
- Improvement of the uterine cavity morphology/volume vs endometrial injury
- HOME-DU vs standard technique
- Relevance of anti-adhesions treatment

The real voyage of discovery consists not in seeking new landscapes, but having new eyes

Proust
Office Essure in Uterine Didelphys

Karina Haber, M.D.
Montefiore Medical Center, Bronx, New York

**Study Objective:** To show a unique case of office essure placement in a patient with a double vagina, double cervix, and uterine didelphys.

**Design:** Step-by-step explanation of the technique using educative video.

**Setting:** Müllerian duct anomalies (MDA’s) occur in approximately 1% of the general population and are associated with uterine, cervical, and vaginal abnormalities. Office based hysteroscopic sterilization has been shown to be a well tolerated in women with normal female anatomy and has been concluded to be good option for those who desire permanent sterility. In women with MDA’s, office hysteroscopy can be used to confirm anatomical variations. In experienced hands, office based hysteroscopic sterilization should be considered as a feasible option in women with a double vagina, double cervix, and/or uterine anomalies.

**Interventions:** Office hysteroscopic placement of Essure device in a woman with a rare MDA and desires permanent sterilization.

**Conclusions:** This technique of office-based hysteroscopic sterilization is a reasonable choice for women with Müllerian duct anomalies.
TRIPTORELIN, LETROZOLE AND ULIPRISTAL ACETATE TREATMENT BEFORE HYSTEROSCOPIC RESECTION OF LARGE MYOMAS: PROSPECTIVE COMPARATIVE STUDY

Simone Ferrero, MD, PhD

Department of Obstetrics and Gynecology,
San Martino Hospital and National Institute for Cancer Research, University of Genoa Italy

OBJECTIVES OF THE STUDY

- Primary objective: to investigate the usefulness of preoperative treatment with triptorelin (gonadotropin releasing hormone agonist), letrozole (aromatase inhibitor) and ulipristal acetate (selective progesterone receptor modulator) in patients undergoing hysteroscopic removal of large uterine submucosal myomas (20-35 mm)
- Secondary objective: to assess the changes in myoma volume caused by the three hormonal therapies

After this lecture, the attendee should implement the preoperative hormonal treatment prior to hysteroscopic myomectomy.

BACKGROUND

- Hysteroscopic resection is the standard treatment of submucosal myomas.
- Contradictory results have been reported on the usefulness of preoperative administration of gonadotropin releasing hormone agonists prior to hysteroscopic myomectomy (Muzii et al., 2010; Mavrelos et al., 2010; Kamath et al., 2014).
- Letrozole (a non-steroidal aromatase inhibitor) and ulipristal acetate (a selective progesterone receptor modulator) have been used to decrease the volume of uterine myomas and control uterine bleeding (Gurates et al., 2008; Parsanezhad et al., 2010; Dommez et al., 2012; Duhan et al., 2013; Song et al., 2013; Leone Roberti Maggiore et al., 2014; Dommez et al., 2014).

MATERIALS AND METHODS

Study design: single center prospective non-randomized comparative study

Study patients underwent either direct surgery (group S) or received a 3-month preoperative treatment with one of the following drugs:
- triptorelin (3.75 mg intramuscular injection every 28 days; group T)
- letrozole (2.5 mg/day; group L) *
- ulipristal acetate (5 mg/day; group U)

* Letrozole is not approved for the treatment of uterine myomas by the FDA and Italian Ministry of Health and, therefore, the use of these drugs should be considered experimental.

Inclusion criteria:
- premenopausal age
- myomas graded as type 0, type 1 or type 2 according to the FIGO classification (Munro et al., 2011) with diameter between 20 and 35 mm

Exclusion criteria:
- associated polyps
- associated non-hysteroscopic surgical procedures
- > 2 myomas requiring hysteroscopic resection

AUTHORS’ DISCLOSURE

I have no financial relationships to disclose
**Results**

Flow chart showing recruitment and women's progress through the study.

- **Group S** (n = 20)
  - Patients enrolled in the study (n = 23)
  - Patients included in the analysis (n = 20)

- **Group T** (n = 20)
  - Patients enrolled in the study (n = 20)
  - Patients included in the analysis (n = 20)

- **Group L** (n = 11)
  - Patients enrolled in the study (n = 11)
  - Patients included in the analysis (n = 11)

- **Group U** (n = 7)
  - Patients enrolled in the study (n = 7)
  - Patients included in the analysis (n = 7)

There was no case of uterine perforation or fluid overload.

Postoperative patient pain was minimal and non significantly different among the four study groups (p = .538).

Similarly, patient satisfaction was similar in the four study groups (p = .762).

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**Table: Changes in the Volume of the Largest Myoma Caused by 3-Month Hormonal Treatment**

All medical treatments caused a significant decrease in the volume of the largest myoma:
- **Group T**, p < .001
- **Group L**, p < .001
- **Group U**, p = .006

The percentage decrease in myoma volume was lower in group **U** (-21.0%) than in group **T** (-37.1%) and in group **L** (-34.5%) (p = .010).
DISCUSSION

• Preoperative treatment with triptorelin and letrozole facilitates the hysteroscopic resection of large uterine submucosal myomas by decreasing the operative time and the volume of fluid absorbed.

• The surgical advantages of preoperative hormonal therapies should be balanced with the incidence of adverse effects and with the cost of treatments.

• The operative results obtained in group S demonstrate that hysteroscopic myomectomy can be safely performed in most of the patients without the administration of preoperative hormonal treatment.

• In selected cases with multiple myomas or in case of procedures performed by less experienced surgeons, the shrinking of the myomas may allow to perform hysteroscopic procedures in patients that would be candidate to more invasive surgical techniques or to obtain a complete myoma resection during a single surgical procedure.

REFERENCES

Resection of Retained Products of Conception with the Myosure XL

Nicholas Ryan, MD
Baylor College of Medicine, Houston, Texas

Study Objective: To demonstrate a novel technique for resection of retained products of conception using the MyoSure XL® (Hologic, Bedford, MA) device.

Design: Step-by-step explanation of the technique using video.

Setting: A 33 year old G2P1001 had a missed abortion at approximately 10 weeks gestation and underwent a dilatation and suction curettage at an outlying hospital. The procedure was complicated by a 2 liter blood loss that required transfusion. She presented two weeks later with recurrent vaginal bleeding. Ultrasound confirmed retained products of conception with a possible arteriovenous malformation. Hematocrit at this time was 23.1%. She underwent bilateral uterine artery embolization (UAE) using Gelfoam® (Pfizer, New York, NY). Ten days following UAE, she underwent hysteroscopic resection of the retained products of conception using the MyoSure XL device.

Interventions: Hysteroscopic resection of retained products of conception using the MyoSure XL device.

Conclusions: In certain circumstances, retained products of conception following dilatation and curettage can be safely and effectively resected under direct visualization using the MyoSure XL device. This technique could theoretically reduce the likelihood of perforation, confirm complete removal of the lesion, and facilitate minimal dissection into the myometrium and disruption of the opposing uterine walls to effectively reduce the risk of Asherman’s syndrome.

Keywords: Retained products of conception; Operative hysteroscopy; MyoSure XL
Diagnosis work-up for postmenopausal bleeding
a randomized clinical trial

N. van Hanegem, MD
Maastricht UMC+
The Netherlands

Disclosures
I have no financial relationships to disclose.

Learning objectives
How to handle a patient with:
• a first episode of postmenopausal bleeding
• an endometrial thickness of > 4 mm and
• a benign histology after endometrial sampling.

Diagnostic work-up PMP bleeding1,2,3

Vaginal examination, Cervical cytology and TVS

Endometrium > 4 mm or non-measurable

Endometrial biopsy

Benign histology

Insufficient sample

Hysteroscopy

(Pre)malignancy

Treatment

Patients with postmenopausal bleeding

• Regardless of endometrial thickness4,5:
  • No abnormalities 50%
  • Endometrial carcinoma 10%
  • Endometrial polyp 20%
  • Sensitivity endometrial biopsy for endometrial cancer: 92-95%6,7
• Endometrial thickness > 4 mm8,9:
  • 40% endometrial polyps
  • No evidence that removal of polyps can reduce recurrent bleeding

Scientific question
Does further work-up for and treatment of benign endometrial lesions reduce the risk of recurrent postmenopausal bleeding9?
**Study design**

Randomized clinical trial

P Women with postmenopausal bleeding

I Hysteroscopy

C Expectant management

O Recurrent bleeding within 1 year
  • Recurrent bleeding > 1 year
  • (Pre)malignancy

**Methods**

Inclusion criteria:
• Postmenopausal bleeding
• Double endometrial thickness > 4 mm
• Benign histology after endometrial biopsy

Exclusion criteria:
• Abnormal cervical cytology
• Aromatase-inhibitor/anti-estrogen

Sample size: 50% reduction of recurrent bleeding (drop-out rate 20%; power 80%; α 5%)

→ N=200

**Methods: Allocation**

Intervention:
• Diagnostic hysteroscopy. In case of an endometrial polyp, polypectomy was performed.

Comparison:
• No further diagnostic work-up.

All patients were instructed to contact the outpatient clinic in case of recurrent bleeding and contacted for follow-up after 1 year.

**Results: flow chart**

200 women included

98 hysteroscopy 87 received assigned intervention

102 exp management nobody had hysteroscopy

3 follow-up ongoing

2 lost to follow-up 7 follow-up ongoing

95 included in analyses Median follow up 60 weeks

93 included in analyses Median follow up 63 weeks

**Results: Recurrent bleeding < 1 year**

<table>
<thead>
<tr>
<th>Recurrent bleeding</th>
<th>No recurrent bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysteroscopy</td>
<td>14 (14%)</td>
</tr>
<tr>
<td>Expectant management</td>
<td>16 (17%)</td>
</tr>
<tr>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recurrent bleeding</th>
<th>No recurrent bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysteroscopy</td>
<td>84</td>
</tr>
<tr>
<td>Expectant management</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>161</td>
</tr>
</tbody>
</table>

RR 0.91 (95% CI 0.63-1.3)

**Results: (pre)malignancy in hysteroscopy-group**

87 of 98 women received allocated intervention.

- Polyp
- Hyperplasia
- Hyperplasia+atypia
- Benign
- Carcinoma
- No result
Results: Recurrent bleeding during complete FU

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometrial biopsy</td>
<td>3</td>
</tr>
<tr>
<td>Carcinoma</td>
<td>1</td>
</tr>
<tr>
<td>Ultrasound, thin endometrium</td>
<td>3</td>
</tr>
<tr>
<td>No investigation</td>
<td>4</td>
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</tbody>
</table>

Conclusions

- Women with postmenopausal bleeding and benign endometrial biopsy have a 17% risk of recurrent bleeding within 1 year.
- Hysteroscopy does not reduce this risk.
- However, unexpected 3 endometrial carcinomas and 3 pre-malignancies (6%) were diagnosed after an initially benign endometrial biopsy.

Research group

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- M.Y. Bongers MD PhD, Maxima Medical Center, Veldhoven
- B.H. van Koot MD PhD, The Robinson Institute, Adelaide, Australia
- A. Timmermans MD PhD, Academic Medical Center

References

A randomized, single blind, placebo-controlled trial for the pain reduction during the outpatient hysteroscopy after Ketoprofen or intravaginal Misoprostol

Tadeusz Issat, MD, PhD
Department of Reproductive Health, Institute of Mother and Child
Warsaw, Poland

Disclosure
I have no financial relationships to disclose.

Study design
Aim of the study was to assess the pain during and after outpatient hysteroscopy, depending on the use of intravaginal Misoprostol (400 μg), intravenous non-steroidal anti-inflammatory agent Ketoprofen (1mg/ml) or placebo

Known factors that might reduce pain during office hysteroscopy
- Transcutaneous electrical nerve stimulation
- Intravenous and intracervical lidocaine
- Sublingual buprenorphine
- Pain reduction
- Reduction in waiting time for procedure

Guidelines
"...RCOG, women without contraindications should be advised to consider taking standard doses of non-steroidal anti-inflammatory agents (NSAIDs) around 1 hour before their scheduled outpatient hysteroscopy appointment with the aim of reducing pain in the immediate postoperative period."
Procedure

- The procedure according to the RCOG Green-Top Guideline Nr 59
- The tablets (Misoprostol or placebo) in the posterior vaginal fornix approx. 4 h before hysteroscopy and after the randomisation
- The procedure approx. 30 min after Ketoprofen or 100 ml of 5% glucose in a placebo and Misoprostol arms
- The 3.2mm Versascope hysteroscope (Gynecare division of Ethicon, Inc., Somerville, New Jersey, US) with normal saline solution as a distension medium
- When appropriate, a Versapoint (Gynecare) used to cut the polyps or fibroids, the 5F forceps used to facilitate extraction of fragments. Only the 5F forceps used for the simple biopsy of endometrium. Vaginoscopy involved in all procedures, no dilators used
- 300 W xenon lamp and video camera
- Distension fluid pressure generated using an automated flow-meter pump set for 120 mmH2O of intrauterine pressure

For one-dimensional assessment of pain, a visual analog scale (VAS) was used. The patients were asked to mark VAS scale before, during, 5 minutes and 15 minutes after the procedure.

Secondary measures the following complications were investigated:

- Vaginal bleeding
- Nausea
- Vomiting
- Diarrhea
- Fever
- Infection
- Uterine perforation
- False cervical passage
- Cervical laceration
- Bleeding and pain after Misoprostol
- Failure rate and the time of the procedure were recorded

Patients characteristics

<table>
<thead>
<tr>
<th></th>
<th>Placebo (N=50)</th>
<th>Ketoprofen (N=50)</th>
<th>Misoprostol (N=50)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs); median (IQR)</td>
<td>43.50 (36.50 - 56.00)</td>
<td>49.00 (39.75 - 59.25)</td>
<td>51.30 (47.00 - 52.30)</td>
<td>0.388</td>
</tr>
<tr>
<td>Weight (kg); median (IQR)</td>
<td>66.50 (61.50 - 76.00)</td>
<td>66.00 (60.00 - 75.50)</td>
<td>71.25 (67.10 - 72.30)</td>
<td>0.686</td>
</tr>
<tr>
<td>Height (cm); median (IQR)</td>
<td>164.00 (160.00 - 168.00)</td>
<td>163.00 (157.50 - 167.50)</td>
<td>164.10 (162.40 - 165.70)</td>
<td>0.481</td>
</tr>
<tr>
<td>Parity; n(%)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Nulliparous</td>
<td>12 (24.00)</td>
<td>15 (30.00)</td>
<td>16 (32.00)</td>
<td>0.890</td>
</tr>
<tr>
<td>Multiparous</td>
<td>38 (76.00)</td>
<td>35 (70.00)</td>
<td>34 (78.00)</td>
<td></td>
</tr>
<tr>
<td>Postmenopausal; n(%)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 (38.00)</td>
<td>26 (54.00)</td>
<td>25 (50.00)</td>
<td>0.159</td>
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<tr>
<td>Referral diagnosis n(%)</td>
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<td></td>
<td></td>
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<tr>
<td>Abnormal endometrium on US</td>
<td>10 (20.00)</td>
<td>14 (28.00)</td>
<td>13 (26.00)</td>
<td>0.151</td>
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<tr>
<td>Infertility</td>
<td>1 (2.00)</td>
<td>2 (4.00)</td>
<td>0</td>
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<tr>
<td>Uterine bleeding</td>
<td>9 (18.00)</td>
<td>16 (32.00)</td>
<td>12 (24.00)</td>
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<tr>
<td>Other</td>
<td>1 (2.00)</td>
<td>1 (2.00)</td>
<td>2 (4.00)</td>
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<tr>
<td>Procedure type; n(%)</td>
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<td></td>
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<tr>
<td>Operative hysteroscopy</td>
<td>31 (62.00)</td>
<td>24 (48.00)</td>
<td>24 (48.00)</td>
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<tr>
<td>Diagnostic hysteroscopy</td>
<td>19 (38.00)</td>
<td>26 (54.00)</td>
<td>26 (52.00)</td>
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</tr>
</tbody>
</table>

Results

<table>
<thead>
<tr>
<th></th>
<th>Placebo (N=50)</th>
<th>Ketoprofen (N=50)</th>
<th>Misoprostol (N=50)</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td>Procedure time (s); median (IQR)</td>
<td>255.00 (150.00 - 240.75)</td>
<td>190.00 (120.00 - 204.00)</td>
<td>277.00 (155.00 - 370.00)</td>
<td>0.158</td>
</tr>
<tr>
<td>Pain assessment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>VAS score before the procedure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.686</td>
</tr>
<tr>
<td>VAS score during the procedure</td>
<td>4.00 (2.75 - 5.25)</td>
<td>3.00 (2.00 - 5.00)</td>
<td>3.00 (2.00 - 4.00)*</td>
<td>0.329</td>
</tr>
<tr>
<td>VAS score at the end of the procedure</td>
<td>1.00 (0 - 2.00)</td>
<td>1.00 (0 - 2.00)</td>
<td>0 (0 - 1.00)*</td>
<td>0.005</td>
</tr>
<tr>
<td>VAS score 15 min. after the procedure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.160</td>
</tr>
<tr>
<td>Need for additional oral analgesic; n(%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2 (4.00)</td>
<td>2 (4.00)</td>
<td>0.153</td>
<td></td>
</tr>
</tbody>
</table>

* p<0.05
**Results**

The median VAS scores measured directly after the procedure

The median VAS scores measured during the procedure

Vaginal misoprostol reduces pain during and at the end of the outpatient hysteroscopy when compared to non-steroidal anti-inflammatory agents or placebo.

**Objective**

- 400 μg vaginal misoprostol administrated 4 hours before the procedure of outpatient hysteroscopy appears to be a better alternative to NSAID's in terms of pain reduction during and directly after the procedure.

- This observation does not depend on the patients' age, hormonal status, parity or type of the procedure (operative or diagnostic).

**References:**

- RCOG Green-top Guideline No.59 Best Practice in Outpatient Hysteroscopy March 2011
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166,”Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.