

Office hysteroscopy without anesthesia, is it really possible?

Editorial

During the last decade the number of hysteroscopic procedures performed in an office setting has been increasing constantly. Initially it was only the diagnostic hysteroscopy that was performed in office but today we are performing an important number of surgical procedures in office and without any kind of anesthesia, including polypectomy, myomectomy, metroplasty among others. Pain is something we can deal with, develop strategies/treatments to decrease it or even control it, but anxiety is the most important reason of impossibility and failure to perform the procedure. The anxiety increases the perception of pain, pain is subjective but we always have to respect what the patients says, even if our perception is different.

In order to reduce anxiety there are some steps we must follow.

- i. Inform the patient about the procedure and all the steps. Especially about the moments that may be associated with discomfort. Assure the patients that “she is the boss” and if she asks us to stop we will respect her will.
- ii. Avoid long waiting time before the procedure. To seat and waiting to come in increases very much the anxiety.
- iii. To be in constant verbal communication with the patient during the procedure. The way we talk, our words, our voice tone must be clear, understandable and calm.

What are the factors that make it possible to reduce pain?

- I. Vaginoscopy:** One of the most important factors for women’s discomfort is the use of speculum, especially if it is associated to tenaculum/Pozzi. The vaginoscopy approach allows us to avoid this discomfort.
- II. Smaller diameter optics:** With the use of an optic with an external diameter lower than 5mm, the pass through the endocervical channel can be performed with minimal discomfort to the patient, and it is achieved in most of the cases. This is the most important limiting factor. Depending on parity (nulliparus) or menopausal stage (post menopausal), the discomfort may increase. Sometimes stenosis with important fibrosis of the internal ostium will increase the difficulty of passing through. The use of misoprostol and/or the use of scissors/laser for cutting the fibrosis will help to overcome the problem in a well-tolerated way. Another important factor associated to patient’s discomfort is the hysteroscopist experience.
- III. Distension medium:** Can be either CO₂ or saline solution. Some authors report that the discomfort is lower with saline solution and actually, this is the most used distension media
- IV. Intrauterine Pressure during the procedure:** Although there are different recommendation to what should be the minimal and the maximal pressure, we should use the minimal pressure for achieve the maximum distension of the endometrial cavity. Some patients will need just “2 drops” and others, specially multiparous

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fertile women will need the maximum and not always will help to get a good distension of the cavity. The precaution of not using too much pressure brings us to the second limiting factor of a procedure without anesthesia; the uterine cavity distension is associated to a discomfort that gradually increases in time. The time limits goes in most cases from 15 to 30 minutes depending on the patient tolerance.

- V. New small surgical devices/energies:** Today we can find new small diameter devices. Those that have a diameter of more of 5mm will need the use of at least local anesthesia (morcellators/mini-resectoscope), others that can be introduced through the 5Fr working channel of the hysteroscope (Laser/mechanical instruments/Bipolar) won’t need any kind of anesthesia.

Strategies

Based on the subjective perception of the pain we try to develop distraction strategies during the procedure.

Stress ball

We asked our patients to concentrate on the ball performing serials of 10 times pressing then stop 1 second and continue doing so. We randomized 2 groups of similar patients, 20 patients in each group. After the procedure we gave the patient a Visual Analogue Scale (VAS) for evaluating the level of pain. There were no significant differences in the pain score between the groups.

Music

We randomized our patients into 2 groups of 30 women each, one with music and the other without. Both groups were similar in characteristics and procedures. The music group had to choose in the application Spotify the music they usually listen to and is relaxing for them. We used wireless headphones. A VAS was used after the procedure, again there were not significant differences between the groups regarding pain but we found a statically significance regarding

satisfaction in favor of the music group. So, the next questions would be, why distraction is not so useful when dealing with pain tolerance to a hysteroscopic procedure? To understand this we need to know what is the pain a woman usually feels during the procedure.

In our case, based in 2200 procedures in office using diode laser (polypectomy/ myomectomy/ septoplasty etc.) without any kind of anesthesia, 90,5% of the women referred that what they felt was equal or less than their normal menstruation. Still, we have cancelled around 5% of the hysteroscopies based on intolerance to the procedure.

Basically, office hysteroscopy is a well-tolerated procedure, but we still need to find more strategies to improve the tolerance and avoid pain/anxiety in those patients that still need it.

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Conflicts of interest

None.