

Operative Hysteroscopy - for polyps/ fibroids/uterine septum/removing IUD's

What happens?

Under GA (sleeping anaesthetic) a 9 mm diameter telescope with a channel for instruments, attached to a video camera is passed through the cervix (or mouth of the womb). The actions needed may be carried out using a small electrical wire loop, probe or scissors. Occasionally a laparoscopy is required at the same time. The telescope system has a constant flow-through fluid (glycine or saline) which washes out any blood or debris so it usually doesn't matter if you have your period.

For what reasons are operative hysteroscopies carried out?

May include

- removing parts of fibroids within the cavity of the uterus,
- remove polyps or scar tissue
- to correct certain abnormalities of the uterus, which may inhibit fertility, and
- to remove IUD's when they cannot be removed in the office for whatever reason

The visual examination and microscopic examination of the endometrial tissue performed by the pathologist can help to establish certain diagnoses including endometrial cancer, endometrial polyps or pre-cancerous conditions of the lining of the uterus (endometrial hyperplasia).

Fibroids that lie completely within the wall of the uterus (intramural) or lie in the outside layers of the uterus (sub-serosal) cannot be removed this way.

Preparation

You will need a general (sleeping) anaesthetic and will be required to fast for around six hours. Please check with my secretarial staff if you are not sure when to fast from. Some patients, depending on the medical condition and associated conditions, may need blood tests, imaging studies or other investigations to be performed. The operation can usually be performed during a patient's period. **It may be necessary to prepare the cervix (make it more "stretchy") for the examination by using misoprostol pessaries inserted into the vagina**, which makes passage of the curette and hysteroscope easier.

It is important to give Dr. Thomas a full list of your medications and allergies prior to the procedure. This also includes natural therapies, herbal preparations and fish oil tablets, which may have an unpredictable effect on the blood's ability to clot.

Perform a home pregnancy test the day before unless you or your partner has been sterilized, or if you are over 50.

Duration of Procedure

Not usually more than one hour.

Post-Procedure Care

After leaving the operating theatre you will usually have a drip or intravenous line in your arm. This is to maintain your hydration as you will have been fasting prior to the procedure. You will be cared for in the Recovery area of the Operating Theatre which involves one on one care by a specialist member of the nursing staff. After around one to two hours you will be offered something to eat or drink if appropriate, will be able to change back into your street clothes and arrangements for discharge will be initiated. The vast majority are performed as day surgery.

Post-Discharge Care

Most patients should be able to resume their regular activities within one to two days. Mild cramping and spotting may occur over a few hours or days. Cramping can be treated with anti-inflammatory medications such as Naprogesic or Nurofen in combination with Panadol or Endone. If still actively bleeding bathing is allowed but swimming in public pools should be avoided for around two weeks. The next menstrual period may occur in around four to six weeks and may not be the same as your regular period.

Excessive bleeding after the procedure is uncommon although I am unable to give you an exact figure as to how long the bleeding will persist. You should notify me should you develop a fever (temperature greater than 37.5 degrees), pain or cramping that does not respond to regular doses of Panadol and Nurofen, or bleeding involving clots or foul smelling vaginal discharge.

A watery discharge is common after fibroid or endometrial resection and may persist for several weeks.

Things to be aware of

This procedure is exceedingly common and major complications are particularly rare. Your safety is my absolute priority!

Heat or physical uterine perforation (<1/1000) of uterus

Rare. May require laparoscopy (keyhole surgery) or laparotomy (larger cut on abdomen) to investigate this if there is a concern at the time of primary surgery. It is possible that this sort of problem may not become apparent for days afterwards.

Infection

Infection is rare but may arise any time over the first few weeks. The infection generally occurs from the patient's own bacteria. Intravenous antibiotics are given during the procedure to minimize the likelihood.

Intra-uterine Adhesions (scarring inside the uterus)

Adhesions can rarely form in the uterus following an operative hysteroscopy. This most common when a curette is done just after a pregnancy or miscarriage and there is active infection. In some cases this can lead to irregularities in the menstrual cycle, painful menstrual cycles, difficulty falling pregnant or miscarriage. Adhesions within the uterus are generally treatable. Sometimes an IUD will need to be inserted for a period of time to help the uterus heal.

Failure to Complete the Procedure.

Occasionally the procedure may not be able to be completed if the cervix is very tight which means that I can't get the telescope through. Other reasons are curtailment of the procedure *if taking more than one hour* (due to the small risk of excess fluid absorption into the patient's body) or *inadequate vision due to blood or floating debris*. Also, It is sometimes impossible to remove fibroids completely in one sitting. Some fibroids need to be resected over two or more operations for technical reasons.

Results from Examination

Pathology results usually take at least forty-eight hours. A post-operative visit will be scheduled after the procedure to discuss.

Questions?

Please don't hesitate to call us before the day of surgery if you have any questions about your operation. Urgent matters can be directed to my paging service on 03 93871000.

