MR JULIAN PAMPIGLIONE MD FRCOG
DORSET FERTILITY

DIAGNOSTIC HYSTEROSCOPY

WHAT IS A HYSTEROSCOPY?

The Womb (uterus) is made of two parts; the cervix (often called the neck of the womb) and the endometrial or womb cavity where implantation and pregnancy occur. In the event of abnormal bleeding the womb cavity may need investigating and possibly a biopsy may be required. This visualization of the uterine cavity is is called a hysteroscopy.

HOW IS A HYSTEROSCOPY PERFORMED?

A hysteroscope is a fibre-optic, lensed straight telescope that is inserted into the womb (uterus). This allows visualization of the inside of the womb cavity. This means that any abnormality within the womb can be seen directly with a camera attached to the hysteroscope. This type of examination is far more accurate then its predecessor the ‘D&C’. Structures such as polyps within the womb (glandular areas of tissue on a stalk) can often be removed and the womb cavity checked afterwards to ensure it has gone. If there is an abnormal area within the womb we can be ensure that any biopsy taken is representative of that area and the chance of missing an abnormality is much lower.

Fibroids that distort the uterine cavity can also be resected and removed.

Hysteroscopy is usually carried out under a short general anaesthetic. It is possible, in certain circumstances, to have it done without anaesthetic. The patient is put to sleep and the legs are placed in a support. If you have had hip or back problems then let the theatre staff know and they can adjust the position of the poles to protect your hips or back. The vagina is cleansed with cleansing fluid and the cervix is located. It has a central passage in it (called the cervical canal) through which the womb cavity is reached. This passage often has to be widened slightly to allow the hysteroscope to pass through it. A set of graded dilators each of which is 1mm larger than the last is passed through to widen the cervical canal. The hysteroscope is then inserted into the womb cavity and the cavity distended with saline fluid, which flows there through the hysteroscope. This separates the two walls of the womb cavity and allows a direct view of these walls and also the point at which the fallopian tubes join the womb.

AFTER THE OPERATION

You would normally expect to go home the same day. You may get some discharge. If you experience loss greater than your normal period then contact the Hospital. You should not drive the next day if you have had an anaesthetic. You may get some period like pains. Take pain killers for these if necessary.

DIAGNOSTIC HYSTEROSCOPY

RISKS
Serious complications of hysteroscopy are rare. They occur about 2 in 1000 operations in women of all ages. These include bleeding, infection and perforation (puncture through the womb wall) with either dilators or hysteroscope. Usually if perforation occurs no action is required but occasionally a laparoscopy may be performed whilst you are still asleep. This involves placing a fibre-optic tube through the umbilicus to visualize the womb from insidethe abdomen (the other side of the perforation to the womb cavity) to assess the problem. Very rarely immediate
surgery is required to correct the perforation.
The mortality is 2-8/100,000 operations partly due to coexisting disease or age.

Please bring sanitary towels with you (not tampons).It will be more comfortable to wear loose-fitting clothing. If you wish you may bring your own dressing gown and slippers.

Please let the staff know if you are menstruating. If you are it may be difficult to perform the procedure, as the view will be obscured by blood, and we may not get the information we hope to obtain from the procedure. In this circumstance it may be necessary to change the date of your procedure. We can usually avoid these dates by agreeing the date of your procedure with you in advance.

Updated 11-7-12 JSP