EDITORIAL

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In outpatient hysteroscopy, experience matters

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Eisenberg-Kogan et al.[1] are to be congratulated on their randomised controlled trial published in this issue of Facts Views and Vision in Gynaecology highlighting an important yet sometimes underestimated aspect of outpatient hysteroscopy: preparation. As awake hysteroscopy is now established as routine practice across the United Kingdom, how we prepare women matters as much as the procedure itself. Standardised, effective, and compassionate information, such as pre-procedure videos, can shape expectations, influence anxiety, and ultimately affect the overall experience.

In this randomised trial of 100 women undergoing awake diagnostic and operative hysteroscopy, an explanatory animated video was compared with verbal preparation. Pre-operative anxiety was low in 72 women, moderate in 25, and high in three. There were no significant demographic, gynaecological, or procedural differences between women with low anxiety and those with moderate to high anxiety. Unsurprisingly, higher pre-procedure anxiety correlated with higher post-procedure visual analogue scale (VAS) pain scores.[1]

The animated video reduced moderate/high anxiety compared with verbal counselling. However, post-procedure pain scores did not differ between groups. A pre-procedure video is easy to implement in routine care and can be shared in advance, allowing time for reflection and the option to decline awake hysteroscopy if preferred.

The increasing emphasis on patient-reported outcomes is appropriate. Pain and anxiety are central to women's experience of hysteroscopy, and contemporary funders expect such outcomes in clinical trials. In procedures like hysteroscopy, experience is as important as technical success.

Awake hysteroscopy is now ubiquitous in National Health Service (NHS) practice. Miniature instruments, vaginoscopic approach, and morcellation systems enabling single-pass procedures have transformed theatre-based surgery into a walk-in, walk-out intervention suitable for most women. NHS England's "Getting It Right First Time" programme recommends that a high proportion of hysteroscopies are performed awake. Yet this shift exists within a tension field. Clinicians and managers aim for cost-effective, minimally invasive, efficient, and safe care. Many women prefer avoiding general anaesthesia and the convenience of outpatient treatment. However, a subset report significant pain and, in some cases, emotional distress or trauma. Advocacy groups such as Women Against Painful Hysteroscopy have highlighted the need to prioritise comfort, choice, and informed consent.

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Previous difficult gynaecological experiences can make awake procedures less tolerable.[2] Awake hysteroscopy is not right for every woman. Nonetheless, for those choosing it, any intervention that reduces pre-procedure anxiety deserves attention.

The absence of an effect on pain in this study should not detract from its importance. Pain during hysteroscopy is multifactorial. Patient-related factors include menopause, nulliparity,[3] abnormal uterine angles,[4] chronic pelvic pain, or a history of trauma. Procedural duration and complexity, as well as operator experience also contribute. Anxiety is only one component of this complex interplay. The finding that modifying anxiety did not reduce pain scores does not diminish its relevance.

Crucially, procedural pain does not automatically equate to an unacceptable experience. Mahmud et al.[5] reported that 82% of women described outpatient hysteroscopy positively and only 7% negatively, despite 35.5% reporting VAS pain scores between 70–100 mm. Pain is a physical sensation; acceptability is broader, encompassing communication, trust, dignity, and perceived control.

Pain is easier to tolerate when patients feels informed, safe, and respected. Education before a procedure fosters psychological safety. Many hysteroscopists recognise the scenario of an anxious woman who leaves the clinic visibly relieved after a straightforward procedure. Reducing anxiety may enhance satisfaction even without lowering pain scores. Inclusion of validated satisfaction measures would have strengthened the study's assessment of overall experience.

The finding that video information reduced anxiety more effectively than verbal counselling raises important questions. The content and standardisation of the verbal briefing are not described. Was pain explicitly discussed? Was the script consistent across clinicians? A key advantage of video is standardisation—eliminating inter- and intra-operator variability in wording, tone, and emphasis. In busy clinics with rotating staff, this consistency may be invaluable.

Generational shifts may also play a role. Visual explanations that illustrate anatomy and instruments may resonate more with Gen Z and Millennials accustomed to digital media. With artificial intelligence–supported translation tools, high-quality video counselling can also be made accessible to women who do not speak English as a first language.

Having led a team of filmmakers, researchers, and clinicians to co-develop an educational animation for awake hysteroscopy (Figure 1), I found it fascinating to compare our approach with the video used in this trial.

Figure 1. BSGE accredited information video on awake hysteroscopy co-produced with women with lived experience.

Co-development with women with lived experience introduced priorities clinicians might overlook. These included explicit emphasis on conscious choice, reassurance that awake hysteroscopy is optional, and clear scripting on how to withdraw consent if the procedure becomes unacceptable.

Women involved in our workshops were particularly concerned about how the hysteroscope was depicted. They did not want imagery suggesting impalement or exaggerated scale. They stressed accurate portrayal of the outpatient setting and inclusive representation across age and culture.

The most powerful lesson from co-development was the centrality of control. Explicit phrases such as "stop means stop," alongside agreed non-verbal cues like raising a hand, were highlighted as an important pre-procedure agreement between patient and healthcare professional. Although withdrawal of consent is uncommon, knowing that one can stop at any time is empowering. That sense of agency may itself reduce anxiety.

The co-development process also revealed variation in United Kingdom practice, including deviations from vaginoscopic technique, lapses in dignity, and instances where requests to stop were dismissed. These accounts underscore the need for reflective practice as well as better information. Hysteroscopists must comply with standards of care[6,7] and will benefit from studying patient information themselves, particularly the expectation of a vaginoscopic approach. An educational video on techniques to minimise discomfort in vaginoscopy will soon be available for professional training for healthcare professionals.

User involvement in developing patient information can add peer narratives of how it feels to experience the procedure. The gold standard for future patient information on medical procedures should be co-development with women who have lived experience. This aligns with shared decision-making and patient-centred care.

Ultimately, we should ask ourselves what standard of preparation for a medical procedure we would like to receive for ourselves or our families. Adequate preparation can make or break the experience of awake hysteroscopy. This study demonstrates that a simple, scalable intervention can reduce anxiety. That alone is worthwhile.

Future research could explore co-developed video content and include validated satisfaction measures. Reducing anxiety may not abolish pain, but it may transform the experience. In outpatient hysteroscopy, experience matters.

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References

1. Eisenberg-Kogan N, Gal-Kochav M, Naor-Dovev M, Segal H, Mor M, Smorgick N. A prospective trial comparing the effect of preoperative information given verbally with the use of an explanatory animated video before outpatient hysteroscopy on patients' anxiety and pain. Facts Views Vis Obgyn. 2026;18:25-31.
2. Royal College of Obstetricians and Gynaecologists. Outpatient hysteroscopy: information for you [Internet]. London: RCOG; 2025. Available from: https://www.rcog.org.uk/media/beidjnh2/pi-outpatient-hysteroscopy_2025.pdf
3. Coimbra AC, Falcão V, Pinto P, Cavaco-Gomes J, Fernandes AS, Martinho M. Predictive factors of tolerance in office hysteroscopy - a 3-year analysis from a tertiary center. Rev Bras Ginecol Obstet. 2023;45:38-42.
4. Tercan C, Dagdeviren E, Yeniocak AS, Can S. The role of uterine anteversion and flexion angles in predicting pain severity during diagnostic hysteroscopy: a prospective cohort study. Ginekol Pol. 2025;96:524-31.
5. Mahmud A, De Silva P, Smith P, Justin Clark T. Patient experiences of outpatient hysteroscopy. Eur J Obstet Gynecol Reprod Biol. 2023;288:142-52.
6. Clark TJ, Morris E, Lord J, Connor M, Shakir F, Ball E. Pain relief and informed decision making for outpatient hysteroscopy procedures. Good Practice Paper No. 16 [Internet]. London: Royal College of Obstetricians and Gynaecologists; 2023. Available from: https://www.rcog.org.uk/media/ymvha2n3/gpp16-final-publication-proof.pdf
7. De Silva PM, Smith PP, Cooper NAM, Clark TJ; Royal College of Obstetricians and Gynaecologists. Outpatient Hysteroscopy: (Green-top Guideline no. 59). BJOG. 2024;131:e86-e110.