

Research and audit are essential for improving women's experience of outpatient hysteroscopy

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Outpatient hysteroscopy is one of the most common procedures in contemporary gynaecology. The convenient setting and avoidance of general anaesthesia or sedation¹ allow for quicker recovery and avoids hospital admission.² Most patients consider the degree of discomfort experienced as acceptable. However, up to a third of patients experience severe pain.³ This means abandoning the procedure in 5-10% of all patients undergoing the procedure and subsequent rescheduling to an operating theatre for a general anaesthetic.²

Severe pain is the biggest driver of poor patient experience and a wider negative perception of outpatient hysteroscopy among some women. In the United Kingdom (UK), the Women's Health Strategy for England,⁴ has prioritised the need to ensure that women do not endure painful procedures. Evidence-based guidelines have been published⁵ outlining the evidence for interventions that minimise pain and recommendations for implementation. The guidance identified the need to find and evaluate novel interventions in outpatient hysteroscopy, and gynaecology more broadly, to reduce pain and improve the patient experience.

In this issue of Facts, Views and Vision in ObGyn (FVVO), a group in Italy has conducted a randomised controlled trial (RCT) comparing the use of intraoperative music or oral analgesia premedication for pain control during outpatient hysteroscopy.⁶ Neither intervention was found to reduce pain compared to their standard approach, where no additional pain control measures were used. This negative finding probably reflects their routine use of evidence-based technical aspects⁵ such as adoption of a vaginoscopic technique and the use of small-diameter hysteroscopes, as well as limiting procedures to diagnostic or minor operative interventions. Methodologically, the study has limitations that limit clinical inferences. These include failure to define a minimally important magnitude of pain reduction to power the study and restriction of patient-reported outcomes to pain scores. Other measures of experience, such as acceptability and willingness to undergo the procedure again, would have provided more granularity. This RCT was conducted in a single centre by the same expert gynaecologist, potentially limiting generalisability. Outpatient hysteroscopy may be performed by clinicians with differing levels of expertise, including residents and nurse

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hysteroscopists, and operator experience may influence procedural outcomes and patient experience. Future studies should therefore consider including multiple operators across different centres and reporting operator experience (e.g., procedural volume rather than operator grade or type) to better reflect real-world practice. Nevertheless, the authors should be congratulated for completing an RCT in this much-needed area.

An international consensus paper¹ has defined pain control options in the outpatient setting according to three levels: Level 1- no medication or the use of oral non-sedative medication; Level 2- Local anaesthetic to the genital tract and Level 3 (a)- Oral or inhalational medications with a sedative effect. The RCT published in this issue of FVVO⁶ has evaluated Level 1 pain relief interventions. More such trials are needed to evaluate pain relief options for outpatient hysteroscopy across all levels, whether used in isolation or in combination. To this end, we have recently been funded to conduct a large multi-centre RCT in the UK, to evaluate the use of Pentrox as a mobile, handheld device that allows patients to self-administer a rapidly acting analgesic medication with a mild sedative effect, methoxyflurane, by breathing in and out of the mouthpiece [equating to pain relief Level 3(a)]. The technology is widely used for the relief of trauma-associated pain, often in emergency settings, but has shown promise for elective interventions, including outpatient hysteroscopic procedures.^{7,8} We will compare Pentrox against nitrous oxide and include diagnostic and operative hysteroscopic and other intrauterine procedures, including endometrial ablation. We hope that this RCT will allow us to better understand the relative roles of inhalational analgesia and which patients and which procedures, if any, will benefit from the use of Pentrox.

We also propose developing a core outcome set, using established methodology, for measurement and reporting in all outpatient hysteroscopy trials.⁹ These outcomes will include measures of safety, effectiveness and patient experience. Our proposal will involve all relevant stakeholders and an international collaboration of clinicians. Standardising outcomes will aid interpretation of trials, like the one published in this issue of FVVO,⁶ enhancing evidence-based decision-making and the quality of research in outpatient hysteroscopy.

Outside of research aimed at discovering the best ways of conducting outpatient hysteroscopy, it is also important that we quality assure our practice to

ensure we are actually implementing these optimal practice interventions and achieving expected levels of performance. The British Society of Gynaecological Endoscopy (BSGE) has developed a patient reported outcome measure; the OutPatient Hysteroscopy-Patient Satisfaction Survey (OPH-PSS).^{3,10} Moreover, the recent joint Royal College of Obstetricians and Gynaecologists/BSGE evidence-based guidelines for outpatient hysteroscopy⁵ includes an audit tool covering procedural aspects, such as success, vasovagal reactions, uterine trauma, infection, and hospital admissions, for clinicians to complete and evaluate against published standards. We are planning to use this audit tool alongside the OPH-PSS to conduct a national UK audit across National Health Service hysteroscopy units over a 3-6 month period. This will allow us to collect an electronic dataset for thousands of consecutive women undergoing outpatient hysteroscopic procedures to understand what the real world performance and experience of outpatient hysteroscopy is. In this way we hope to improve care by identifying themes, disseminating good practice and examining the causes and potential solutions for areas of deficiency.

Outpatient hysteroscopy remains one of the most common and useful diagnostic and therapeutic interventions in modern gynaecology. Our patients deserve high quality care. To this end we must develop and participate in research to improve clinical outcomes, including patient experience. Furthermore, we must effectively implement best practices and reassure ourselves and our patients that we are delivering high quality, evidence-based care. This mandates regular audit of our services.

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