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Letter to the Editor: Research and audit are essential to improving women's experience of outpatient hysteroscopy

Valerie Humphreys

(formerly) School of Law, Birmingham City University, Birmingham, United Kingdom

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Dear Editor,

It is pleasing to see the authors[1] acknowledging the significant concern expressed in the Department of Health and Social Care (DHSC) Renewed Women's Health Strategy[2] in which pain suffered during gynaecological procedures, in particular outpatient hysteroscopy (OPH), is highlighted and drives two of its action points:

"Action 7: We will co-develop with women a standard of care for the delivery of gynaecological procedures such as hysteroscopy, ensuring women have informed consent and choice of pain relief"

"Action 4: We will test patient power payments-prioritising some gynaecological services…-which would vary the amount Trusts are reimbursed depending on women's feedback on their experiences, including pain management"

The authors also make reference to the RCOG Green Top Guideline (GTG) on OPH[3] stating that the Guideline contains "evidence of interventions to minimise pain and recommendations for implementation".

In fact, the only intervention routinely recommended in the Guideline is pre-medication with NSAIDs. Local anaesthesia is considered unnecessary unless cervical dilatation is planned and sedation in an outpatient setting is deemed to provide little additional pain relief and to be inadvisable on safety grounds. So-called "vocal local" is mentioned but without evidence that it has any effect on pain. However, the paper "Music and Oral Premedication for Pain Management during Outpatient Hysteroscopy: Results from a Randomised Controlled Trial"[4] indicates that such premedication has no effect on pain, as acknowledged in the editorial.

There is therefore something of an incongruity here. As premedication has no effect, the GTG therefore has nothing to offer women, one third of whom suffer severe pain, in terms of routine pain relief. It is difficult to reconcile this with the view that, if the GTG were fully implemented, this would improve women's experience.

It is notable that ACOG guidance[5] contains a list of options for pain management in OPH, including

Corresponding Author: Valerie Humphreys, (formerly) School of Law, Birmingham City University, Birmingham, United Kingdom
E-mail: vehumphreys@gmail.com **ORCID ID:** orcid.org/0009-0003-5889-3462
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benzodiazepine, opiates, topical anaesthetic, intracervical and paracervical blocks and that the Faculty of Sexual and Reproductive Healthcare Guideline[6] on intrauterine contraception lists several pain management options.

Whilst it is encouraging to see that Penthrox is becoming more widely used, I am at a loss to understand why the GTG has not been amended to reflect what is becoming apparent, viz that OPH will, for ethical, financial and patient satisfaction reasons, be acceptable to women and, importantly, to the DHSC only if a full range of pain management options is routinely offered.

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