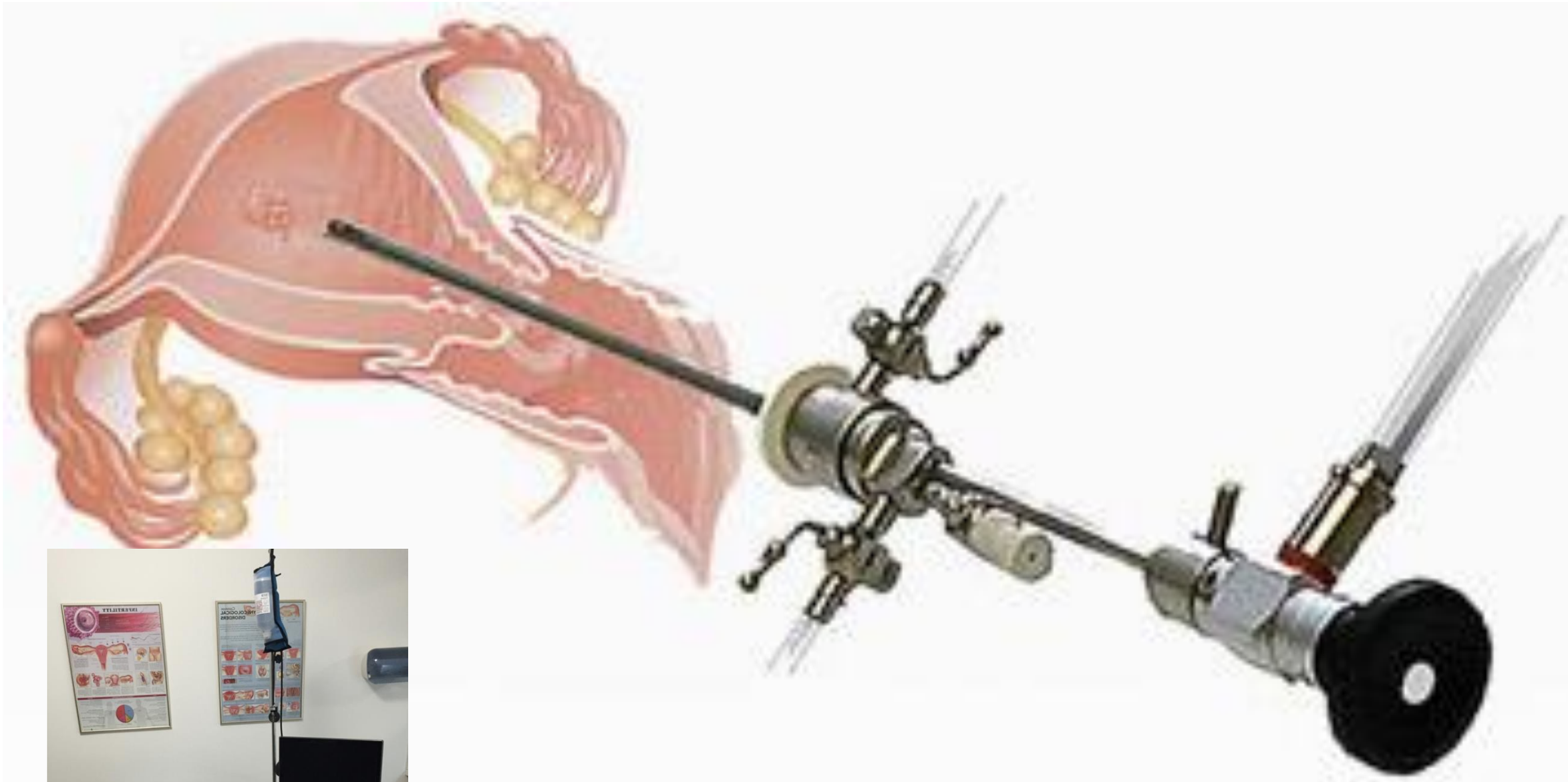
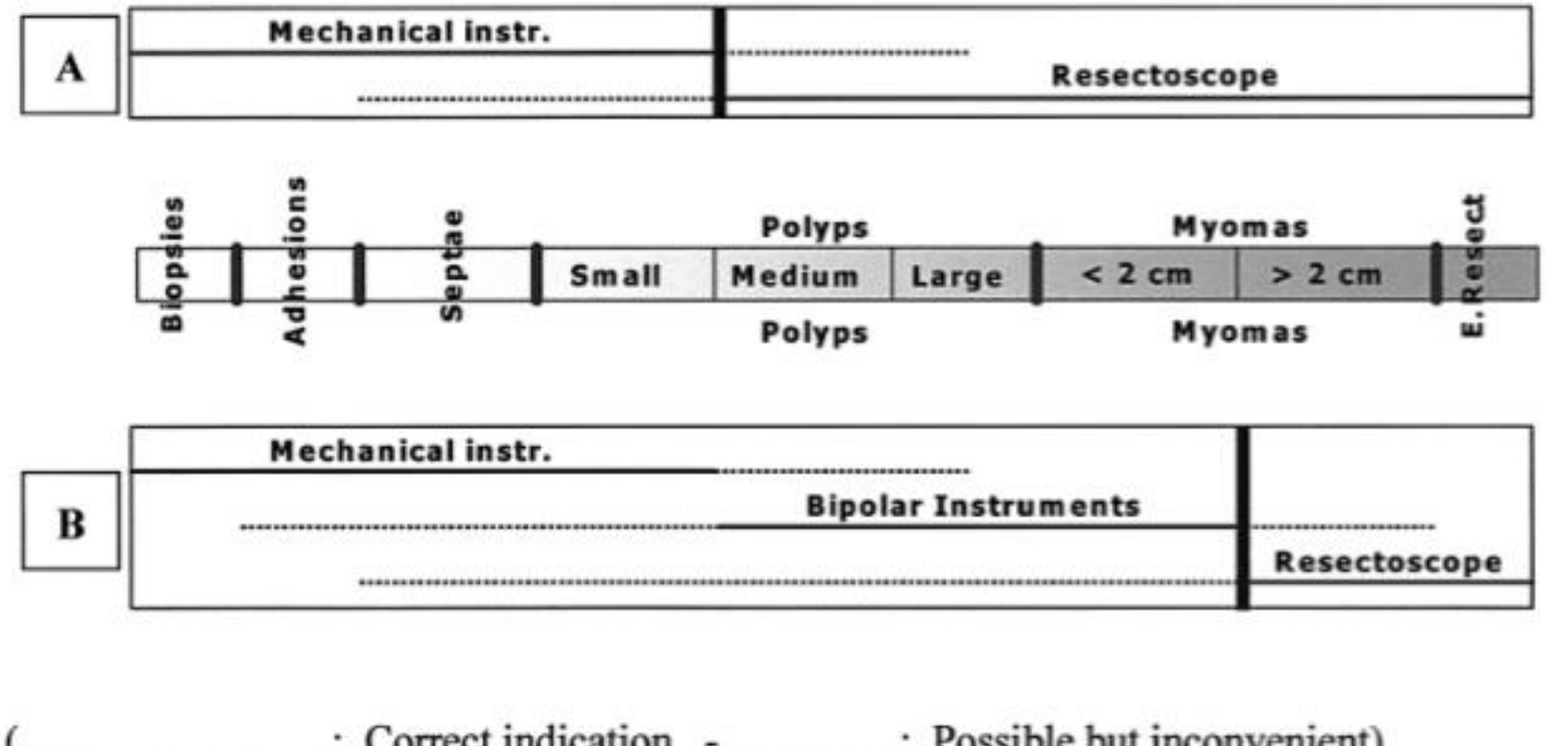
New Hysteroscopic Systems for Outpatient Use

Prudence V. Aquino-Aquino,MD
Hysteroscopy & Infertility Simultaneous Session





(_____: Correct indication - ……. : Possible but inconvenient)

Figure 4. Scheme of our treatment indications for office operative hysteroscopic surgery, before (**A**) and after (**B**) 1998.

Vilos, GA(1999) Intrauterine surgery using a new coaxial bipolar electrode in normal saline (versapoint): a pilot study. Fertl. Sterility., 72, 740-743.

Mechanical Operating Systems with tissue preservation

Campotrophyscope

IBS

Mechanical Operating Systems with tissue preservation

CAMPO Compact Hysteroscope TROPHYscope®

Special Features:

- **Enables the primary approach to the uterine cavity under visual control with an outer diameter of only 2.9 mm**
- **Innovative sheaths with sliding mechanism**
  - Sheaths are only used when required
  - Atraumatic dilation of the cervix with the telescope
- **2.9mm, 3.7mm, 4.4mm**

Mechanical Operating Systems with tissue preservation

CAMPO Compact Hysteroscope TROPHYscope®

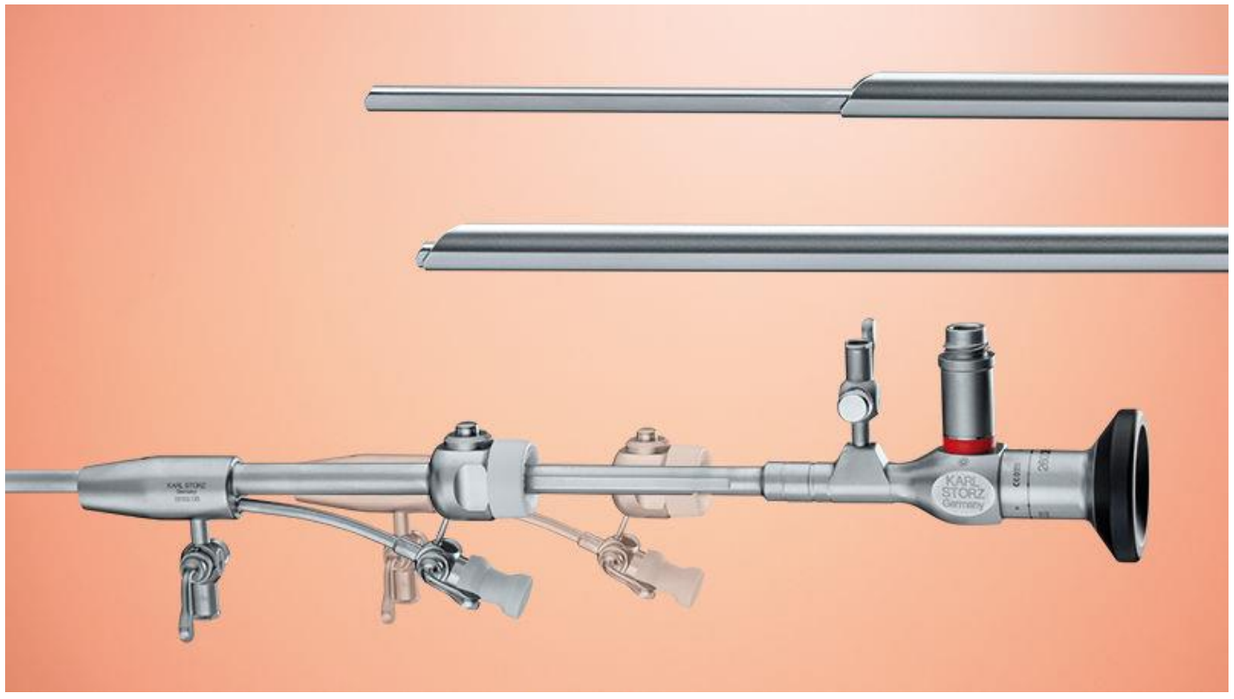
Hysteroscopes diameters

:

2.9mm

3.7mm

4.4mm



No cervical dilation is required so no general anaesthesia/analgesia

Mechanical Operating Systems with tissue preservation

CAMPO Compact Hysteroscope TROPHYscope®

Scissors

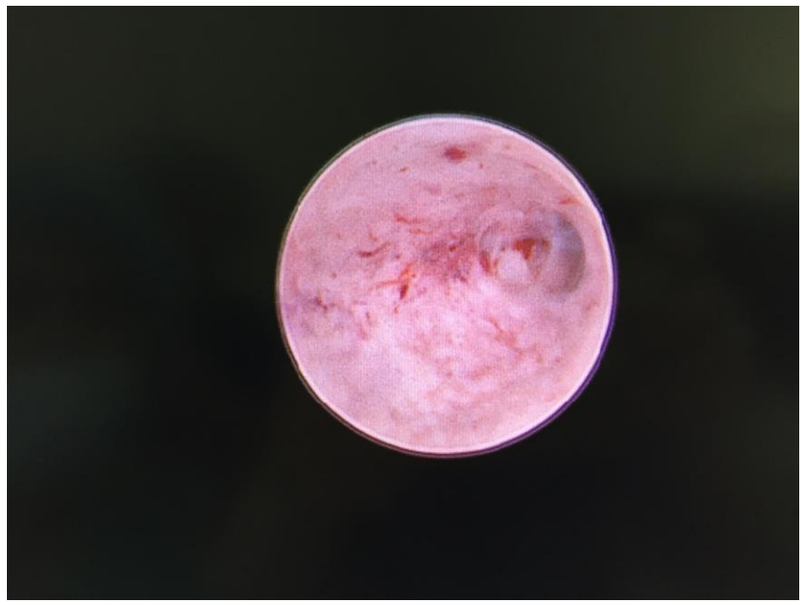
Biopsy forceps

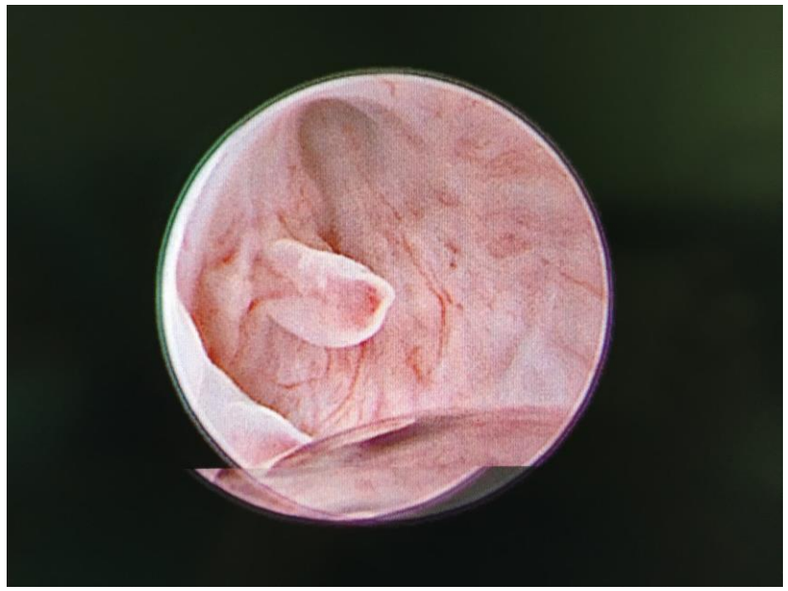
Grasper

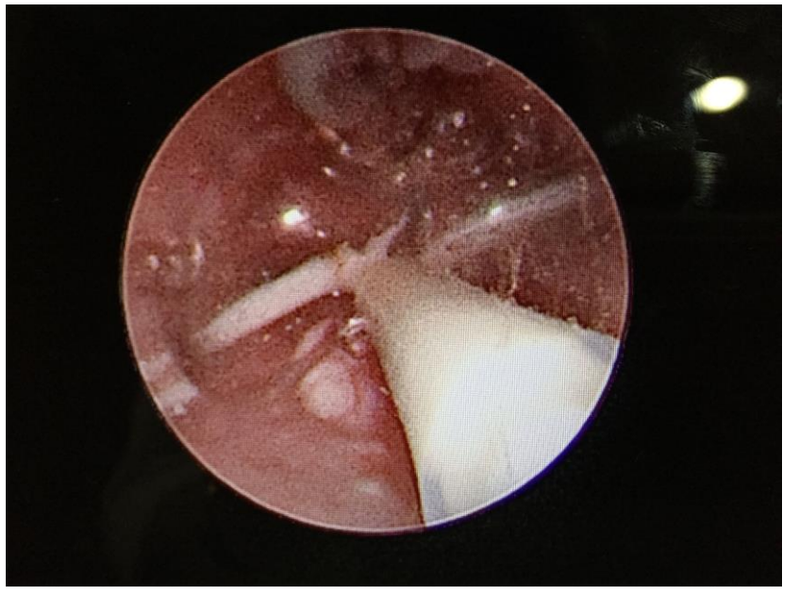
Campo can be also used with bipolar needles to cut septum and removed with grasper

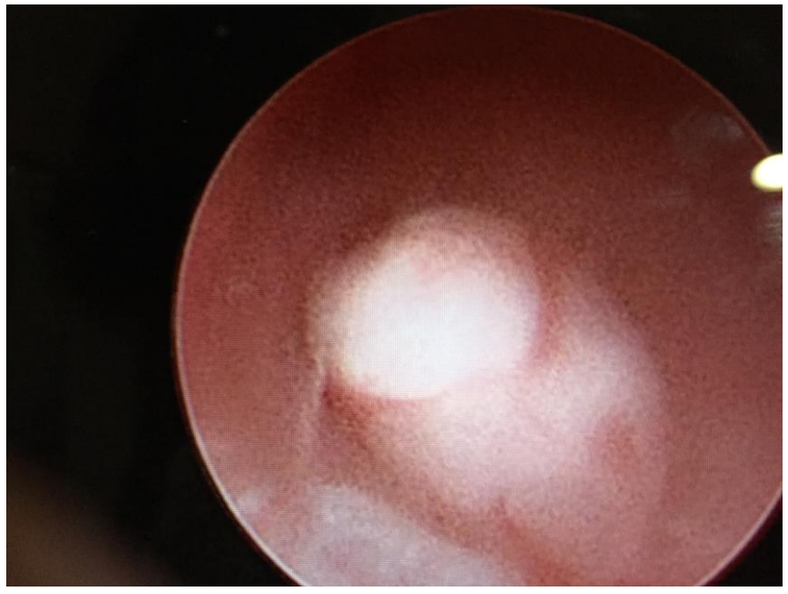
CAMPO Compact Hysteroscope TROPHYscope®

Indications:

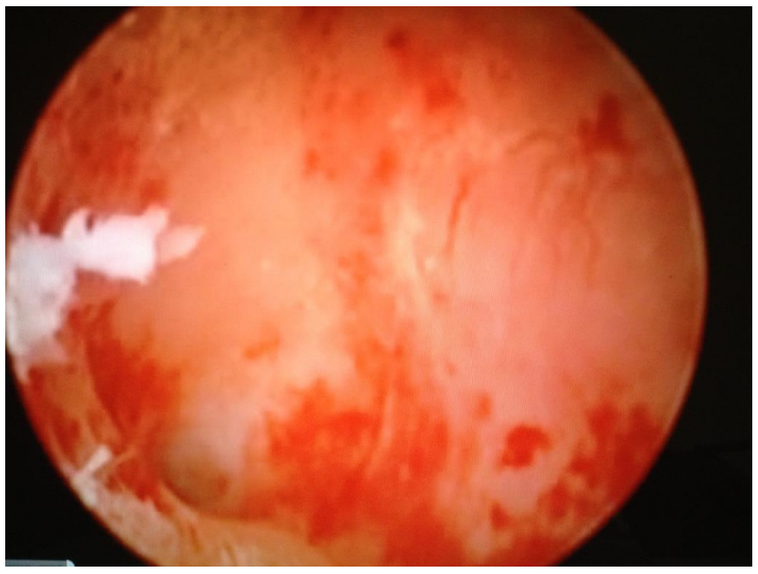


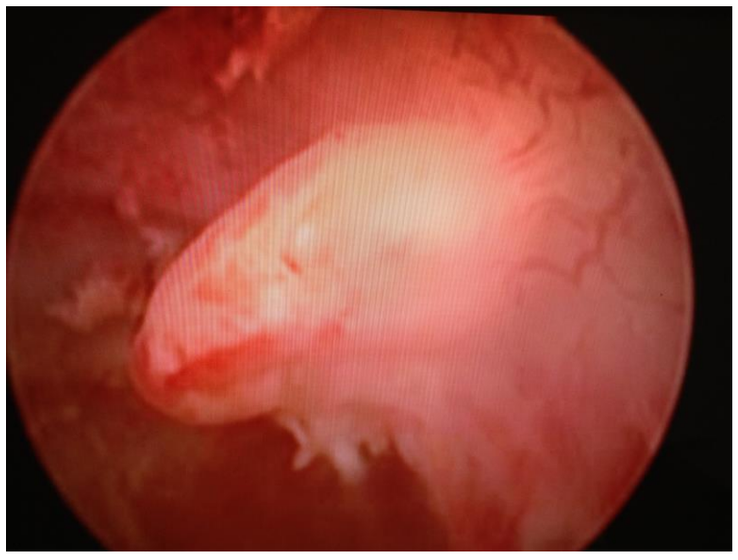


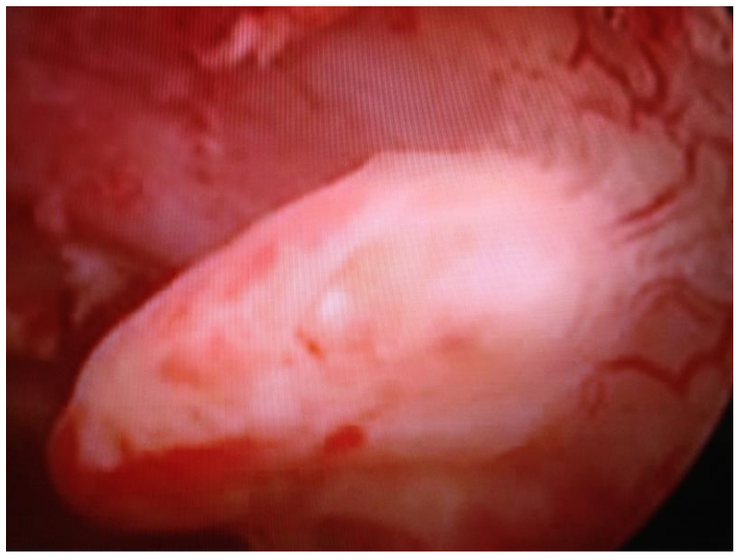


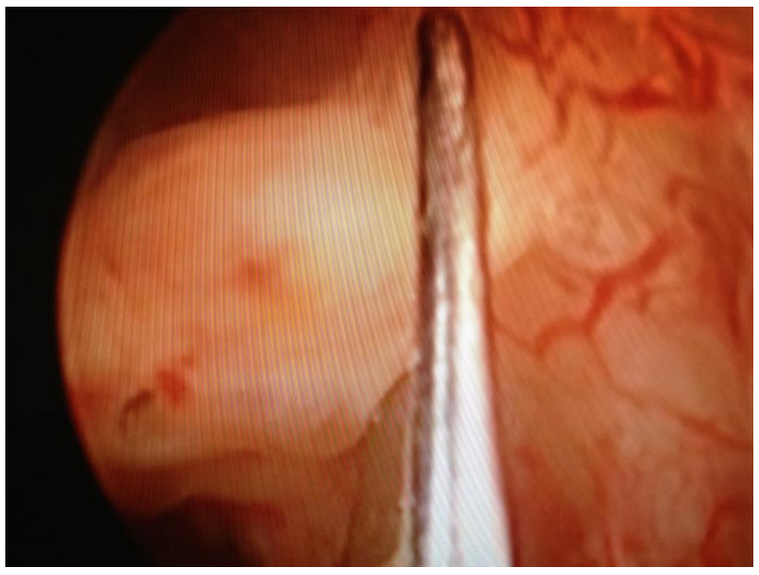


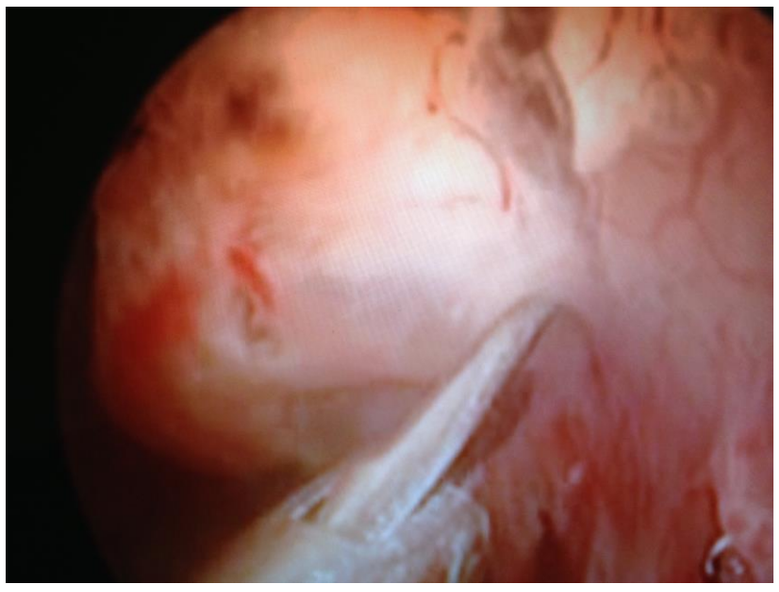
CAMPO Compact Hysteroscope TROPHYscope®











CAMPO Compact Hysteroscope TROPHYscope®

Insert video of challenging cases

Eur J Obstet Gynecol Reprod Biol. 2008 Aug;139(2):210-4. doi: 10.1016/j.ejogrb.2007.11.008. Epub 2008 Jan 14.

Outpatient operative polypectomy using a 5 mm-hysteroscope without anaesthesia and/or analgesia: advantages and limits.

Litta P1, Cosmi E, Saccardi C, Esposito C, Rui R, Ambrosini G.

OBJECTIVE:
To assess the predictors of office-based operative hysteroscopic polypectomy using a 5.2mm continuous flow office hysteroscope without anaesthesia and/or analgesia for the treatment of endometrial and/or isthmic polyps and to define procedure limits.

STUDY DESIGN:
=Women with hysteroscopic diagnosis of endometrial or isthmic polyps were offered to proceed in the same session with operative hysteroscopy after 15 min without anaesthesia and/or analgesia.
=All procedures were performed using a 5.2 mm continuous flow office hysteroscope.
=Patient procedure compliance was assessed by means of a visual analogue scale (VAS) using a rating scale with 11 categories.
= A VAS < or = 4 was considered as patient procedure compliance.
Regression analysis was performed to correlate the following variables: time required, size and number of polyps with VAS. A ROC analysis was performed to assess the cut-off of the strongest predictors. The influence of previous vaginal delivery and menopausal status was correlated with the VAS.

RESULTS:
217 women underwent the office-based hysteroscopic procedure and 253 polyps were removed,
=170 were endometrial and 83 isthmic polyps. 181 women with single polyps and 36 women presented multiple polyps.
=The size of polyps ranged from 0.5 to 5 cm.
=Median time of the procedure was 10 min (range 3-30 min).

CONCLUSIONS:
=Office-based hysteroscopic polypectomy is a safe and feasible procedure and should be addressed in patients with endometrial or isthmic polyps < or = 2 cm in diameter,
=Predictors of success of the procedure:
1) size of polyps and operating time,
2)independent from menopausal status and previous vaginal delivery.

PMID: 18248873 DOI: 10.1016/j.ejogrb.2007.11.008

J Am Assoc Gynecol Laparosc. 2004 Feb;11(1):59-61.
Operative office hysteroscopy without anesthesia: analysis of 4863 cases performed with mechanical instruments.
Bettocchi S1, Ceci O, Nappi L, Di Venere R, Masciopinto V, Pansini V, Pinto L, Santoro A, Cormio G.
(http://www.ncbi.nlm.nih.gov/pubmed/15104833)

Author information
Abstract
STUDY OBJECTIVE:
To evaluate the efficacy of, and patients' satisfaction with, office hysteroscopic treatment of benign intrauterine pathologies using 5F hysteroscopic instruments.
DESIGN:
Observational clinical study (Canadian Task Force classification II).
SETTING:

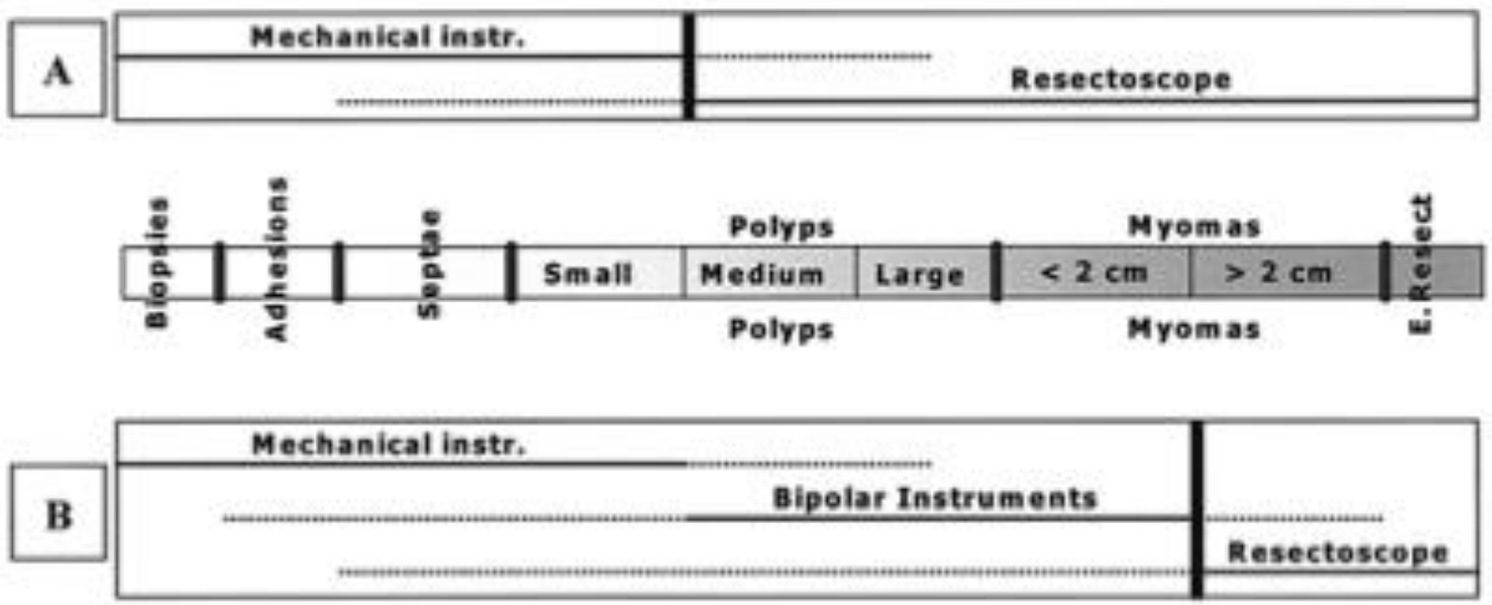
CONCLUSION:
Simple instruments enable us to perform many operative procedures in an office setting with excellent patient satisfaction, provided that the indications are

Findings:
5F mechanical instruments (scissors, grasping forceps) to treat cervical and endometrial polyps ranging between 0.2 and 3.7 cm, as well as intrauterine adhesions and anatomic impediments.
=71.9% to 93.5% of women underwent the procedure without discomfort for all pathologies treated except endometrial polyps larger than the internal cervical os,
=63.6% experienced low or moderate pain.
=At 3-month follow-up, pathology persisted in 364 patients (5.6%)

SLMC QC experience

show data

Mechanical Operating Systems with tissue preservation



(_____ : Correct indication - ..... : Possible but inconvenient)

Figure 4. Scheme of our treatment indications for office operative hysteroscopic surgery, before (**A**) and after (**B**) 1998.

Intrauterine BIGATTI Shaver - IBS

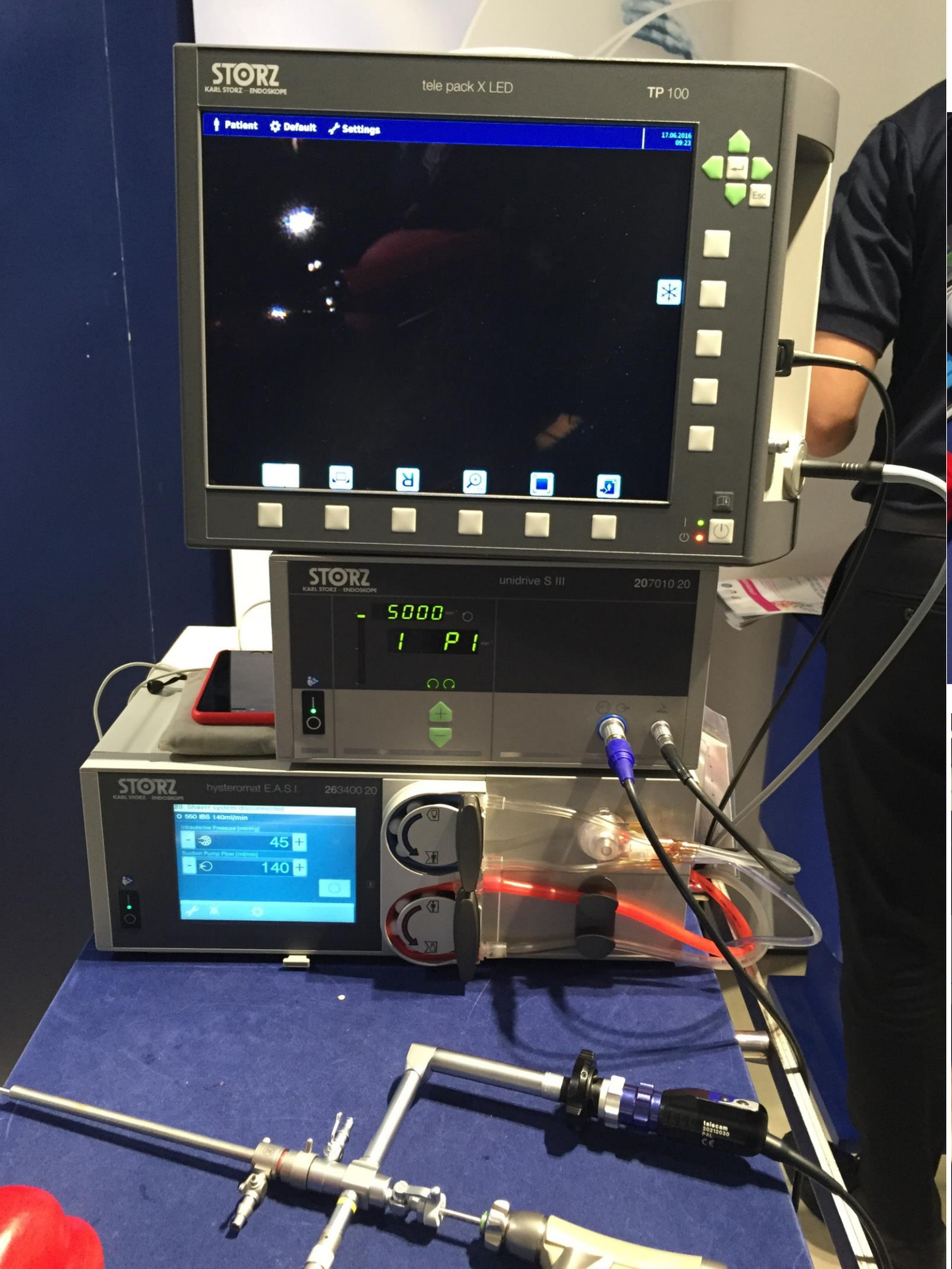
=Innovative and effective device
=Proposed and it may become in the near future a valid alternative to the traditional transcervical resectoscopic myomectomy.

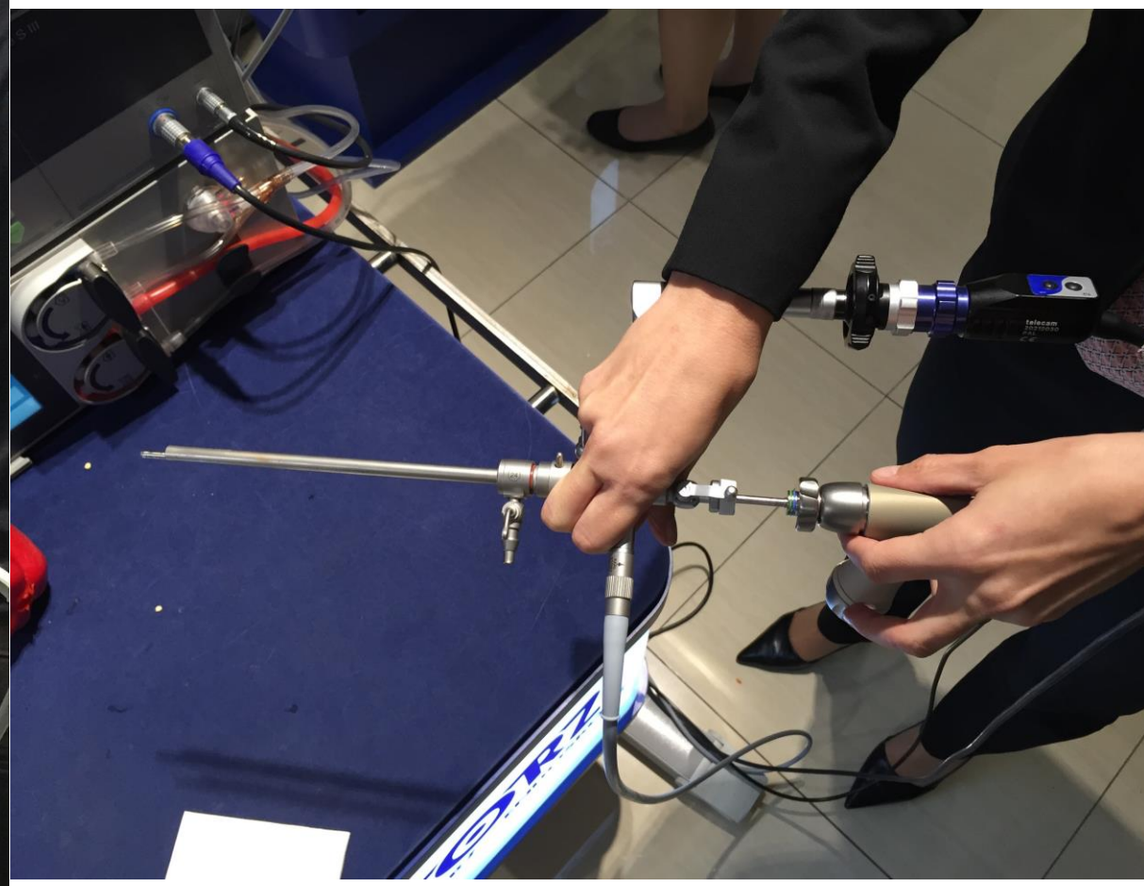
Emanuel and Wamsteker, 2005

Intrauterine BIGATTI Shaver - IBS

Continous flow of fluids + suction of fluids with shaved tissues

Problems that are addressed:
fluid overload, uterine perforation due to uni/bipolar currents and lack of visualisation due to specimens


STORZ
KARL STORZ - ENDOSKOPE
tele pack X LED
TP 100
Patient
Default
Settings
17.06.2016
09:23
Esc
STORZ
unidrive S III
20 7010 20
5000
1 P1
STORZ
hysteromat E.A.S.I.
263400 20
550 IBS 140ml/min
45
140



Intrauterine BIGATTI Shaver - IBS

26208 SA

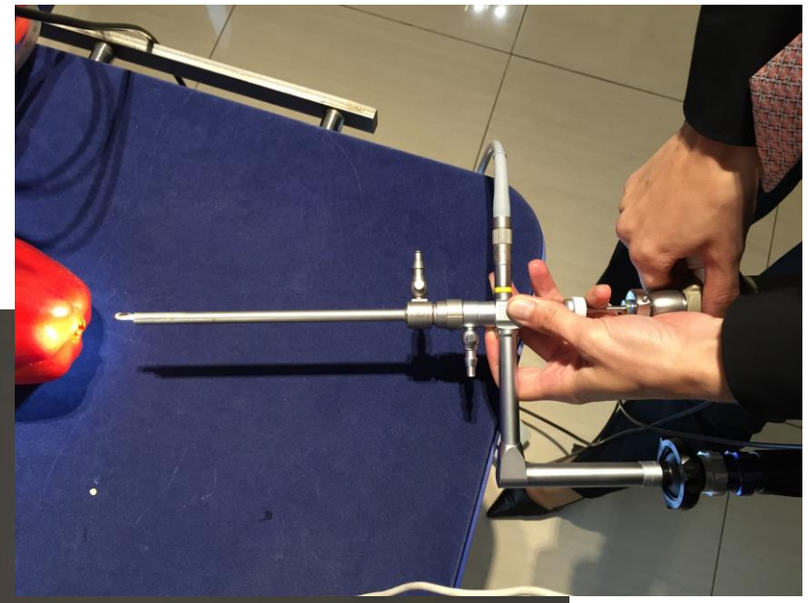
Shaver Blade GYN, straight, sterilizable, concave cutting edge, double serrated, oval cutting window, diameter 4 mm, length 32 cm, for use with DRILLCUT-X® II Handpiece **26** 7020 50, color code: blue-green

26208 SB

Shaver Blade GYN, straight, sterilizable, double serrated cutting edge, rectangular cutting window, diameter 4 mm, length 32 cm, for use with DRILLCUT-X® II Handpiece **26** 7020 50, color code: blue-yellow

Direct Extraction of resected tissues through the suction channel - Operating Sheath OD 8mm(24 Fr)


STORZ



J Minim Invasive Gynecol. 2005 Jan-Feb;12(1):62-6.

The Intra Uterine Morcellator: a new hysteroscopic operating technique to remove intrauterine polyps and myomas.

Emanuel MH[1], Wamsteker K.

⊕ Author information

Abstract

STUDY OBJECTIVE: A new hysteroscopic operating technique was compared retrospectively with conventional resectoscopy.

DESIGN: Retrospective comparison (Canadian Task Force Classification II-2).

SETTING: Gynecology department of a university-affiliated teaching hospital.

PATIENTS: Fifty-five women, 27 with endometrial polyps and 28 with submucous myomas.

INTERVENTION: Patients were treated with a prototype of the Intra Uterine Morcellator (IUM). This cutting device, 35 cm in length, was inserted into a straight working channel of a 90-mm hysteroscope.

MEASUREMENTS AND MAIN RESULTS: The major advantages were ease of removal of tissue fragments through the instrument and the use of saline solution instead of electrolyte-free solutions used in monopolar high-frequency resectoscopy. The mean operating time was 8.7 minutes (95% CI: 7.3-10.1) for the removal of endometrial polyps compared with 30.9 minutes (CI: 27.0-34.8) for resectoscopy, and 16.4 minutes (CI: 12.6-20.2) for submucous myomas compared with 42.2 minutes (CI: 39.7-44.7) for resectoscopy. All procedures were uneventful.

Conclusion
This new technique: easier to perform
Fewer fluid over-load
learn curve shorter vs traditional resectoscope

t in fewer fluid-related

Review of the complications after hysterosocpic myoemctomy

=Two cases of uterine rupture following such surgery (Derman et al., 1991; Yaron et al., 1994)

Interval between uterine operation infringing on the myometrium and attempts for pregnancy
= should not be less than one year from the date of uterine surgery (Valle and Buggish, 2007).
=caesarean section should be preferred when-ever you are dealing with fibroids with intramural development (Keltz et al., 1998; Cravello et al., 2004),

Post-operative IUA

Incidence of post-operative IUAs
=the major long- term complication of hysterosocpic myomectomy ranging from 1 to 13% (Wamstecker et al., 1993; Hallez, 1995; Giatras et al., 1999).
To minimize the risk of post-operative IUA:
1) avoid forced cervical manipulation, and trauma of healthy endometrium and myometrium surrounding the fibroid;

2) it is also advisable to reduce the usage of electrosurgery especially during the removal of fibroids with extensive intramural involvement (Mazzon, 1995) and multiple fibroids on opposing endometrial surfaces (Indman, 2006).

3) An early second-look hysteroscopy after any hysteroscopic surgery is another effective preventive and therapeutic strategy (Wheeler and Taskin, 1993).

OUTPATIENT HYSTEROSCOPY

	LOR
Topical application of **local anaesthetic** to ectocervix where application of a cervical tenaculum is necessary	A
Local anaesthetic into or around cervix reduces pain during hysteroscopy. Routine administration of intracervical or paracervical LA recommended in postmenopausal women	A
Conscious sedation should not be routinely used in outpatient hysteroscopic procedures, it confers no advantage in terms of pain control and satisfaction over LA.	A
Vaginoscopy reduces pain during diagnostic rigid outpatient hysteroscopy	A
Routine cervical dilatation is associated with pain, vasovagal reactions and uterine trauma and should be avoided	C

RCOG Green-top Guideline No. 59 (2011

Thank You