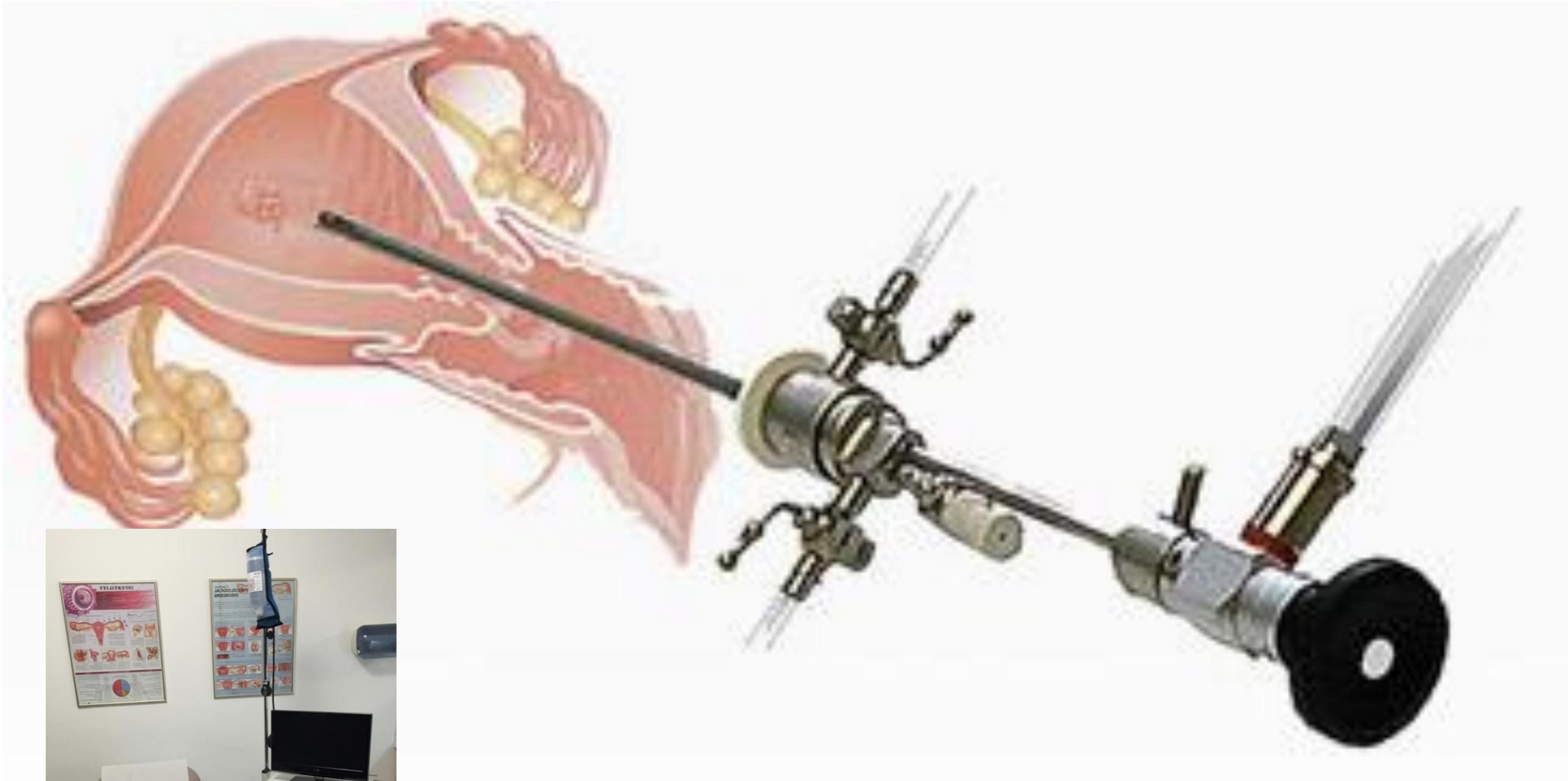
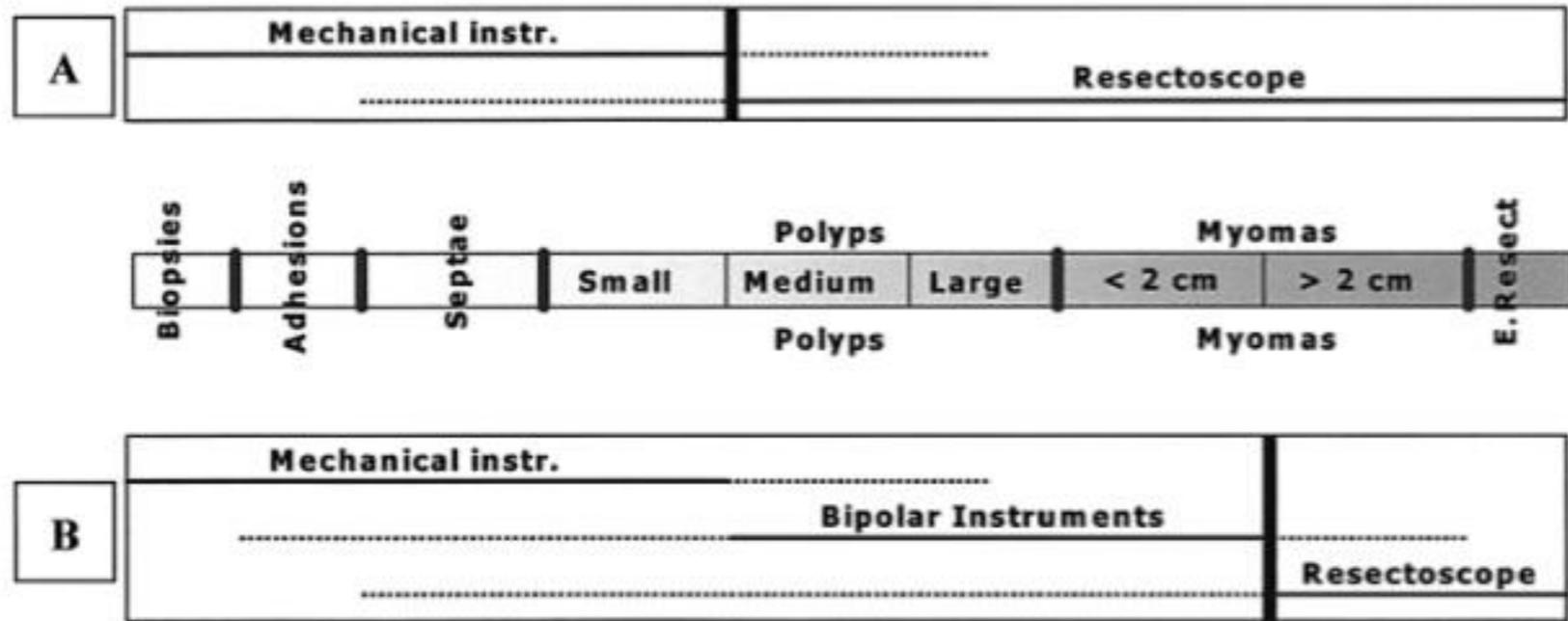


Hệ thống Nội soi Buồng Tử Cung mới cho Bệnh nhân ngoại trú

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.

Hệ thống Phẫu thuật Cơ học bảo toàn mô

Campotrophyscope
IBS

CAMPO Compact Hysteroscope TROPHYscope®

Tính năng đặc biệt:

- Cho phép tiếp cận tới khoang tử cung bằng điều khiển trực quan với đường kính ngoài chỉ 2.9 mm
- Vỏ cải tiến với cơ cấu trượt
 - Chỉ sử dụng vỏ khi cần
 - Nong cổ tử cung không tổn thương bằng ống soi
- 2.9mm, 3.7mm, 4.4mm



Hệ thống Phẫu thuật cơ học bảo toàn mô

CAMPO Compact Hysteroscope TROPHYscope®

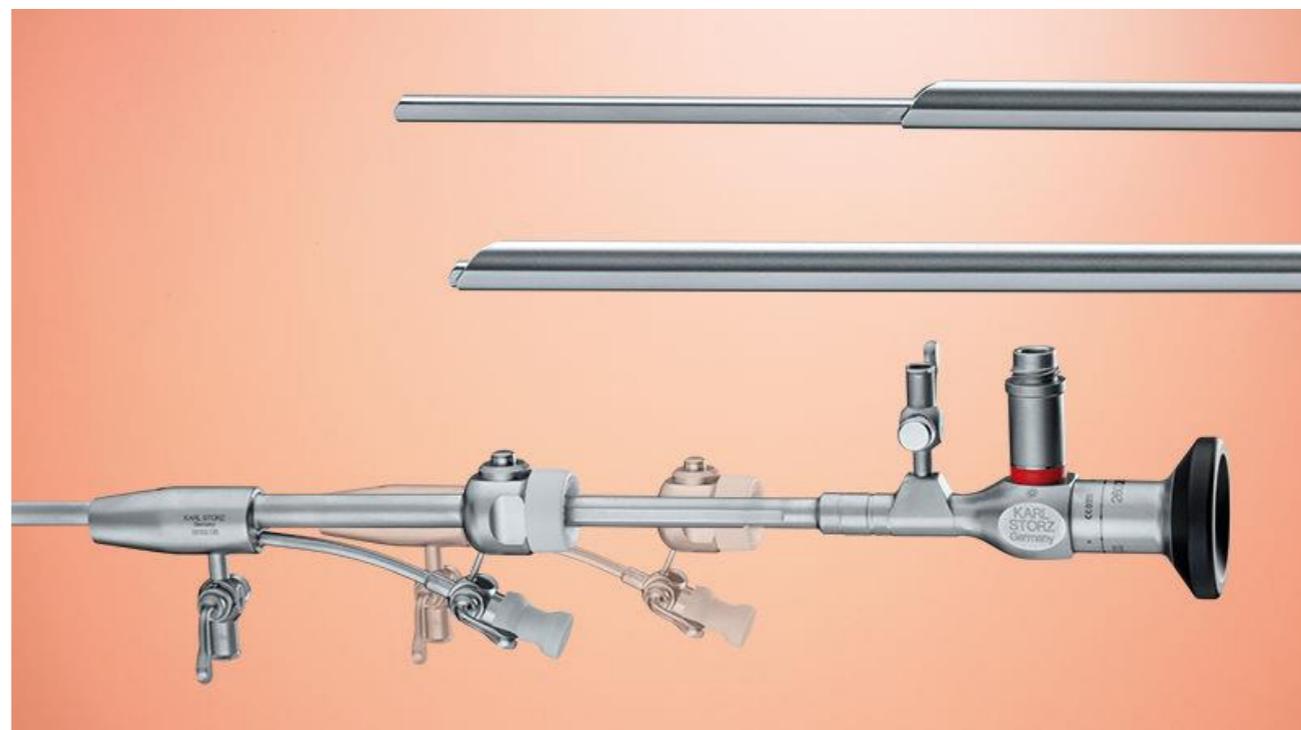
Đường kính ống soi :

2.9mm

3.7mm

4.4mm

Không cần nong cổ tử cung, do đó không cần gây mê/thuốc giảm đau



Hệ thống Phẫu thuật cơ học bảo toàn mô

CAMPO Compact Hysteroscope TROPHYscope®

Scissors



Biopsy forceps



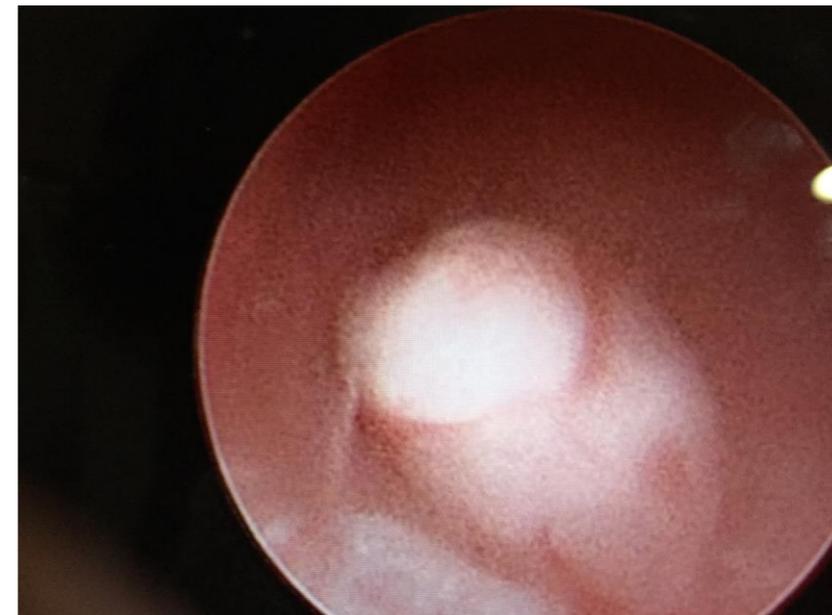
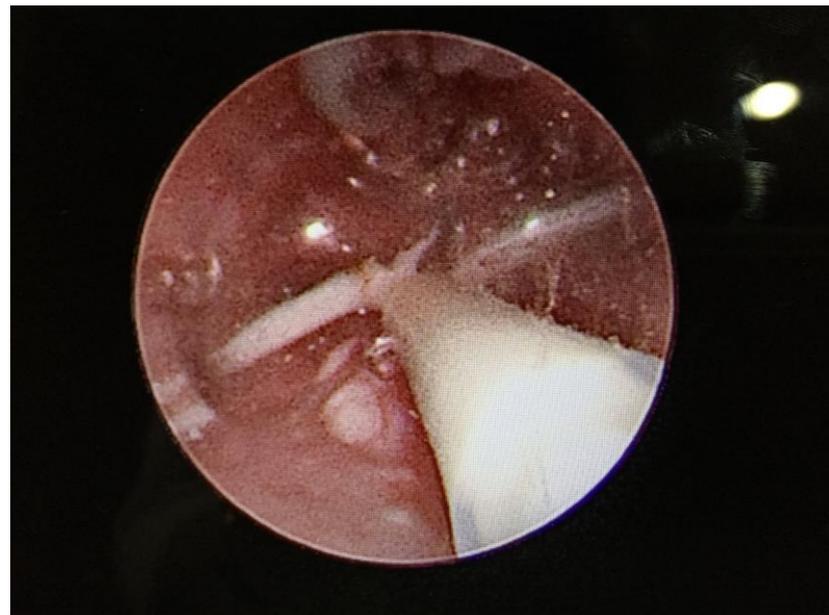
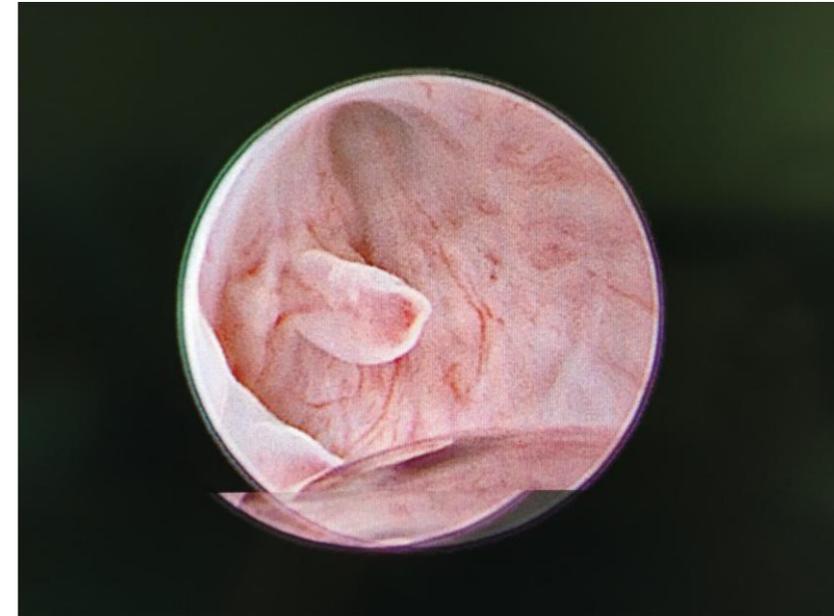
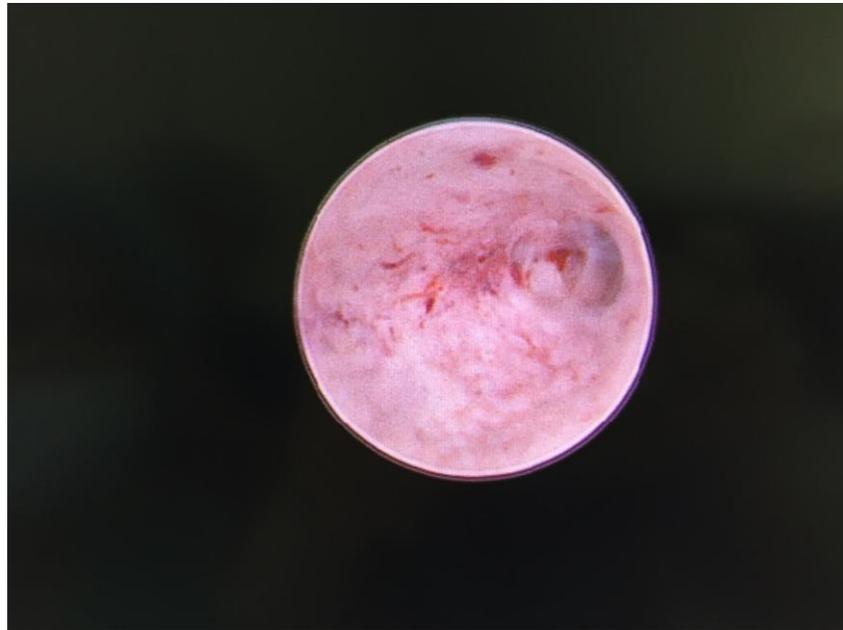
Grasper



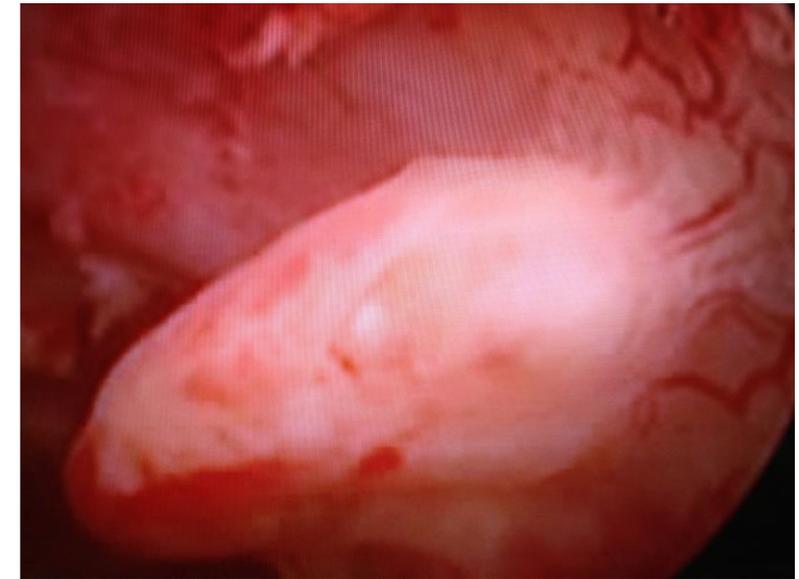
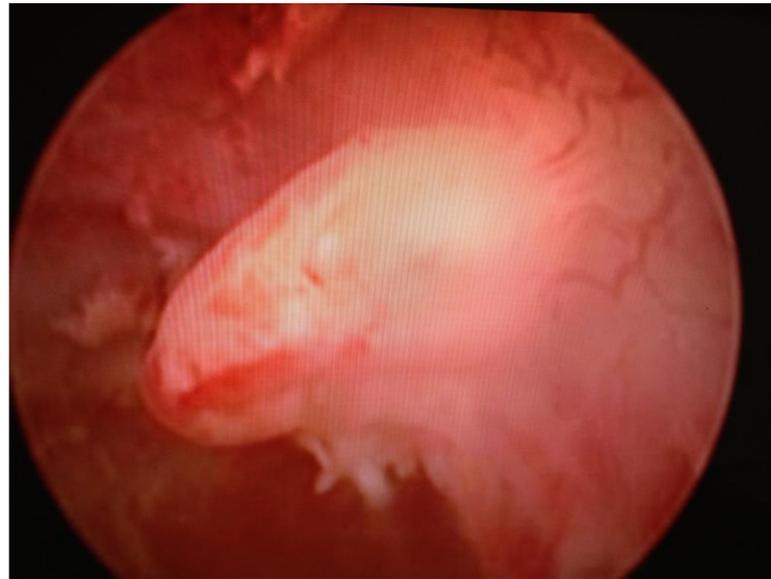
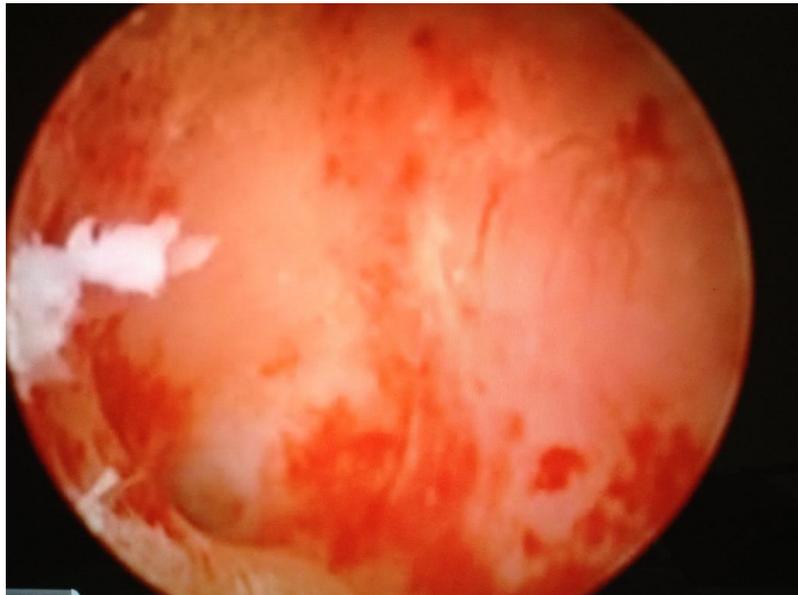
Ống soi cứng có thể sử dụng với kim lưỡng cực để cắt vách ngăn và loại bỏ bằng kim gấp

CAMPO Compact Hysteroscope TROPHYscope®

Chỉ định:



CAMPO Compact Hysteroscope TROPHYscope®



CAMPO Compact Hysteroscope TROPHYscope®

Video các ca khó

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 \leq 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).

Regression analysis showed a statistical significant correlation between VAS and size of polyps and between VAS and operating time independent to the number of polyps. Using the ROC analysis a VAS \leq 4 was obtained when polyps

were \leq 2 cm and/or time of the procedure lasted \leq 15 min. Menopausal status and previous vaginal deliveries were not significantly correlated to the VAS.

CONCLUSIONS:

Office-based hysteroscopic polypectomy is a safe and feasible procedure and should be addressed in patients with endometrial or isthmic polyps \leq 2 cm in diameter, and the procedure limits in terms of patient procedure compliance are size of polyps and operating time, 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:

University center.

PATIENTS:

Four thousand eight hundred sixty-three (4863) women.

INTERVENTION:

Office hysteroscopy without analgesia or anesthesia.

KEY WORDS: Hysteroscopy, Mechanical instruments.

We used 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. From 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, for which 63.6% experienced low or moderate pain. At 3-month follow-up,

pathology persisted in 364 patients (5.6%).

CONCLUSION:

Simple instruments enable us to perform many operative procedures in an office setting with

excellent patient satisfaction, provided that the indications are correct.

PMID: 15104833

[PubMed - indexed for MEDLINE]

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PMID: 15104833

[PubMed - indexed for MEDLINE]

SLMC QC experience

show data

Hệ thống Phẫu thuật cơ học bảo toàn mô

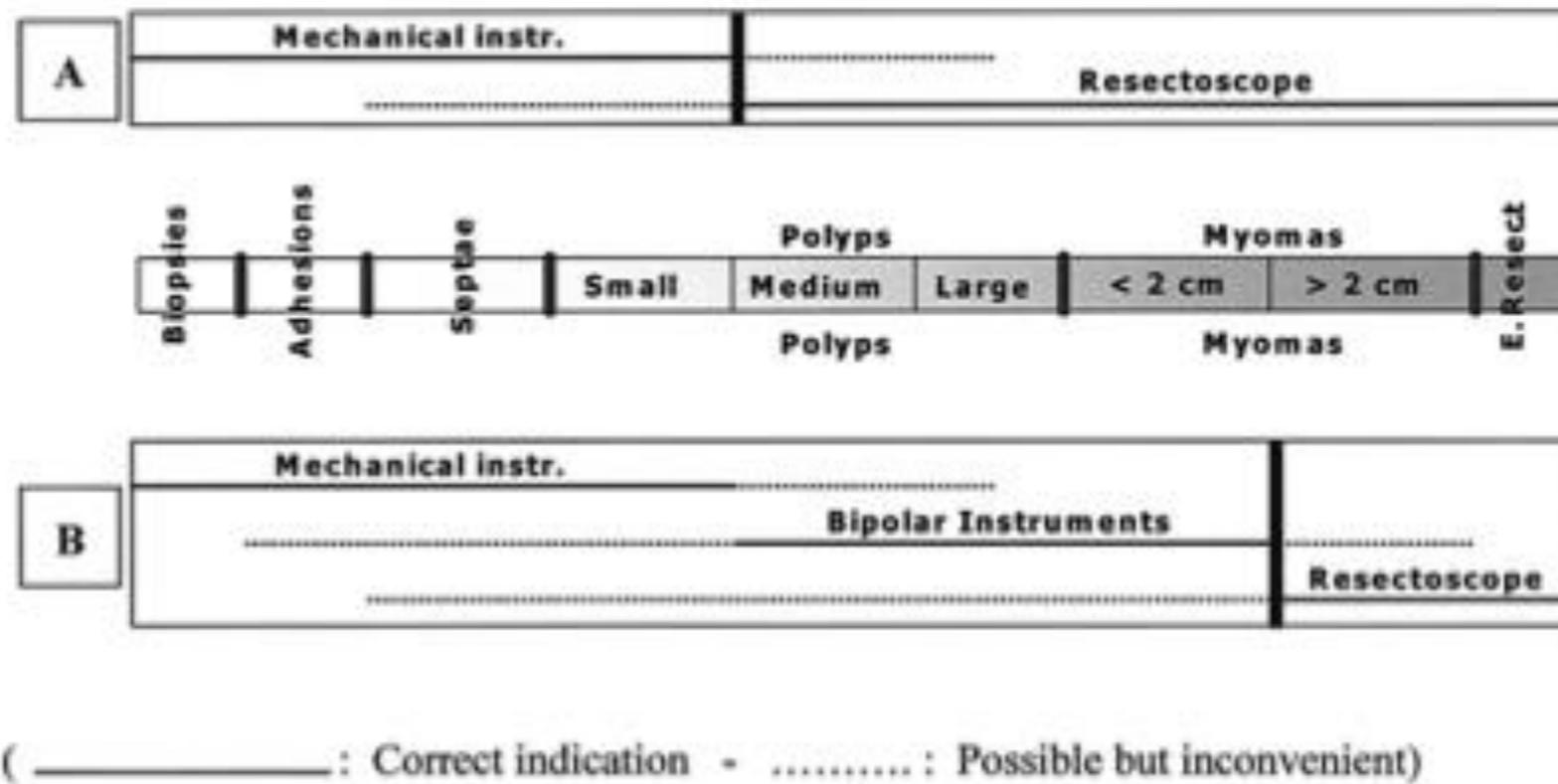


Figure 4. Scheme of our treatment indications for office operative hysteroscopic surgery, before (A) and after (B) 1998.

Máy bào trong tử cung BIGATTI - IBS

=Thiết bị cải tiến và hiệu quả
=Được đề xuất và có thể trở thành phương pháp thay thế cho cắt u xơ tử cung trong tương lai gần.

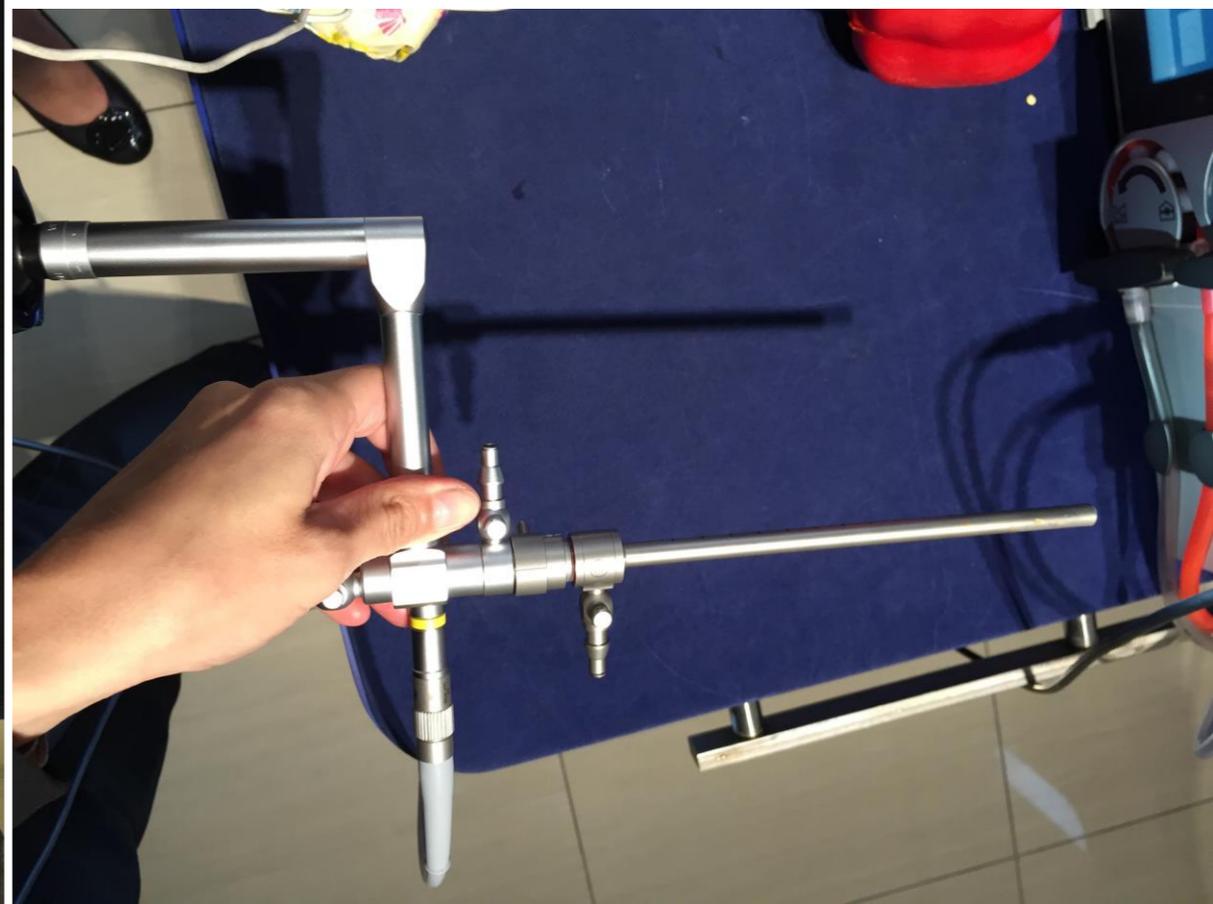
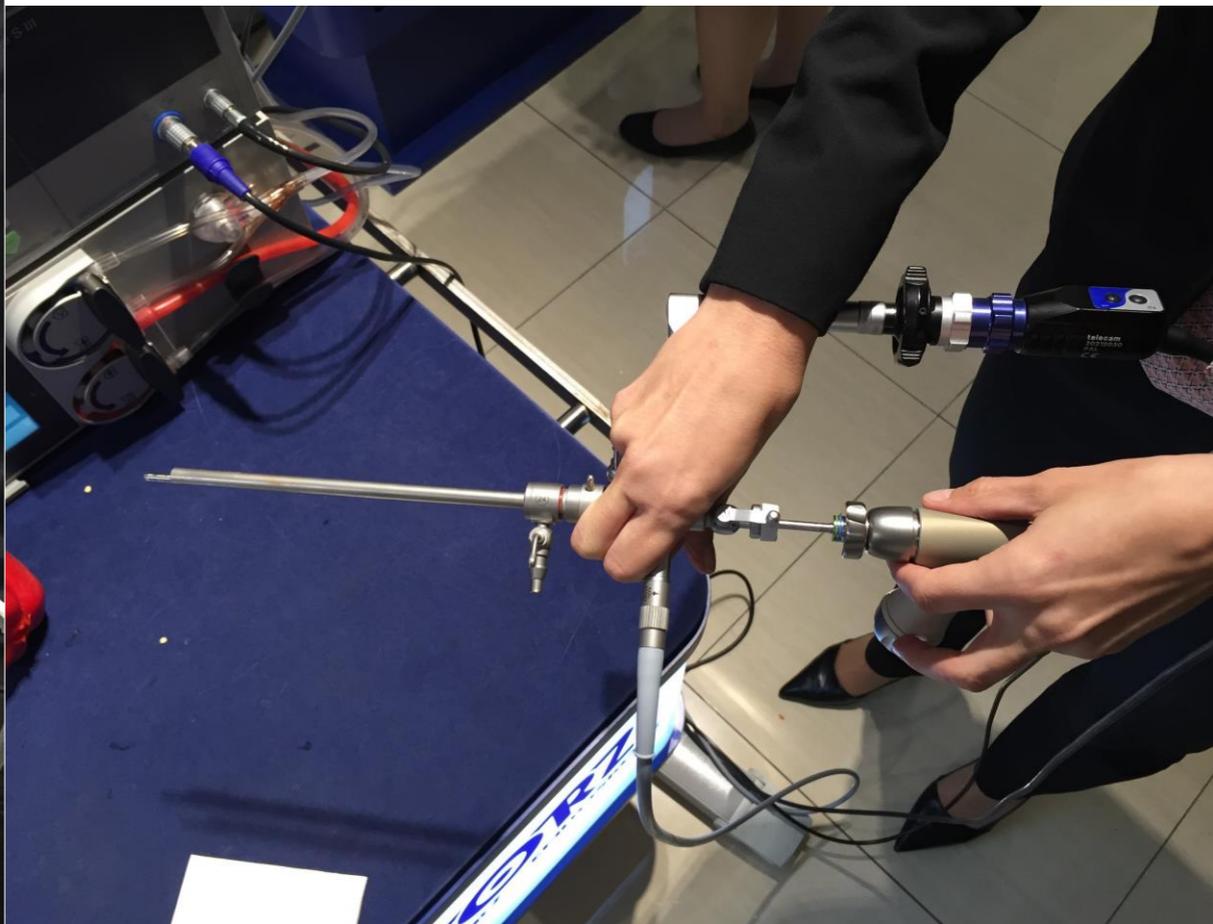
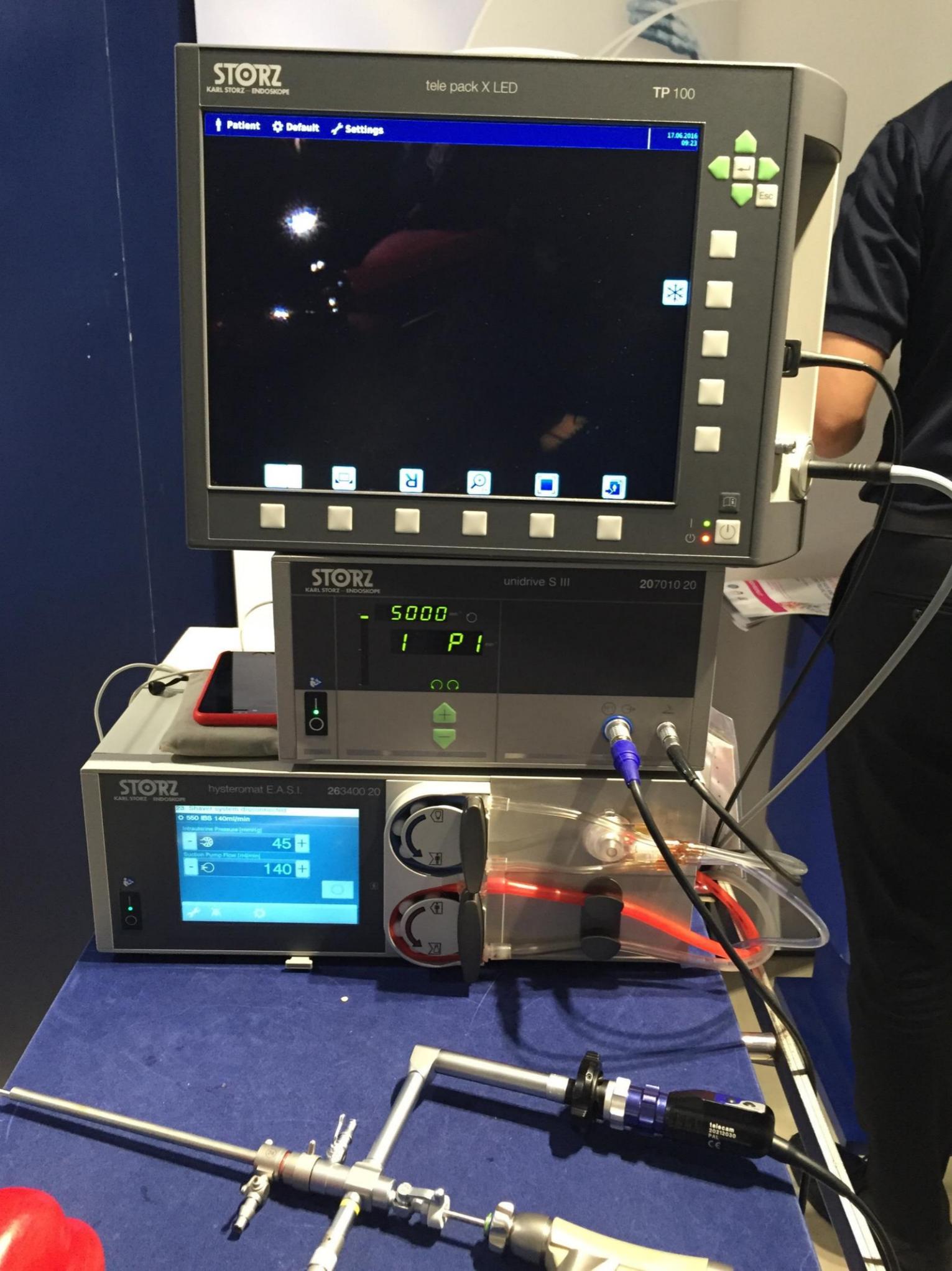
Emanuel và Wamsteker, 2005

Máy bào trong tử cung BIGATTI - IBS



Dịch tưới và hút liên tục cùng với mô bào

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



Máy bào trong tử cung BIGATTI -IBS



26208 SA

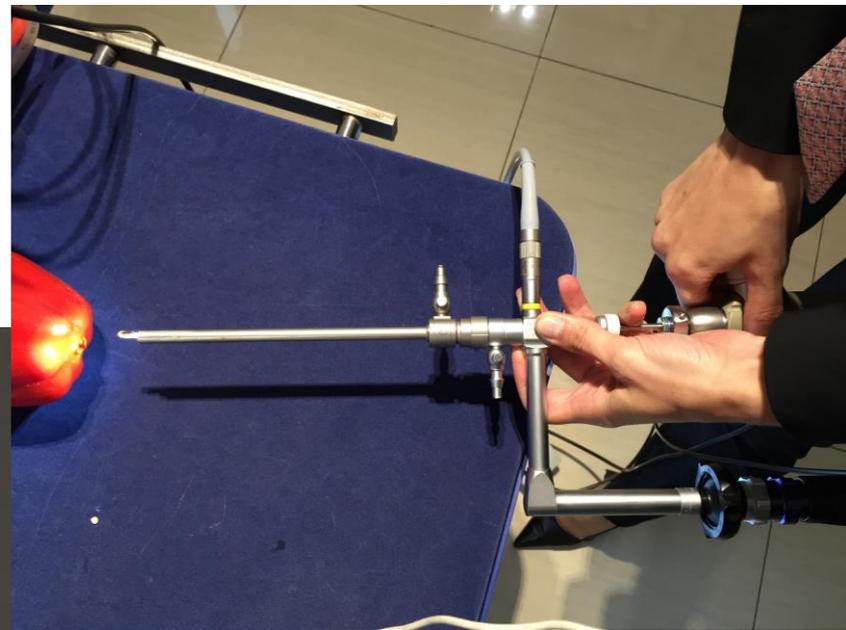
Shaver Blade GYN, straight, sterilizable, concave cutting edge, double serrated, oval cutting window, diameter 4 mm, length 32 cm, for use with DRILLCUT-X® II Handpiece **26 7020 50**, color code: blue-green



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

Lấy trực tiếp mô đã cắt thông qua kênh hút-
Đường kính ngoài Vỏ phẫu thuật 8mm(24 Fr)



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

Emanuel MH¹, 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

it in fewer fluid-related

Review of the complications after hysteroscopic myomectomy

=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 hysteroscopic 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
- ▶ Local anaesthetic into or around cervix reduces pain during hysteroscopy. Routine administration of **intracervical or paracervical LA** recommended in postmenopausal women
- ▶ **Conscious sedation** should **not** be routinely used in outpatient hysteroscopic procedures, it confers no advantage in terms of pain control and satisfaction over LA.
- ▶ **Vaginoscopy** reduces pain during diagnostic rigid outpatient hysteroscopy
- ▶ Routine cervical dilatation is associated with pain, vasovagal reactions and uterine trauma and should be avoided

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RCOG Green-top Guideline No. 59 (2011)

Thank You

