Chapter 38

Operative Hysteroscopy

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When a surgery is performed using a hysteroscope, it is called Operative Hysteroscopy.

Indications for operative hysteroscopy

1. **Fibroids**
   Submucous fibroids can be resected (removed) with an operative hysteroscope (Chapter 40).
2. **Polyps**
   Small growths that develop on the lining of the uterus that can cause irregular and heavy menses (Chapter 6)
3. **Intrauterine Adhesions**
   Scar tissues in the uterine cavity that may cause absent periods or infertility (Chapter 40).
4. **Missing Intrauterine Contraceptive Device (IUCD)**
   IUCD may be lost and this can be retrieved with a hysteroscope (Figure 37.1).
5. **Fallopian tube obstruction**
   When a fallopian tube is seen to be blocked via a hysterosalpingogram (HSG), a hysteroscopy can be performed and the fallopian tube can be cannulated (g) to open up the blocked tube. This may be performed with the assistance of laparoscopy (Figure 40.5,40.6 and 40.7)
6. **Uterine septum**
   Uterine septum may cause repeated miscarriage. A hysteroscopy can be performed to cut this uterine septum (Figure 40.3 and Figure 40.4))

Preoperative preparation

In some patients a preoperative injection of GnRH (gonadotrophin releasing hormone) analogue may be given for 1 - 3 months before the surgery. In patients whose cervical Os is believed to be narrow (tight) misoprostol tablets may be placed in the vagina a few hours before the surgery to soften the cervical Os so that it can be dilated easily.

How is Operative Hysteroscopy performed?

Operative hysteroscopy can be performed under spinal or general anaesthesia. The advantage of performing the procedure under spinal anaesthesia is that the patient is awake and complications such as fluid overload (eg cough) can be detected early. During the procedure, patient will be placed in a lithotomy position (legs up and apart) so that the surgeon can have access to the vagina. The perineum and vagina is cleaned with antiseptic solution and a drape is used to cover the legs and the abdomen, only exposing the perineum. The cervix is held with an instrument and the cervical Os will be dilated to permit the passage of an operative hysteroscope (the diameter of an operative hysteroscope is larger than that of a diagnostic hysteroscope). The surgeon than performs the surgery while looking at a video monitor. When the surgery is performed under spinal anaesthesia, the anaesthetist or a nurse will be constantly talking to the patient. At the end of the surgery, the legs will be brought down and the patient will be returned to the ward. If the surgery is performed under spinal anaethesia, she will experience a lack of sensation in the lower limbs for about 6 hours, after which that she may return home.

Advantages of Operative Hysteroscopy

There are only several conditions where surgery can be performed using a hysteroscope but if a surgery is performed in this manner, the patient has several benefits:

1. **There are no abdominal incisions**
   Both laparoscopic myomectomy and myomectomy by laparotomy will result in scar formation in the abdomen. No scars will be formed in the hysteroscopic resection of a fibroid.
2. **There are no incisions or scars in the uterus**
   In laparoscopic myomectomy and myomectomy by laparotomy, one or more incisions are made in the uterus to remove the fibroids. Such incisions will leave scars on the uterus. The presence of such scars may be a contraindication for normal vaginal delivery and the patient may have to undergo a caesarean delivery. When hysteroscopic resection of a fibroid is performed, there are no scars in the uterus and so when the patient conceives, she can undergo a normal vaginal delivery.
3. **Day surgery**
   This procedure can be performed as a day procedure. The patient will feel normal after the surgery. She can usually get back to work the next day.

Summary

Operative Hysteroscopy is performed under spinal/epidural or general anaesthesia. It has many advantages over surgery performed by laparotomy or laparoscopy.