

# Wider use of office flexible hysteroscopy urged

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SCOTTSDALE, ARIZ. -- To hear Dr. Keith Isaacson talk about it, you'd think that office-based flexible hysteroscopy is far and away the best means of getting a good look at a submucous myoma.

So why are only 3% of U.S. gynecologists doing office flexible hysteroscopy?

One reason why this technology hasn't been more widely embraced is that initially only rigid hysteroscopes were available. Inserting a rigid scope in an anteflexed uterus required a paracervical block, attachment of a tenaculum, and pulling on the tenaculum to straighten the uterus, a maneuver that's quite painful for the patient, he said at an international congress on uterine fibroids sponsored by the American Association of Gynecologic Laparoscopists.

Today only about 15% of U.S. gynecologists do office hysteroscopy of any kind--rigid or flexible. "When we have something that's good technology but it causes pain, it usually doesn't go anywhere," said Dr. Isaacson, who has received payments from hysteroscope manufacturers to lecture at hysteroscopy courses.

When flexible hysteroscopes came on the scene in the early 1990s, the quality of the images they produced was quite poor. Today the quality of images produced by flexible hysteroscopes is comparable with that of rigid scopes, said Dr. Isaacson of Harvard Medical School, Boston, and Newton-Wellesley Hospital in Newton, Mass.

The flexible scope's ability to bend to the shape of the uterus avoids much of the pain associated with the procedure. One study of 387 women who underwent flexible hysteroscopy with no anesthesia and no tenaculum found that 84% rated pain during the procedure as tolerable, acceptable, or easily accepted. Another 12% described the pain as barely tolerable, and 4% found it intolerable.

Another reason for the slow growth in office flexible hysteroscopy is that it's a "disruptive technology": one that starts with poorer quality than the standard technology and improves with time but takes 5-15 years to become accepted as the instrument of choice. "It takes a while to get out of the habit of doing blind D&Cs" to evaluate the uterine cavity of a woman with a suspected submucous myoma. With better methods available, D&Cs no longer should be performed just for evaluation, he said.

Among the other methods for diagnosing and categorizing submucous myomas, hysterosalpingogram is less sensitive and less specific than office hysteroscopy. The image obtained from diagnostic office hysteroscopy is exactly what's seen during treatment, providing information that cannot be procured through diagnosis with transvaginal ultrasound or

sonohysterography "We don't operate [on submucous fibroids] with ultrasound or with sonohysterography We operate with a hysteroscope, Dr. Isaacson said.

Diagnostic hysteroscopy helps with preoperative planning, allowing physicians to know what pathology awaits them and assemble the right tools to deal with it. They'll also be able to see whether the fibroid has tremendous vasculature or very few vessels, which can help determine whether to pretreat with a GnRH agonist before surgery.

The more intramural involvement is seen on hysteroscopy, the less likely that the entire fibroid can be removed in one myomectomy Patients can be better counseled about the likelihood that they may need a second procedure, which allows them to make a better-educated decision about which treatment to pursue.

Office flexible hysteroscopy does not require anesthesia or a paracervical block and is less painful than a Pipelle endometrial biopsy Many patients appreciate the ability to see their fibroids on the video monitor during the procedure, Dr. Isaacson said.

Flexible hysteroscopy takes about 40 seconds or about 10 minutes between the time the patient enters and leaves the exam room. It requires little physician training.

"Close to 100% of urologists look in the bladder with a flexible cystoscope in their office. We see more pathology in the uterus than they do in the bladder. There's no reason we shouldn't be using this technology more and more," he said.

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Together, a flexible hysteroscope, monitor, light source, camera, and cart cost \$12,000-\$15,000 at a minimum. In addition, "you'll probably want a video printer as well," Dr. Isaacson said.

Disposable supplies for office flexible hysteroscopy cost about \$6 per procedure for a 60-cc syringe, intravenous tubing, and a few other items. Any exam room easily can be used for the procedure, avoiding the costs and turnover issues associated with an operating room.

He uses the same CPT code and gets the same professional fee (around \$250 per case) for flexible hysteroscopy whether it's done in the office or operating room. In general, fees received for doing two office flexible hysteroscopies per month cover the cost of the lease-to-own agreement for the equipment. Fees from additional procedures are profit.

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