

Cervical preparation prior to outpatient hysteroscopy: Friend or foe? (Mini-commentary on BJOG-20-1841.R1)

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Mini-commentary on BJOG-20-1841.R1: Cervical dilatation and preparation prior to outpatient hysteroscopy: A systematic-review and meta-analysis

Cervical preparation prior to outpatient hysteroscopy: Friend or foe?

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The advent of outpatient hysteroscopy has revolutionised the diagnosis and management of uterine pathology by circumventing the need for general anaesthesia and its associated complications, reducing post-operative recovery time and decreasing the financial burden on the NHS. However, 12% of outpatient hysteroscopies fail, commonly due to pain from cervical stenosis, which is encountered frequently in nulliparous and post-menopausal women. (Genovese et al, *Eur J Obstet Gynecol Reprod Biol* 2020;245:193-197) Current RCOG guidance (*Best Practice in Outpatient Hysteroscopy 2011*) advises against routine cervical dilatation and notes that evidence for routine cervical priming before outpatient hysteroscopy is lacking.

De Silva *et al.* (*BJOG* 2020 xxxx) have provided a welcome update on current evidence for cervical preparation and dilatation prior to outpatient hysteroscopy. They included all randomised controlled trials of women undergoing outpatient hysteroscopy randomised to cervical preparation (misoprostol/ mifepristone/ carboprost/ dinoprostone) or dilatation compared to a control/placebo. The primary outcome was pain. Their systematic review and meta-analysis revealed that cervical preparation using vaginal misoprostol and dinoprostone significantly reduced pain during outpatient hysteroscopy compared to placebo, with premenopausal and nulliparous women being the most likely to benefit. Cervical priming with these agents also improved feasibility by providing easier hysteroscopic entry, greater cervical dilatation and shorter procedure times. Hysteroscopic approach following misoprostol administration showed significantly reduced pain scores when vaginoscopy was performed. Cervical preparation did, however, incur significantly more side-effects including genital tract bleeding, abdominal pain and gastrointestinal symptoms, and made no difference to clinician experience. Two thirds of studies reported a degree of bias, which is unsurprising given the nature of hysteroscopic procedures and the need for patient selection.

In light of the evidence, cervical preparation with vaginal misoprostol or dinoprostone should be considered in premenopausal and nulliparous women, and vaginoscopy without speculum performed where possible. Notably, there were no trials investigating mechanical dilatation, and future work on this topic is needed.

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