



Invited Editorial

The implications of hysteroscopy in the updated guidelines on heavy menstrual bleeding from the UK National Institute for Health and Care Excellence (NICE)

HIGHLIGHTS

- Heavy Menstrual Bleeding (HMB) is a common condition that significantly impacts on quality of life.
- Updated national guidelines recommend increased use of hysteroscopy in the management of HMB.
- This change will have a significant resource implication on service organisation.
- The acceptability of hysteroscopy to patients must be considered and steps taken to improve this.
- The guideline provides a benchmark, which should provide a catalyst for a dramatic drive for change.

Keywords:

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Heavy menstrual bleeding (HMB) affects a quarter of menstruating women. It significantly impacts on their well-being and accounts for 12% of all referrals to gynaecological services in the UK [1].

In 2014, the Royal College of Obstetrics and Gynaecology (RCOG) published the National HMB Audit to assess patient outcomes and experiences with HMB in England and Wales over a four-year period [2]. The study found that 30,000 women undergo surgical treatment for HMB annually, resulting in a substantial improvement in their symptoms and health-related quality of life [2]. The RCOG Standards for Gynaecology, released in 2008, stated that every NHS Trust should set out specific requirements relating to the management of HMB [2]. Now, ten years later, these standards are still relevant. Despite this recommendation, the National HMB audit found that only one-third of hospitals had a dedicated menstrual bleeding clinic [2].

The National Institute for Health and Care Excellence (NICE) published updated guidelines for the assessment and management of HMB in March 2018 [1]. One recommendation is to initiate pharmacological treatment without investigation in women whose only symptom is HMB [1]. A key change in the guideline is the new recommendation to offer outpatient hysteroscopy to all women with HMB where the history is suggestive of submucosal fibroids, polyps or endometrial pathology [1]. Importantly, “blind” endometrial biopsies should no longer be offered to women with symptoms of HMB [1]. The rationale behind the change is that current hysteroscopic techniques are more accurate in identifying endometrial pathology than pelvic ultrasound, with minimal complications [1]. Pelvic ultrasound should be considered as a first-line investigation in these women only if they decline hysteroscopy in any form, and they need to “understand and accept” that ultrasound is less diagnostic than hysteroscopy in this circumstance [1].

The NICE guidelines recognise that this will have a resource implication on service organisation and training, and this will lead to an increase in direct-access booking into one-stop hysteroscopy services. NICE feels delivery should extend into community-based clinics and eventually into primary care [1]. It points out that the increased cost of offering 10,000 more hysteroscopies annually, preferably at a one-stop clinic, would be offset by a reduced number of ultrasound scans and follow-up appointments [2,3]. In 2014, the National Heavy Menstrual Bleeding Audit reported that 80% of hospitals had access to ultrasound, hysteroscopy and endometrial biopsy but only 38% of hospitals had a dedicated menstrual bleeding clinic; 90% of these were one-stop clinics, and 30% had a local written HMB protocol [2]. Although this was four years prior to the NICE guidance update, over the four-year period of this audit, the organisation of clinical services for women with HMB had remained relatively stable [2]. In contrast, the NICE guidelines call for a meteoric shift in undertaking more hysteroscopic procedures and so escapes the practical realities that currently exist. This is the major concern from many clinicians. The British Society of Gynaecological Endoscopy (BSGE) ran an all-day meeting on the contemporary management of HMB following the publication of these guidelines, in part to discuss these concerns [4].

Another key issue is the patient's acceptance of this procedure; several studies have documented a favourable response particularly in the outpatient setting [3]. NICE also state that hysteroscopy is “acceptable to women if done according to best practice guidelines” [1]. This is a highly charged, emotive, subject for many women and this statement is felt by many to be contentious, so much so that patient advocacy campaign groups have formed. This has resulted in parliamentary debates on the topic over a number of years and multiple stories in national

newspapers [5]. The lay press and NICE both emphasise adhering to best practice guidelines [3]; this will understandably raise patient's satisfaction and so this should be the prime target. If this is achieved substantially, then the rise in procedures can follow. A hallmark of patient acceptability is lucid information and the offering of clear options. Thus the BSGE has cautioned that after being explicitly informed, women should be given the choice of none, local or general anaesthetic and that the procedure should be stopped at the request of the patient, nursing staff or clinician [4]. This, along with appropriate patient selection and counselling will hopefully continue to improve the patient experience.

Best practice includes techniques and equipment to minimise discomfort and pain during the procedure with no compromise in efficacy [1,3]. The advances in hysteroscopic technology are continuing. There are a wide range of scopes, allowing the clinician a greater range to suit the individual patient's unique circumstances. Vaginoscopy is being utilised increasingly with improved patient satisfaction [3]. Outpatient operative hysteroscopy using a morcellator devoid of electrosurgery can safely and effectively resect endometrial polyps and small serosal fibroids [3]. This allows the one-stop diagnostic clinic to also become treatment focused.

Another factor required to improve service provision is the appropriate use of human resources. Similar to colposcopy, nurse-led hysteroscopy clinics are already being run in some units. Trusts and the respective Directorates should be proactive and expansion of this service should be considered.

Worldwide, HMB has a major negative impact on women's health. Currently less resources are directed to this area as it fortunately rarely leads to mortality. The current NICE guidelines provide a benchmark, which should provide the catalyst for a dramatic drive for change. Along with this desire for change, the required resources must be provided by stakeholders. The overture by NICE towards wider implementation of diagnostic and operative hysteroscopy is a step in the right direction. Some time will be required to meet these recommendations but this should be as short as possible so that we as clinicians can provide the care that our patients deserve.

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